



**BlueCross  
BlueShield  
of Arizona**

An Independent Licensee  
of the Blue Cross and  
Blue Shield Association

# 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

**Instructions:** 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.** Staple or tape pharmacy receipt (label) to the back of this form. A separate form must be completed for each patient and for each pharmacy patronized. For compounded medications, please use the **Compounded Medication Claim Form** to submit your claim.

Section 1 - Cardholder Information				
Cardholder's ID Number		Group/Employer or Plan Name		Group ID Number
Cardholder's Name (Last, First, Middle Initial)		Cardholder's Date of Birth	Cardholder's Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Cardholder's Phone Number
Cardholder's Address (Street, City, State, Zip)				

Section 2 - Patient Information				
Patient's Name (Last, First, Middle Initial)		Patient's Date of Birth	Patient's Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to Cardholder <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent

Section 3 - Reason for Request	
Check all that apply	
<input type="checkbox"/>	The pharmacy tells you that you are not eligible for coverage.
<input type="checkbox"/>	Coverage for the prescription was denied in whole or in part.
<input type="checkbox"/>	You feel that you paid the wrong copay or other cost-sharing amount for the prescription.
<input type="checkbox"/>	You were required to pay other amounts you feel you are not required to pay.
<input type="checkbox"/>	Medication required Precertification (Prior Authorization) and has since been approved, but you paid out-of-pocket prior to the approval.
<input type="checkbox"/>	Out of area/ urgent/emergency request, please explain:
<input type="checkbox"/>	Obesity Weight Loss Program Reimbursement Program. <b>If this is the reason, provide the following information:</b> Name of the Obesity Weight Loss Program you participated or are participating in: _____ Start Date: _____ Completion Date: _____
<input type="checkbox"/>	Tobacco Cessation Reimbursement Program. <b>If this is the reason, provide the following information:</b> Name of the Tobacco Cessation Program you participated or are participating in: _____ Start Date: _____ Completion Date: _____
<input type="checkbox"/>	Other, please explain:

Section 4 - Claim Information									
1.	Rx Number	Date Prescribed	Date Filled	Refill	Quantity Dispensed	Day's Supply	National Drug Code (NDC) (11-digits)	DAW Code	Claim Amount \$
	Prescribing Physician's Name		Physician's National Provider No. (NPI)		Physician's Phone Number		Medication Name, Strength, Form		
	Dispensing Pharmacy's Name		Pharmacy's National Provider No. (NPI)		Pharmacy Phone Number		Pharmacy's Address (Street, City, State, Zip)		
2.	Rx Number	Date Prescribed	Date Filled	Refill	Quantity Dispensed	Day's Supply	National Drug Code (NDC) (11-digits)	DAW Code	Claim Amount \$
	Prescribing Physician's Name		Physician's National Provider No. (NPI)		Physician's Phone Number		Medication Name, Strength, Form		
	Dispensing Pharmacy's Name		Pharmacy's National Provider No. (NPI)		Pharmacy Phone Number		Pharmacy's Address (Street, City, State, Zip)		

**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.**

Section 5 - Attestation	
Certifies that the information provided above is true, accurate, and complete.	
Member's Signature	Date

