Florida Blue

Prescription Drug Claim Form

DIRECTIONS:

1. Complete and sign claim form below. Use a separate form for each patient.
2. Attach Explanation of Benefits (if applicable) and Prescription Receipts.
3. Send completed Form & Pharmacy receipts to:
   PRIME THERAPEUTICS, LLC; P.O. Box 14430; Lexington, KY 40512-4430

I. POLICY HOLDER INFORMATION

POLICY HOLDER NAME (LAST, FIRST, MIDDLE)	MEMBER ID NUMBER H	DATE OF BIRTH (MM/DD/YYYY)
GROUP NUMBER		
STREET ADDRESS		SEX ☐ MALE ☐ FEMALE
CITY, STATE, ZIP CODE		

II. PATIENT INFORMATION **(Must be completed if patient is a dependent child or spouse.)**

PATIENT NAME (LAST, FIRST, MIDDLE)	DATE OF BIRTH (MM/DD/YYYY)	
ADDRESS (If different than member)	SEX ☐ MALE ☐ FEMALE	RELATIONSHIP ☐ SPOUSE ☐ CHILD ☐ DISABLED DEPENDENT CHILD
CITY, STATE, ZIP CODE		

III. GENERAL INFORMATION

A. Was condition related to an accident? ☐ YES ☐ NO Accident Date (MM/DD/YYYY) _____

If yes, was it related to: ☐ Auto Accident ☐ Workers' Comp ☐ Other _____

B. Is other insurance applicable to charge? ☐ YES ☐ NO

If yes, complete the information below. You must submit an Explanation of Benefits (EOB) for your claim to be processed.

Other Carrier Name _____ Policy # _____

Name of Policy Holder _____ Amount Paid By Other Insurance $ _____

IV. PHARMACY INFORMATION

The Pharmacy NCPDP number can be found on the pharmacy receipt, or may be obtained from the pharmacy.

PHARMACY NAME	NCPDP #	NPI #	PHONE
STREET ADDRESS	CITY, STATE, ZIP CODE		
PHARMACIST SIGNATURE		PHARMACIST LICENSE NUMBER	

V. PRESCRIPTION INFORMATION

Prescription receipts are required for processing. Cash register receipts are not acceptable. Ensure each receipt shows the information below. Ask your pharmacist to provide any missing information. A pharmacy patient history may be submitted in lieu of a receipt, but must be signed by the pharmacist.

- Patient Name
- Pharmacy Name and Address
- Drug Name and NDC#
- Fill Date
- Prescription Number
- Total Charge
- Days Supply
- Quantity
- Doctor Name and DEA#
- DAW (Dispense as Written Code)

VI. CERTIFICATION

I certify all information provided on this form and on the attached itemized statement to be true and correct to the best of my knowledge. I understand that any person who knowingly and with intent to injure, defraud or deceive any insurer, or files a statement of claim or application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

POLICY HOLDER/PATIENT SIGNATURE	DATE

Reason for mailing in claim: ☐ System not available at pharmacy ☐ My information not on file at pharmacy ☐ Non-participating pharmacy ☐ Pharmacy would not submit claim ☐ I had not received my Florida Blue card yet ☐ Extension of benefits ☐ MediScript ☐ Primary coverage is with another carrier (Attach Explanation of Benefits from primary carrier) ☐ Other _____