



**Questions about completing this form?**  
**Call 24 hours a day, seven days a week**  
 BlueJourney PPO 1-866-987-4213  
 BlueJourney HMO 1-800-779-6962  
 TTY: 711

**Mail your completed claim form(s) and original, detailed pharmacy receipts to:**  
 Capital BlueCross  
 PO Box 20970  
 Lehigh Valley, PA 18002-0970

# Medicare Part D Drug Claim Form

Please complete each section of this form.

## MEMBER INFORMATION

First name	
Last name	
Date of birth	___ / ___ / _____
Identification #	_____
Street address	
City	
State	Zip

**Your identification (ID) number is listed on your member ID card.**

## PHARMACY INFORMATION

Name		
Street address		
City	State	Zip

## OTHER HEALTH INSURANCE INFORMATION

If you have other pharmacy benefit insurance (i.e., auto) that covers this drug, please send copies of:

1. Both sides of your other health insurance card
2. The Explanation of Benefits (EOB) page that shows the amount paid, or the reason why coverage was denied.

## WHY ARE YOU SENDING THIS CLAIM?

Please check any of the reasons shown below, or write your own reason.

- I became sick or ran out of my medicine while traveling outside of my plan's service area (but still within the U.S.).
- I couldn't get a covered drug when I needed it because I couldn't find a 24-hour network pharmacy near me.
- The covered drug I needed is not usually stocked at a network retail (local) or home delivery pharmacy service.
- I couldn't use a network pharmacy because I was evacuated or displaced due to a federally-declared disaster or health emergency.
- I couldn't choose a network pharmacy because I received the covered drug while in an ER department, medical clinic, or other outpatient setting (i.e., same-day surgery).
- Other (explain)

.....  
 .....

**INSTRUCTIONS FOR COMPLETING THIS FORM**

- Part D payment rules say that your doctor must:
  - Have a valid 10-digit National Provider Identifier (NPI) number, *and*
  - Accept Medicare claims, *or*
  - Have filed forms to show he or she has asked for Medicare’s approval to write prescriptions.
- Use one claim form for each member and each pharmacy.  
(i.e., one member + two pharmacies = two forms. If two members each use two pharmacies = four forms)
- If you need more claim forms, visit [www.capitalbluemedicare.com](http://www.capitalbluemedicare.com), or call the member service number shown on your ID card.
- Do not use this form to submit charges for durable medical equipment.(i.e., blood glucose meter or test strips).
- Original, detailed pharmacy receipts are required. Not accepted: canceled checks or receipts that only show the amount paid.
- Before you send in your claim(s), be sure to make a copy of all forms and receipts.

**DRUG CLAIM INFORMATION**

Original pharmacy receipts are required. Please do not staple them to this form.

Receipts must show:

- |  |   |                                    |                                       |  |
|--|---|------------------------------------|---------------------------------------|--|
| <input type="checkbox"/> Pharmacy name | <input type="checkbox"/> Drug name      | <input type="checkbox"/> Quantity  | <input type="checkbox"/> NDC number   | <input type="checkbox"/> NPI number          |
| <input type="checkbox"/> Strength      | <input type="checkbox"/> Date purchased | <input type="checkbox"/> Drug cost | <input type="checkbox"/> Days’ supply | <input type="checkbox"/> Prescription number |

All the fields below must be completed in order to process your claim. If you need help finding the information, please ask your pharmacist.

**CLAIM FORM**

Example form

Rx number	0 0 0 0 0 6 0 1 1 4 8 1			<p>Your pharmacist can give you the national drug code (NDC) and your doctor’s national provider identifier (NPI) numbers.</p> <p><b>National Drug Code</b></p> <p><b>National Provider Identifier</b></p>
Date filled	1 0 / 0 1 / 2 0 1 6			
Quantity	60	Days’ supply	30	
Drug name	Name of Drug			
NDC number	0 0 1 8 6 5 0 2 2 2 8			
NPI number	9 2 1 5 2 4 1 1 6 3			
Total cost of drug	\$146.04	Amount you paid	\$36.57	

Claim 1

Rx number	_____			<p>Your pharmacist can give you the national drug code (NDC) and your doctor’s national provider identifier (NPI) numbers.</p> <p><b>National Drug Code</b></p> <p><b>National Provider Identifier</b></p>
Date filled	__ / __ / ____			
Quantity		Days’ supply		
Drug name				
NDC number	_____			
NPI number	_____			
Total cost of drug		Amount you paid		

## Claim 2

Rx number	_____	<i>Your pharmacist can give you the national drug code (NDC) and your doctor's national provider identifier (NPI) numbers.</i> <b>National Drug Code</b> <b>National Provider Identifier</b>
Date filled	___/___/___	
Quantity	_____ Days' supply	
Drug name	_____	
NDC number	_____	
NPI number	_____	
Total cost of drug	_____ Amount you paid	

## COMPOUND DRUG INFORMATION

A compound drug is made of two or more drugs that are combined. If you are taking a compound drug, your pharmacist needs to enter the NDC numbers for all the ingredients used.

NDC number	Drug ingredient	Quantity	Cost

## MEMBER CERTIFICATION

Your signature below certifies that:

- The information on this form is correct
- The member named above is eligible for pharmacy benefits
- The member named above received the drug(s) listed
- These benefits have not been assigned; any further assignment is void
- I give my permission to share the details of this form with Prime Therapeutics LLC

Member or legal representative signature \_\_\_\_\_

Date \_\_\_\_\_

## OTHER RESOURCES



**1-800-MEDICARE (1-800-633-4227)**

TTY/TDD: 1-877-486-2048

Calls answered 24 hours/day,  
7 days/week, except on federal holidays.



**Health Care Insurance Fraud Hotline:**

1-800-706-4071

TTY/TDD 1-800-693-3816

Monday through Friday, 8 a.m. to 5 p.m. CT.

It is a crime to knowingly give false information or submit a fraudulent claim to get paid for a benefit. It is a crime to give false information on an insurance application. If convicted, the person may have to do any or all of the following: pay the money back, pay a fine, and/or serve time in prison.

Fraud increases the cost of health care for all of us. If you know of (or suspect) any type of health insurance fraud, please call one of the hotline numbers listed above. You don't need to give your name; all calls are confidential.

## DISCLAIMER

BlueJourney PPO is offered by Capital Advantage Insurance Company® and BlueJourney HMO is offered by KeyStone Health Plan® Central, subsidiaries of Capital BlueCross. All are independent licensees of the BlueCross BlueShield Association. Communications issued by Capital BlueCross in its capacity as administrator of programs and provider relations for all companies.

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**Capital BlueCross provides free aids and services to people with disabilities or whose primary language is not English, such as:**

- ✓ Qualified sign language interpreters.
- ✓ Written information in other formats (large print, audio, accessible electronic format, other formats).
- ✓ Qualified interpreters, and information written in other languages.

If you need these services, call 800.962.2242 (TTY: 711).

If you believe that Capital BlueCross has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator. You can file a grievance in person or by mail, fax, or email at:

### Capital BlueCross

PO Box 779880, Harrisburg, PA 17177-9880

800.417.7842 (TTY: 711), fax: 855.990.9001

**CRC@capbluecross.com**

If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue, SW., Room 509F, HHH Building  
Washington, D.C. 20201

Toll-free: 800.368.1019, 800.537.7697 (TDD)

Complaint forms are available at <https://www.hhs.gov/ocr/office/file/index.html>.

### Language assistance

To talk to an interpreter in your language at no cost, call 800.962.2242 (TTY: 711).

Para hablar con un intérprete de forma gratuita, llame al 800.962.2242 (TTY: 711).

欲免费用本国语言洽询传译员 · 请拨电话 800.962.2242 (TTY: 711).

Để nói chuyện với thông dịch viên bằng ngôn ngữ của quý vị không phải mất phí, xin gọi 800.962.2242 (TTY: 711).

Для бесплатного разговора с переводчиком на своем языке, позвоните по тел.: 800.962.2242 (TTY: 711).

Fa koschdefrei schwetze mit me dolmetscher in deinre Schrooch, ruf 800.962.2242 uff (TTY: 711).

무료 전화통역 서비스 800.962.2242 (TTY: 711).

Per parlare con un interprete nella vostra lingua gratis, chiami 800.962.2242 (TTY: 711).

للتحدث مجاناً إلى مترجم للغتك، يرجى الاتصال بـ 800.962.2242 (الهاتف النصي: 711)

Pour parler à un interprète dans votre langue sans charges, téléphoner à 800.962.2242 (TTY: 711).

Um in Ihrer Sprache gebührenfrei mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 800.962.2242 an (TTY: 711).

ငွေမပါဘဲ ချစ်ခင် နားထောင်ပေးပေးရန်အတွက် 800.962.2242 (TTY: 711) နှင့် ချစ်ခင် နားထောင်ပါ။

Aby porozmawiac z tłumaczem w języku polskim, prosze zadzwonic na numer darmowy telefonu 800.962.2242 (TTY: 711).

Pou pale avèk yon entèprèt nan lang ou grastis, rele nan 800.962.2242 (TTY: 711).

ដើម្បីនិយាយជាមួយអ្នកបកប្រែផ្ទាល់មាត់ជាភាសារបស់អ្នកដោយមិនគិតថ្លៃ សូមហៅទៅកាន់ 800.962.2242 (TTY: 711).

Para falar com um intérprete em seu idioma de graça, ligue para 800.962.2242 (TTY: 711).

C-572 (11/30/18)