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

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**

- **2016 Part D payment rules say that your doctor must:**
  a. Have a valid 10-digit National Provider Identifier (NPI) number, and  
  b. Accept Medicare claims, or  
  c. 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 MyPrime.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:

- Pharmacy name  
- Drug name  
- Quantity  
- NDC number  
- NPI number  
- Strength  
- Date purchased  
- Drug cost  
- Days’ supply  
- 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

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

Claim 1

<table>
<thead>
<tr>
<th>Rx number</th>
<th>___________________</th>
<th>Date filled</th>
<th>___________________</th>
<th>Your pharmacist can give you the national drug code (NDC) and your doctor’s national provider identifier (NPI) numbers.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quantity</td>
<td>___________________</td>
<td>Days’ supply</td>
<td>___________________</td>
<td>National Drug Code</td>
</tr>
<tr>
<td>Drug name</td>
<td>___________________</td>
<td></td>
<td>___________________</td>
<td>National Provider Identifier</td>
</tr>
<tr>
<td>NDC number</td>
<td>___________________</td>
<td></td>
<td>___________________</td>
<td></td>
</tr>
<tr>
<td>NPI number</td>
<td>___________________</td>
<td></td>
<td>___________________</td>
<td></td>
</tr>
<tr>
<td>Total cost of drug</td>
<td>$______</td>
<td>Amount you paid</td>
<td>__________</td>
<td></td>
</tr>
</tbody>
</table>

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Claim 2

<table>
<thead>
<tr>
<th>Rx number</th>
<th>Date filled</th>
<th>Quantity</th>
<th>Days’ supply</th>
<th>Drug name</th>
<th>NDC number</th>
<th>NPI number</th>
<th>Total cost of drug</th>
<th>Amount you paid</th>
</tr>
</thead>
</table>

Your pharmacist can give you the national drug code (NDC) and your doctor’s national provider identifier (NPI) numbers.

National Drug Code
National Provider Identifier

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.

<table>
<thead>
<tr>
<th>NDC number</th>
<th>Drug ingredient</th>
<th>Quantity</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

Blue Cross and Blue Shield of North Carolina is a HMO/PPO/PDP plan with a Medicare contract. Enrollment in Blue Cross and Blue Shield of North Carolina depends on contract renewal.
Multi-language Interpreter Services

**English:** ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call the Customer Services number on the back of your member ID card.

**Spanish:** ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame a Servicio de Atención al Cliente al número que figura al dorso de su tarjeta de identificación.

**Chinese:** 注意：如果您講廣東話或普通話，您可以免費獲得語言援助服務。請撥打您的會員ID卡背面的客服部電話號碼。

**Vietnamese:** CHÚ YÊU: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số Dịch vụ khách hàng trên mặt sau thẻ thành viên ID của bạn.

**Korean:** 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 가입자 ID 카드 뒷면에 있는 고객 서비스 전화번호로 전화해 주십시오.

**French:** ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Téléphonez le Service clients au numéro qui figure au dos de votre carte de membre.

**Arabic:** ملاحظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوفر لك بالمجان. اتصل برقم خدمة العملاء الموضح على ظهر بطاقة هوية العضو الخاصة بك.

**Hmong:** LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau tus nab npawb xovtooj ntawm Lub Chaw Pab Cuam Tswv Cuab uas nyob sab tom qab koj daim npav tswv cuab ID.

**Russian:** ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Позвоните в Отдел обслуживания по номеру, указанному на оборотной стороне вашей карточки участника.

**Tagalog:** PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tawagan ang numero ng Serbisyo sa Kostumer sa likod ng Id kard ng miyembro.

**Gujarati:** સૂચના: તમે ગુજરાતી બોલતા હોવ તો તમારા માટે ભાષા સેવાઓ મુકાલ્મ ઉપલબ્ધ છે. તમારા સભ્યપદા કાર્ડના પીછે પણ સેવાસેવાના નંબર પર કોલ કરો.

**Khmer:** បានស្វែងរកលែងក្នុងការគ្រប់គ្រងការនូវភាសានៃអ្នកសម្រាប់សិល្បៈ េូរការមុនក្នុងការបញ្ជាក់ការជួយឯកសារ និងការជួយប្រការ ដែលមានលក្ខណៈជាការសម្រេចក្នុងការជួយអ្នកទាំងអស់។

**German:** ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufen Sie die Nummer des Kundenservice an, die auf der Rückseite Ihrer Mitglieds-ID-Karte angegeben ist.

**Hindi:** ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। अपने सदस्य आईडी कार्ड के पीछे मौजूद ग्राहक सेवाएं, नंबर पर कॉल करें।

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Multi-language Interpreter Services

Lao: ลือระข่วน ทุกดำเนินการด้านการบริการ มีการบริการทุกกลุ่มรายได้ด้านการพิการถ้วน ให้เกิดการตอบสนองที่เป็นประโยชน์ต่อผู้ใช้แน่นอน

Japanese: 注意事項： 日本語を話される場合、無料の言語支援をご利用いただけます。メンバードカードの裏面のカスタマーサービス番号にお電話ください。

Blue Cross and Blue Shield of North Carolina is an HMO and PPO plan with a Medicare contract. Enrollment in Blue Cross and Blue Shield of North Carolina depends on contract renewal.
Non-Discrimination and Accessibility Notice

Discrimination is Against the Law

• Blue Cross and Blue Shield of North Carolina ("BCBSNC") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.
• BCBSNC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

BCBSNC:
• Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  • Qualified interpreters
  • Written information in other formats (large print, accessible electronic formats, etc.)
• Provides free language services to people whose primary language is not English, such as:
  • Qualified interpreters
  • Information written in other languages

• If you need these services, contact Customer Service by calling the number on the back of your ID card.

• If you believe that BCBSNC 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:
  ➢ BCBSNC, PO Box 2291, Durham, NC 27702, Attention: Civil Rights Coordinator-Privacy, Ethics & Corporate Policy Office, Telephone 919-765-1663, Fax 919-287-5613, TTY 1-888-291-1783 civilrightscoordinator@bcbsnc.com

• You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Civil Rights Coordinator-Privacy, Ethics & Corporate Policy Office is available to help you.


• This Notice and/or attachments may have important information about your application or coverage through BCBSNC. Look for key dates. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call Customer Service at the number on the back of your ID card.

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