INSTRUCTIONS FOR COMPLETING/SUBMITTING THE BLUE CROSS BLUE SHIELD OF MICHIGAN DRUG CLAIM FORM

(PLEASE TYPE OR PRINT ALL ENTRIES)

CLAIMS FROM PARTICIPATING PHARMACIES SHOULD BE SUBMITTED ELECTRONICALLY FROM THE PHARMACIST. Please print the following information clearly in the appropriate areas on the claim form. If you are submitting more than one claim, each form must be filled out completely. However, you may now submit up to six receipts per patient on one claim form.

The **claim form** must contain the following information in order to be processed:

1. CONTRACT NUMBER.....Your nine-digit contract number on your Blue Cross and Blue Shield of Michigan (BCBSM) I.D. card.
   GROUP NUMBER.....The group number or description found on your I.D. card.
   COVERAGE/SERVICE CODE.....The service code or description found on your I.D. card.
   ENROLLEE/SUBSCRIBER LAST NAME, FIRST.....Your complete last name followed by first name.
2. PROVIDER NAME, ADDRESS & NABP #..... The name, address and NABP # of the pharmacy from which you purchased the drug. The NABP # is required and the pharmacy can provide it.
3. PATIENT'S NAME, BIRTHDATE, SEX AND.....Print patient's first name, birthdate, sex and mark the appropriate box to RELATIONSHIP TO SUBSCRIBER. identify patient's relationship to the subscriber.
4. OTHER INSURANCE..... If patient has other insurance besides BCBSM, mark YES and name the the company. If not, check NO.
5. DATE OF SERVICE.....Enter the date that the prescription was purchased.
   PRESCRIPTION NUMBER.....The prescription number as it appears on the prescription order.
   REFILL.....Enter "N" for original prescription or "Y" for refill.
   QUANTITY.....The quantity of the drug that you received from pharmacy (total number of pills).
   DAYS SUPPLY.....The number of days supply for which the prescription is dispensed (taking medicine for how many days).
   DI DISPENSING INDICATOR.....If doctor indicates on prescription dispense as written (DAW), mark "X" in the box. If not, leave blank.
   NATIONAL DRUG CODE..... Eleven-digit code which describes the drug dispensed. If you do not see this on your receipt, you will be able to obtain this information from the pharmacy.
   COMPOUND DRUG (CP).....Check here if compound drug.
   MEMBER PAID.....The cost of the member paid for the prescription.
6. Line 1.....The complete name of the drug.
7. SUBSCRIBER ADDRESS.....The complete address which is on file with Blue Cross and Blue Shield of Michigan.
8. RECIPIENT SIGNATURE.....Recipient of the prescription should sign in the space provided.
9. PHARMACIST'S SIGNATURE.....Sign in the space provided.

If you have another insurance plan which is primary, or are covered under Worker's compensation, please make sure to submit the claim for reimbursement to the correct carrier.

PLEASE MAKE SURE TO ATTACH A COPY OF YOUR PAID PRESCRIPTION RECEIPT TO THIS FORM

PLEASE COMPLETE A NEW CLAIM FORM FOR EACH PATIENT FOR EVERY (6) DRUG RECEIPTS

Your claim can not be processed if any of the above information (with the exception of the Refill, DI and CP fields) is missing from the **claim form.** Your claim will be returned for missing or incorrect information. If you are not sure what information to indicate on the claim form (ie: NABP #, Quantity, Days Supply, etc) the pharmacy can provide you with the information.

BENEFITS

The Blue Cross and Blue Shield of Michigan Prescription Drug Program will pay for insulin and all drugs that bear the legend "Caution: Federal Law prohibits dispensing drugs without a prescription," except those identified as exclusions. Disposable needles and syringes are benefits under the Diabetic Supply Provision of the Prescription Drug Program.

EXCLUSIONS

Under most contracts, the following are **NOT** Prescription Drug Program benefits. Please consult your benefit booklet if you have a question.

- Drugs for which the pharmacy customarily charges less than your co-pay amount.
- Contraceptives
- Devices or appliances of any type and other non-medicinal substances.
- Any experimental drug
- All drugs purchased over the counter, except insulin.
- Any covered drug which is entirely consumed at the time and place of service.
- All drug claims with dates of purchase in excess of twelve months.

☐ **FIRST SUBMISSION**

CONTRACT NUMBER		
GROUP NO.	COVERAGE/ SERVICE CODE	
ENROLLEE/SUBSCRIBER LAST NAME	FIRST	

PAYMENT TO SUBSCRIBER

☐ **SECOND SUBMISSION**

PHARMACY NAME		
STREET ADDRESS		
CITY	STATE	ZIP CODE
PROVIDE NO. / NABP #		

PLEASE COMPLETE ALL ITEMS ON FORM AND CONTACT PHARMACY FOR MORE INFORMATION IF NEEDED.

PATIENT'S FIRST NAME	DATE OF BIRTH MO DAY YEAR	PATIENT'S SEX M F	RELATIONSHIP TO SUBSCRIBER SELF SPOUSE DEP	OTHER INSURANCE YES NO NAME
		☐ ☐	☐ ☐ ☐	☐ ☐

LINE NO.	DATE OF SERVICE MO DAY YEAR	PRESCRIPTION NUMBER	REFILL	QTY.	DAYS SUPPLY	DI	NATIONAL DRUG CODE	CP	MEMBER PAID
1									
2									
3									
4									
5									
6									

LINE 1 (NAME OF DRUG)	LINE 2 (NAME OF DRUG)	LINE 3 (NAME OF DRUG)
LINE 4 (NAME OF DRUG)	LINE 5 (NAME OF DRUG)	LINE 6 (NAME OF DRUG)

PAYMENT FOR THE ABOVE PRESCRIPTION SERVICE WILL BE PAID TO THE SUBSCRIBER AND SENT TO THE ADDRESS ON FILE.

NAME OF SUBSCRIBER (PLEASE PRINT)

STREET ADDRESS OF SUBSCRIBER

CITY STATE ZIP CODE

CERTIFICATION STATEMENT

"I certify that the patient for whom this claim is made is an eligible member in the Blue Cross and Blue Shield of Michigan Drug Program, and that the prescription is for the sole use of that member. I hereby authorize the release of any information pertaining to claims under this contract from medical or pharmaceutical records determined to be necessary by Blue Cross and Blue Shield.

X _____
RECIPIENT SIGNATURE

PHARMACIST'S CERTIFICATION STATEMENT

I certify the amount noted above is my charge for the described service which was performed by me.

X _____
PHARMACIST'S SIGNATURE

KEEP A COPY FOR YOUR RECORDS. MAIL ORIGINAL CLAIM FORM TO:

ATTN: PHARMACY, MC B771
BLUE CROSS BLUE SHIELD OF MICHIGAN
PO BOX 500
DETROIT, MICHIGAN 48231-0500

AFTER YOU HAVE COMPLETED THE CLAIM FORM

Please review your claim form to be sure it is filled out correctly. This will enable us to process your purchases promptly.

- Make sure to tape a copy of your paid receipts from the pharmacy indicating the detailed information for the prescription dispensed to this form. Do not overlap receipts, or cover necessary information. If additional space is needed, please use a separate sheet of 8 1/2" x 11" paper - do not use the back of the sheet provided.
- Please contact the BCBSM Service Center telephone number noted on your BCBSM Identification card with questions.
- Mail to: Attn: Pharmacy, MC B771
  Blue Cross Blue Shield of Michigan
  P.O. Box 500
  Detroit, Michigan 48231-0500
- Keep a copy for your records.
- Our response will be sent to you as soon as possible.

PLEASE MAKE SURE TO ATTACH A COPY OF ALL YOUR RECEIPTS TO THE PAPER PROVIDED. IF ADDITIONAL SPACE IS NEEDED, PLEASE USE A SEPARATE SHEET OF 8 1/2" X 11" PAPER - DO NOT USE THE BACK.

TAPE (DO NOT STAPLE) COMPUTERIZED RECEIPTS OR ITEMIZED BILLS TO THE FRONT OF THIS PAGE ONLY

* Do not overlap receipts. If additional space is needed, please use a separate sheet of 8 1/2" x 11" paper. Do not use the back of this sheet

Rx 1

Tape Receipt Here

Rx 2

Tape Receipt Here

Rx 3

Tape Receipt Here

Rx 4

Tape Receipt Here

Rx 5

Tape Receipt Here

Rx 6

Tape Receipt Here

CLAIMS PAYMENT INQUIRY

Allow a minimum of 45 days from submission of original Claim for Payment before sending a follow-up, unless a payment or rejection notice was received. If you are questioning a partial payment or rejection, please contact your local BCBSM Customer Service Office for further information and inquiries. You will find the customer service number on the back of your card. Request for additional claim forms should be sent to:

Attn: L800
Blue Cross Blue Shield of Michigan
53200 Grand River
New Hudson, MI 48165-9801