

Prescription Drug Reimbursement Form



See the back for instructions. Complete all information.
An incomplete form may delay your reimbursement.

Member/Subscriber Information *See your BCBSM ID card.*

RxGroup No. **B C B S M R X 1**

Contract/
Enrollee ID#

Enter your 9-digit numeric Contract/Enrollee ID# only; do not include the alpha prefix. The Contract/Enrollee ID# is found on your BCBSM ID card.

Contract/Enrollee Name (First, Last)

Street Address

City

State/Province

Zip/Postal Code

Country

Daytime phone #

Patient Information

Patient Name (First, Last)

Patient Date of Birth (Month/Day/Year)

Sex

Relationship to Plan Member

- | | | |
|---------------------------------|----------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Female | <input type="checkbox"/> 1 Self | <input type="checkbox"/> 5 Disabled Dependent |
| <input type="checkbox"/> Male | <input type="checkbox"/> 2 Spouse | <input type="checkbox"/> 6 Dependent Parent |
| | <input type="checkbox"/> 3 Eligible Child | <input type="checkbox"/> 7 Nonspouse Partner |
| | <input type="checkbox"/> 4 Dependent Student | <input type="checkbox"/> 8 Other |

Pharmacy Information

Name of Pharmacy

Street Address

City

State

Zip

Telephone (include area code)

Is this an on-site nursing home pharmacy? Yes No

Acknowledgment

I certify that the medication(s) described above was received for use by the patient listed above, and that I (or the patient, if not myself) am eligible for prescription drug benefits. I also certify that the medication received was not for an on-the-job injury or covered under another benefit plan. I recognize that reimbursement will be paid directly to me, and that assignment of these benefits to a pharmacy or any other party is void.

X

Signature of Member

Date

CF11254 MAY 10 CF79477A



Medco is an independent company that provides pharmacy services for Blue Cross Blue Shield of Michigan.

Claim Receipts

Tape receipts or itemized bills on the back.
See back for details.

Check the appropriate box if any receipts or bills are for a:

- Compound prescription**
Make sure your pharmacist lists ALL the VALID 11-digit NDC numbers and ingredients and quantities on the receipt or bill.
- Medication purchased outside of the United States**
Please indicate:
Country _____
Currency used _____

Coordination of Benefits

Please indicate:

Secondary group name _____

Secondary group number (if present on ID card) _____

See back for more information

Any person who knowingly and with intent to defraud, injure, or deceive any insurance company, submits a claim or application containing any materially false, deceptive, incomplete or misleading information pertaining to such claim may be committing a fraudulent insurance act which is a crime and may subject such person to criminal or civil penalties, including fines and/or imprisonment, or denial of benefits.*

**Please tape receipts on the back.
Keep a copy for your records.**

