

PRESCRIPTION DRUG CLAIM FORM



Regence BlueShield is an Independent Licensee of the Blue Cross and Blue Shield Association

1800 Ninth Avenue • P.O. Box 21065
Seattle, WA 98111-3065
<http://www.wa.regence.com/boeing>

Customer Service Inquiries 1 (800) 422-7713

MEMBER INSTRUCTIONS

1. Complete **Part A** below.
2. If this claim is for a prescription filled at a local pharmacy, ask your pharmacist to complete **Part B**.
If the prescription was filled out of town, please complete Part B yourself using the information from your receipt.
3. Sign the form under **Part A** and review form to make certain all information has been completed.
4. Attach the original receipt(s) to the claim form and return it to Regence BlueShield, P.O. Box 21065, Seattle, WA 98111-3065.

IMPORTANT: Please list prescription services from only one pharmacy per claim form.

PART A - MEMBER INFORMATION

Patient's Name (Last, First, M.I.)		Patient's Date of Birth	Patient's Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Employee's/Retiree's Name (Last, First, M.I.)		Patient's Relationship to Employee/Retiree <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	
Address (Street, City, State & Zip)			Telephone Number ()
Alpha Prefix and Member ID (11 digits, see Member card)	Group Name (see Member card)	Group Number (see Member card)	

Do you or any of your immediate family have any other insurance which may cover all or part of this claim? Yes No

If Yes, please indicate the insurance company name: _____

PLEASE INDICATE WHY THE PATIENT DID NOT USE THE PRESCRIPTION DRUG CARD: _____

AUTHORIZATION: I certify that the above statements are correct and hereby authorize any physician, hospital, employer, union, insurance company, HMO or prepayment organization to supply my employer and its agents any information required in connection with this claim. A photocopy of this authorization shall be as valid as the original.

Employee's/Retiree's/Patient's Signature _____ Date _____

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance.

PART B - PHARMACIST USE ONLY

Date Dispensed	Rx Number	National Drug Code & Drug Name	Quantity	Days Supply	Prescriber's Name or DEA#	Total Charge*	DPS Use

* Total paid by patient to pharmacy.

Pharmacy Name _____ NABP # _____

Pharmacy Address _____

Pharmacist's Signature _____ Date _____

(Pharmacist's signature certifies that the information in Part B is correct.)