Prescription Drug Claim Form

Capital Health PLAN
An Independent Licensee of the Blue Cross and Blue Shield Association

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 (Does not apply for COVID home tests)

Pharmacy name

Pharmacy address

City State Zip

X

Pharmacist signature

Pharmacy NPI number

Prescription (Rx) claim information

(Does not apply for COVID home tests)

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.

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 $.

OTC COVID-19 test kit claim

To be reimbursed for a COVID-19 home test kit, please attach itemized register receipts to the back of this form. Please enter the NDC or 12-digit UPC number from the cash register receipt or test kit package. All information below is required. **There is a limit of 8 At-Home Rapid tests per 30 days.**

NDC or UPC number

Date purchased / /

Quantity of test kit(s) purchased _____

Total cost of test kit(s) $.

OTC COVID-19 test kit name _____

IMPORTANT: Your signature is required to attest that the test(s) is for personal use, is not being used for employment purposes and will not be resold.

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

Signature _____

Date signed _____

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
- Prescription cost
- Drug name and NDC number
- Physician NPI number
- Quantity
- Date filled
- Rx number
- Days' supply
- All compound drug information (if applicable)
- Pharmacy NPI number

3. Required information for COVID-19 test kits:
   - Member name
   - ID number
   - Date of birth
   - Total cost of test kit(s)
   - OTC COVID-19 test kit name
   - NDC/UPC number
   - Quantity of test kits purchased
   - Date purchased
   - Itemized receipt
   - Signature
   - Date signed
4. Send this completed form with itemized receipts to:

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

Questions?

- You can call the number on the back of your member ID card
- Your pharmacist may call 800.821.4795

EXAMPLE

Rx number 0 0 0 0 0 0 6 0 1 1 4 8 1

Date filled 0 1 / 1 2 / 2 2

Quantity 30 Days' supply 3 0

Name of medicine "Drug Name"

NDC number 0 0 1 2 3 4 5 6 7 3 1

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

Physician NPI number 0 1 2 3 4 5 6 7 8 9

(Does not apply for COVID home tests)

Prescription cost $ 2 0 5 . 1 4

Balance due $ 2 0 5 . 1 4

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 Receipts

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.