

Prescription Drug Claim Form



Member information (See other side for instructions)

ID number

Group number

Date of birth / / Male Female

Name (First, Last)

Street address

City State Zip

Member's relationship to primary cardholder:

- Self Spouse/Domestic partner Dependent/Child

I certify that:

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

X

Member or legal representative signature

Is this medicine for an on-the-job-injury? Yes No

Do you have other insurance for this prescription medicine? Yes No

If yes, what is the other insurance company's name?

Cardholder information (primary cardholder)

Name (First, Last)

Why are you submitting this Prescription Drug Claim Form?
(check one)

- Did not have my pharmacy card with me when I bought this prescription
- Have not received my pharmacy card
- Picked up my medicine from a non-network pharmacy
- My other insurance is paying for part of this medicine (attach that company's Explanation of Benefits and an itemized receipt)
- Other (please explain) _____

Pharmacy information

Pharmacy name

Pharmacy address

City State Zip

X

Pharmacist signature

Pharmacy NPI number

Prescription (Rx) claim information

Was this prescription medicine purchased outside the U.S.? Yes No

All fields below must be completed. (See example on the back of this form.) Talk to your pharmacist if you need help.

Please attach itemized pharmacy receipts to the back of this form.

Claims are subject to your plan's limits, exclusions and provisions.

If you are requesting reimbursement for a COVID home test kit, a cash register receipt is valid. For these test kits there may not be an Rx#, leave blank, the rest of the information is required. An NDC or UPC code can be used.

IMPORTANT: Your signature is required that you attest that these test kits are not being used for testing required by your employer, return to work, travel, attending recreational event requirements and will not be resold.

Signature _____

1 Rx number

Date filled / /

Quantity _____ Days' supply

Name of medicine _____

NDC number

(Your pharmacist can provide the national drug code (NDC) and national provider identifier (NPI) numbers.)

Physician NPI number

(Does not apply for COVID home tests)

Prescription cost \$.

Balance due \$.

Instructions

1. Use a separate claim form for each member and prescription. All information provided on or attached to this claim form must be for the same person/prescription.
2. Attach original itemized pharmacy receipts provided with your prescription. Be sure that all the required information is visible (staple to the top of the form, if necessary). Note: your claim will be sent back if required information is missing.

Required information

- Member name
- ID number
- Group number
- Date of birth
- Pharmacy name and address
- Total charge
- Drug name and NDC number
- Physician NPI number
- Quantity
- Date filled
- Rx number
- Days' supply
- All compound drug information (if applicable)
- Pharmacy NPI number

Questions?

- You can call the number on the back of your member ID card
 - Your pharmacist may call 800.821.4795
3. Send this completed form with itemized receipts to:

Prime Therapeutics
 Mail route Commercial
 PO 25136
 Lehigh Valley, PA 18002-5136

EXAMPLE

Rx number

Date filled

Quantity Days' supply

Name of medicine Drug Name

NDC number
(Your pharmacist can provide the national drug code (NDC).)

Total prescription charge \$

Is this prescription claim for a compound medicine?
 Yes No

Note: If yes, ask your pharmacist to complete the information below.

Compound Information

Please enter all information for each drug used.

Compound Prescriptions

For pharmacy use only

NDC Number	Drug Ingredient	Quantity	Charge

Rx 1

Attach original itemized pharmacy receipts here

All required information must be visible (see step 2 above).

Keep a copy of this form and your receipt(s) for your records.

Fraud Prevention Regulation: Any person who knowingly and with intent to defraud any health plan or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent health plan act, which is a crime and subjects such person to criminal and civil penalties.

Prime Therapeutics LLC is an independent limited liability company providing pharmacy benefit management services.

Horizon Blue Cross Blue Shield of New Jersey complies with applicable Federal civil rights laws and does not discriminate against nor does it exclude people or treat them differently on the basis of race, color, gender, national origin, age, disability, pregnancy, gender identity, sex, sexual orientation or health status in the administration of the plan, including enrollment and benefit determinations. Horizon BCBSNJ provides free aids and services to people with disabilities (e.g. qualified sign language interpreters and information in other formats) and to those whose primary language is not English (e.g. information in other languages) to communicate effectively with us.

Contacting Member Services

Please call Member Services at **1-800-355-BLUE (2583) (TTY 711)** or the phone number on the back of your member ID card, if you need the free aids and services noted above and for **all other Member Services issues**.

Filing a Section 1557 Grievance

If you believe that Horizon BCBSNJ has failed to provide the free communication aids and services or discriminated against you for one of the reasons described above, you can file a discrimination complaint also known as a Section 1557 Grievance. **Horizon BCBSNJ's Civil Rights Coordinator** can be reached by calling the Member Services number on the back of your member ID card or by writing to the following address: **Horizon BCBSNJ**

Civil Rights Coordinator
PO Box 820, Newark, NJ 07101.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, through the Office for Civil Rights Complaint Portal, online at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf> or by mail at **U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201** or by phone at **1-800-368-1019** or **1-800-537-7697** (TDD). OCR Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

Language assistance

Si habla un idioma diferente al inglés, hay ayuda disponible gratis. Llame al número que aparece al reverso de su tarjeta de identificación.

如果您讲英语以外的语言，可获取免费帮助。请拨打您的身份证背面的号码。

영어 이외의 언어를 사용하는 경우, 무료 지원 서비스를 받을 수 있습니다. ID 카드 뒷면에 있는 번호로 전화하십시오.

Se você fala um idioma diferente do inglês, a ajuda está disponível gratuitamente. Ligue para o número no verso do seu bilhete de identidade.

જો તમે અંગ્રેજી સિવાયની ભાષા બોલતા હોવ, તો મફતમાં મદદ ઉપલબ્ધ છે. તમારા આઈડી કાર્ડની પાછળ આપેલા નંબર પર કોલ.

Jeśli mówisz w języku innym niż angielski, pomoc udzielana jest bezpłatnie. Zadzwoń pod numer podany na odwrocie dowodu osobistego.

Se parli una lingua diversa dall'inglese, è disponibile un servizio di assistenza gratuito. Chiama il numero sul retro della tua carta d'identità.

Kung nagsasalita ka ng isang wika maliban sa Ingles, magagamit ang tulong nang walang bayad. Tumawag sa numerong nasa likod ng iyong ID card.

Если вы не говорите по-английски, вам помогут бесплатно. Позвоните по телефону, указанному на обратной стороне вашей ID-карты.

Si ou pale on lòt lang ke Anglè, gen èd ki disponib gratis. Rele nan nimewo ki ekri nan do kat idantifyan w lan.

यदि आप अंग्रेज़ी से भिन्न कोई अन्य भाषा बोलते हैं, तो निःशुल्क सहायता उपलब्ध है। अपने आईडी कार्ड के पीछे दिए गए नंबर पर .

Nếu bạn nói ngôn ngữ khác ngoài tiếng Anh, thì chúng tôi có thể giúp bạn miễn phí. Hãy gọi số ở mặt sau thẻ ID của bạn.

Si vous parlez une langue autre que l'anglais, l'aide est gratuite. Appelez le numéro au dos de votre carte d'identité.

إذا كنت تتحدث لغة أخرى غير الإنجليزية، نوفر لك المساعدة مجانًا. يُمكنك الاتصال بالرقم الموجود على ظهر بطاقة الهوية
اگر آپ انگریزی کے علاوہ کوئی دوسری زبان بول سکتے ہیں تو مفت مدد دستیاب ہے۔ براہ مہربانی شناختی کارڈ کی پچھلی طرف درج شدہ نمبر پر کال کریں۔