



# PRESCRIPTION MEDICATION REIMBURSEMENT FORM

Mail completed form and original receipts to: Blue Cross Blue Shield of Arizona  
 Mail Stop A115  
 P.O. Box 13466  
 Phoenix, AZ 85002-3466

An Independent Licensee of the Blue Cross and Blue Shield Association

1. Please type or print clearly. All information in each section must be provided.  
**Incomplete forms will be returned, causing a delay in the claim review process.**
2. Tape **original** receipts to the back of this form.
3. A separate form must be completed for **each** patient and for **each** pharmacy patronized.
4. The member must sign each claim form submitted.

For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

## MEMBER INFORMATION

Subscriber Name (Last, First, Middle Initial)		Member I.D. Number	
Address		Daytime Phone (      )	
City		State	Zip
Group or Plan Name		Group Number	
Patient Name (Last, First, Middle Initial)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to Subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	Date of Birth
Does the patient have other prescription coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, please provide the name of coverage	
Did the patient submit this claim to the other coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes. Please attach explanation of benefits.	
To the best of my knowledge the above information is correct and the patient named is eligible for benefits.			
Member's Signature			Date

## PHARMACY INFORMATION

Pharmacy Name	Pharmacy Identifier (NCPDP or NPI Number)
Address	Phone Number (      )
City	State      Zip

## PRESCRIPTION INFORMATION

<b>1</b>	Rx Number	Date Filled	Check One: <input type="checkbox"/> New <input type="checkbox"/> Refill	Quantity	Days' Supply	National Drug Code (NDC)	Claimed Amount
	Prescribing Physician Name (Last, First)				Medication Name, Strength, Form		DAW Code
<b>2</b>	Rx Number	Date Filled	Check One: <input type="checkbox"/> New <input type="checkbox"/> Refill	Quantity	Days' Supply	National Drug Code (NDC)	Claimed Amount
	Prescribing Physician Name (Last, First)				Medication Name, Strength, Form		DAW Code