



## Pharmacy/Prescription Information

- Use a **separate claim form** for each patient. All information provided on or attached to this claim form must be for the same patient.
- Tape or glue pharmacy receipts in the spaces provided. When you tape or glue your receipts, it is not necessary for the receipts to fit exactly within the spaces provided. If the taped or glued receipts overlap each other, be sure that all information on each receipt is readable. Each receipt must show:

- Patient Name
- Pharmacy Name/Address
- Total Charge
- Drug Name and NDC Number
- NPI Number
- Quantity
- Fill Date
- Rx Number
- Days Supply

If any of your receipts do not have **required** information, ask your pharmacist to provide you with the missing information.

Write that information on your receipt(s). If not completed, the claim will be sent back for the required information.

- Call the customer service number on your ID card if you have any questions.
- Have your pharmacist call 800.821.4795 if he/she has any questions.
- Send completed form to:

Prime Therapeutics  
P.O. Box 14624  
Lexington, KY 40512-4624

Rx 1	Rx 2																																
<p style="text-align: center;"><b>EXAMPLE</b> of how to complete the Prescription Drug Claim Form.</p> <p><b>1</b> Rx Number <input style="width: 20px; height: 20px; border: 1px solid black;" type="text" value="0"/><input style="width: 20px; height: 20px; border: 1px solid black;" type="text" value="0"/><input style="width: 20px; height: 20px; border: 1px solid black;" type="text" value="0"/><input style="width: 20px; height: 20px; border: 1px solid black;" type="text" value="0"/><input style="width: 20px; height: 20px; border: 1px solid black;" type="text" value="0"/><input style="width: 20px; height: 20px; border: 1px solid black;" type="text" value="6"/><input style="width: 20px; height: 20px; border: 1px solid black;" type="text" value="0"/><input style="width: 20px; height: 20px; border: 1px solid black;" type="text" value="1"/><input style="width: 20px; height: 20px; border: 1px solid black;" type="text" value="1"/><input style="width: 20px; height: 20px; border: 1px solid black;" type="text" value="4"/><input style="width: 20px; height: 20px; border: 1px solid black;" type="text" value="8"/><input style="width: 20px; height: 20px; border: 1px solid black;" type="text" value="1"/></p> <p>Date Filled <input style="width: 20px; height: 20px; border: 1px solid black;" type="text" value="0"/><input style="width: 20px; height: 20px; border: 1px solid black;" type="text" value="1"/> / <input style="width: 20px; height: 20px; border: 1px solid black;" type="text" value="1"/><input style="width: 20px; height: 20px; border: 1px solid black;" type="text" value="2"/> / <input style="width: 20px; height: 20px; border: 1px solid black;" type="text" value="0"/><input style="width: 20px; height: 20px; border: 1px solid black;" type="text" value="5"/></p> <p>Quantity <input style="width: 40px; border: 1px solid black;" type="text" value="30"/> Day Supply <input style="width: 20px; height: 20px; border: 1px solid black;" type="text" value="3"/><input style="width: 20px; height: 20px; border: 1px solid black;" type="text" value="0"/></p> <p>Name of Medication <u>"Drug Name"</u></p> <p>NDC Number <input style="width: 20px; height: 20px; border: 1px solid black;" type="text" value="0"/><input style="width: 20px; height: 20px; border: 1px solid black;" type="text" value="0"/><input style="width: 20px; height: 20px; border: 1px solid black;" type="text" value="1"/><input style="width: 20px; height: 20px; border: 1px solid black;" type="text" value="2"/><input style="width: 20px; height: 20px; border: 1px solid black;" type="text" value="3"/><input style="width: 20px; height: 20px; border: 1px solid black;" type="text" value="4"/><input style="width: 20px; height: 20px; border: 1px solid black;" type="text" value="5"/><input style="width: 20px; height: 20px; border: 1px solid black;" type="text" value="6"/><input style="width: 20px; height: 20px; border: 1px solid black;" type="text" value="7"/><input style="width: 20px; height: 20px; border: 1px solid black;" type="text" value="3"/><input style="width: 20px; height: 20px; border: 1px solid black;" type="text" value="1"/> <small>(Your pharmacist can provide the NDC number identifying the drug.)</small></p> <p>NPI Number <input style="width: 20px; height: 20px; border: 1px solid black;" type="text" value="9"/><input style="width: 20px; height: 20px; border: 1px solid black;" type="text" value="2"/><input style="width: 20px; height: 20px; border: 1px solid black;" type="text" value="1"/><input style="width: 20px; height: 20px; border: 1px solid black;" type="text" value="5"/><input style="width: 20px; height: 20px; border: 1px solid black;" type="text" value="2"/><input style="width: 20px; height: 20px; border: 1px solid black;" type="text" value="4"/><input style="width: 20px; height: 20px; border: 1px solid black;" type="text" value="1"/><input style="width: 20px; height: 20px; border: 1px solid black;" type="text" value="1"/><input style="width: 20px; height: 20px; border: 1px solid black;" type="text" value="6"/><input style="width: 20px; height: 20px; border: 1px solid black;" type="text" value="3"/></p> <p>Prescription Cost \$ <input style="width: 20px; height: 20px; border: 1px solid black;" type="text" value="2"/><input style="width: 20px; height: 20px; border: 1px solid black;" type="text" value="0"/><input style="width: 20px; height: 20px; border: 1px solid black;" type="text" value="5"/> . <input style="width: 20px; height: 20px; border: 1px solid black;" type="text" value="1"/><input style="width: 20px; height: 20px; border: 1px solid black;" type="text" value="4"/></p> <p>Balance Due \$ <input style="width: 20px; height: 20px; border: 1px solid black;" type="text" value="2"/><input style="width: 20px; height: 20px; border: 1px solid black;" type="text" value="0"/><input style="width: 20px; height: 20px; border: 1px solid black;" type="text" value="5"/> . <input style="width: 20px; height: 20px; border: 1px solid black;" type="text" value="1"/><input style="width: 20px; height: 20px; border: 1px solid black;" type="text" value="4"/></p>	<p>Is this prescription claim for a compound medication? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Note: If yes, make sure your pharmacist completes the information below.</p> <p><b>Compound Information:</b> If a compound prescription, please enter all information per drug used.</p> <p style="text-align: center;"><b>Compound Prescriptions</b> For pharmacy use only</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 15%;">NDC Number</th> <th style="width: 40%;">Drug Ingredient</th> <th style="width: 15%;">Quantity</th> <th style="width: 30%;">Charge</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table>	NDC Number	Drug Ingredient	Quantity	Charge																												
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**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.

Blue Cross and Blue Shield of Texas is a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association.