

**INSTRUCTIONS FOR COMPLETING/SUBMITTING THE BLUE CROSS BLUE SHIELD OF MICHIGAN DRUG CLAIM FORM**

**(PLEASE TYPE OR PRINT ALL ENTRIES)**

**CLAIMS FROM PARTICIPATING PHARMACIES SHOULD BE SUBMITTED ELECTRONICALLY FROM THE PHARMACIST.** Please print the following information clearly in the appropriate areas on the claim form. If you are submitting more than one claim, each form must be filled out completely. However, you may now submit up to six receipts per patient on one claim form.

The **claim form** must contain the following information in order to be processed:

1. CONTRACT NUMBER.....Your nine-digit numerical contract number on your Blue Cross and Blue Shield of Michigan (BCBSM) I.D. card.  
 GROUP NUMBER.....The group number or description found on your I.D. card.  
 COVERAGE/SERVICE CODE.....The service code or description found on your I.D. card.  
 ENROLLEE/SUBSCRIBER LAST NAME, FIRST.....Your complete last name followed by first name.
2. PROVIDER NAME, ADDRESS, PHONE # & NABP #.....The name, address, phone # and NABP # of the pharmacy from which you purchased the drug. The NABP # is required and the pharmacy can provide it.
3. PATIENT'S NAME, BIRTHDATE, SEX AND.....Print patient's first name, birthdate, sex and mark the appropriate box to  
 RELATIONSHIP TO SUBSCRIBER.....identify patient's relationship to the subscriber.
4. OTHER INSURANCE.....If patient has other insurance besides BCBSM, mark YES and indicate the name of the company (and include a copy of the EOB voucher to the claim). If not, check NO.
5. DATE OF SERVICE.....Enter the date that the prescription was purchased.  
 PRESCRIPTION NUMBER.....The prescription number as it appears on the prescription order.  
 QUANTITY.....The quantity of the drug that you received from pharmacy (total number of pills).  
 DAYS SUPPLY.....The number of days supply for which the prescription is dispensed (taking medicine for how many days).  
 DI DISPENSING INDICATOR.....If doctor indicates on prescription dispense as written (DAW), mark "X" in the box. If not, leave blank.  
 NATIONAL DRUG CODE.....Eleven-digit numerical code which describes the drug dispensed. If you do not see this on your receipt, you will be able to obtain this information from the pharmacy.  
 COMPOUND DRUG (CP).....Check here if compound drug.  
 MEMBER PAID.....The amount the member paid for the prescription.
6. Line 1.....The complete name of the drug for all 6 lines.
7. CHECK IF PRIVACY ADDRESS, INDICATE.....Check YES if you have a privacy address on file and NO if you do not have a  
 SUBSCRIBER ADDRESS AND SUBSCRIBER'S.....privacy address on file. Indicate the address you wish to have the payment  
 DAY AND EVENING PHONE NUMBERS.....mailed.
8. RECIPIENT SIGNATURE.....Recipient of the prescription should sign in the space provided.
9. PHARMACIST'S SIGNATURE.....Sign in the space provided.

If you have another insurance plan which is primary, or are covered under Worker's compensation, please make sure to submit the claim for reimbursement to the correct carrier.

**PLEASE MAKE SURE TO ATTACH A COPY OF YOUR PAID PRESCRIPTION RECEIPT TO A SEPARATE SHEET OF PAPER 8 1/2 X 11**

**PLEASE COMPLETE A NEW CLAIM FORM FOR EACH PATIENT FOR EVERY (6) DRUG RECEIPTS**

Your claim cannot be processed if any of the above information (with the exception of the DI and CP fields) is missing from the **claim form**. Your claim will be returned for missing or incorrect information. If you are not sure what information to indicate on the claim form (ie: NABP #, Quantity, Days Supply, etc) the pharmacy can provide you with the information.

**BENEFITS**

The Blue Cross and Blue Shield of Michigan Prescription Drug Program will pay for insulin and all drugs that bear the legend "Caution: Federal Law prohibits dispensing drugs without a prescription," except those identified as exclusions. Disposable needles and syringes are benefits under the Diabetic Supply Provision of the Prescription Drug Program.

**EXCLUSIONS**

Under most contracts, the following are **NOT** Prescription Drug Program benefits. Please consult your benefit booklet if you have a question.

- Drugs for which the pharmacy customarily charges less than your co-pay amount.
- Contraceptives.
- Devices or appliances of any type and other non-medicinal substances.
- Any experimental drug.
- Any covered drug which is entirely consumed at the time and place of service.
- All drug claims with dates of purchase in excess of twelve months.

**PAYMENT  
TO  
SUBSCRIBER**



NUMERICAL CONTRACT NUMBER									
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
GROUP NO.					COVERAGE/ SERVICE CODE				
ENROLLEE/SUBSCRIBER LAST NAME					FIRST				

PHARMACY NAME		
STREET ADDRESS		
CITY	STATE	ZIP CODE
PROVIDER PHONE #. ( )	NUMERICAL NABP # <input type="text"/>	

**PLEASE COMPLETE ALL ITEMS ON FORM AND CONTACT PHARMACY FOR MORE INFORMATION IF NEEDED.**

PATIENT'S FIRST NAME		DATE OF BIRTH MO DAY YEAR		PATIENT'S SEX M F		RELATIONSHIP TO SUBSCRIBER SELF SPOUSE DEP			OTHER INSURANCE (IF YES, INCLUDE A COPY OF THE EOB VOUCHER) YES NO NAME OF OTHER INSURANCE		
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LINE NO.	DATE OF SERVICE MO DAY YEAR	PRESCRIPTION NUMBER	QTY.	DAYS SUPPLY	DI	NATIONAL DRUG CODE	CP	MEMBER PAID
1								
2								
3								
4								
5								
6								

LINE 1 (NAME OF DRUG)	LINE 2 (NAME OF DRUG)	LINE 3 (NAME OF DRUG)
LINE 4 (NAME OF DRUG)	LINE 5 (NAME OF DRUG)	LINE 6 (NAME OF DRUG)

**PAYMENT FOR THE ABOVE PRESCRIPTION SERVICE WILL BE FORWARDED TO YOU AT THE ADDRESS GIVEN BELOW.**

PRIVACY ADDRESS? YES  NO

NAME OF SUBSCRIBER (PLEASE PRINT)

STREET ADDRESS

CITY STATE ZIP CODE

DAY PHONE # EVENING PHONE #  
( ) ( )

**CERTIFICATION STATEMENT**

I certify that the patient for whom this claim is made is an eligible member in the Blue Cross and Blue Shield of Michigan Drug Program, and that the prescription is for the sole use of that member. I hereby authorize the release of any information pertaining to claims under this contract from medical or pharmaceutical records determined to be necessary by Blue Cross and Blue Shield. I certify that the above amount was paid in full by the member.

X \_\_\_\_\_  
RECIPIENT SIGNATURE

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**PHARMACIST'S CERTIFICATION STATEMENT**

I certify the amount noted above is my charge for the described service which was performed by me and the member paid the above amount in full.

X \_\_\_\_\_  
PHARMACIST'S SIGNATURE

**AFTER YOU HAVE COMPLETED THE CLAIM FORM**

Please review your claim form to be sure it is filled out correctly. This will enable us to process your purchases promptly.

- Make sure to tape a copy of your paid receipts from the pharmacy indicating the detailed information for the prescription dispensed to a separate sheet of 8 1/2 x 11 paper. Do not overlap receipts, or cover necessary information. Do not use the back of the sheet provided.
- Please contact the BCBSM Service Center with questions (telephone number noted on the back of your BCBSM identification card).
- Keep a copy for your records.
- Our response will be sent to you as soon as possible.

**Mail claim form and receipts to:**      **Attn: BCBSM Claims Department**  
**C/O MedImpact**  
**P.O. Box 509098**  
**San Diego, CA 92150-9098**

**CLAIMS PAYMENT INQUIRY**

Allow a minimum of 45 days from submission of original claim for payment before sending a follow-up, unless a payment or rejection notice was received. If you are questioning a partial payment or rejection, please contact your local BCBSM Customer Service Office for further information and inquiries. You will find the customer service number on the back of your ID card. This claim form can be printed from our Web site at: [bcbsm.com](http://bcbsm.com), by clicking on "I am a member," "member forms" and "payment to subscriber pharmacy claim form."