Blue Cross Blue Shield of Rhode Island

Prescription Reimbursement Claim Form

CVS CAREMARK

Important!

* Always allow up to 14 days from the time you send this form until the time you receive a response.
* Keep a copy of all documents submitted for your records.
* Do not staple or tape receipts or attachments to this form.

STEP 1 Patient Information

Patient Information - Use a separate claim form for each patient

If address is not filled in, payment will be sent to address on file with BCBSRI.

Identification Number - *as it appears on your member identification card (refer to Step 3)*

Rx Group Number *(refer to Step 3)*

Name *(Last Name)* *(First Name)* *(MI)*

Address

City State Zip

Relationship to Subscriber

Self ☐ Spouse ☐ Child ☐

Date of Birth Male ☐ Female ☐ Phone Number

Subscriber Information

Same as above ☐

Name *(Last Name)* *(First Name)* *(MI)*

Is this claim in regards to a worker's compensation injury? ❍ Yes ❍ No

Other Insurance Information

COB (Coordination of Benefits)

Is the medicine covered under any other insurance? ❍ Yes ❍ No

If yes, is other coverage: ❍ Primary ❍ Secondary

If other coverage is Primary, include the explanation of benefits (EOB) with this form.

Name of Insurance Company________________________ ID #________________

Important! A signature is REQUIRED

NOTICE

Any person who knowingly and with intent to defraud, injure, or deceive any insurance company, submits a claim or application containing any materially false, deceptive, incomplete or misleading information pertaining to such claim may be committing a fraudulent insurance act which is a crime and may subject such person to criminal or civil penalties, including fines, denial of benefits, and/or imprisonment.

I certify that I (or my eligible dependent) have received the medicine described herein. I certify that I have read and understood this form, and that all the information entered on this form is true and correct.

x ____

Signature of Plan Participant **Date**

Blue Cross and Blue Shield of Rhode Island is an independent licensee of the Blue Cross and Blue Shield Association.

STEP 2 ## Submission Requirements:

You MUST include all original receipts in order for your claim to process. Cash register receipts will <u>only</u> be accepted for diabetic supplies. The minimum information required is:

- Patient Name
- Date of Fill
- Total Charge
- Prescription Number
- Metric Quantity
- Pharmacy Name and Address or Pharmacy NABP Number
- Medicine NDC number
- Days Supply

If Foreign Claim: Country:__________________ **Currency:**__________________ **Amount:**__________________

(Foreign Claims not Applicable for Med D Members)

STEP 3 ## Mailing Instructions:

MEDICARE ADVANTAGE

Blue Cross Blue Shield
BlueCHiP for Medicare Group Plus
<FIRST NAME> <M>
<LAST NAME> <TITLE>
<ID NUMBER>
RxBIN 004336
Issuer 80840
RxPCN ADV
RxGrp RX6301
CMS H4152 817
PCP <FIRST NAME> <M> <LAST NAME>, <TITLE>
PCP PHONE <XXX-XXX XXXX>
PCP Visit $<xx>
Specialist Visit $<xx>
Emergency Room $<xx>
Inpatient Adm $<xx>
Issued XX/XX/XX
MEDICARE ADVANTAGE
MedicareRx Prescription Drug Coverage
DENTAL

If your RxGrp is RX6301 or RX6321, please mail completed form and receipts to the following address:

CVS Caremark
P.O. Box 52066
Phoenix, Arizona 85072-2066

ALL OTHER PLANS

Blue Cross Blue Shield
ABCDEFGHIJ A
ABCDEFGHIJKLMNO ABC
ZBF9999999999999
RxBIN 004336
RxGrp BCBSRI
Office Visit $99
Specialist Visit $99
Urgicenter/ER $99/999
Prescription Drug $99/99/99/99
Issued XX/XX/XX
HealthMate Coast-to-Coast Direct
PPO
DENTAL

If your RxGrp is BCBSRI or RX6302, please mail completed form and receipts to the following address:

CVS Caremark
P.O. Box 52136
Phoenix, Arizona 85072-2136

IMPORTANT REMINDER

- If you have any questions or need help filling out this form, please contact Blue Cross & Blue Shield of Rhode Island Customer Service at the phone number located on the back of your Blue Cross & Blue Shield of Rhode Island identification card

To avoid having to submit a paper claim form:

- Always have your card available at time of purchase
- Always use pharmacies within your network
- Use medication from your formulary list
- If problems are encountered at the pharmacy, call the number on the back of your card

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