

# Direct Reimbursement Claim

## PART ONE: To Be Filled Out By You

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SUBSCRIBER IDENTIFICATION NUMBER

|   |   |   |   |   |   |   |   |
|---|---|---|---|---|---|---|---|
| 0 | 1 | 9 | 1 | 0 | 0 | 0 | 0 |
|---|---|---|---|---|---|---|---|

CUSTOMER NUMBER

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SUBSCRIBER NAME

|  |
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MAIL ADDRESS - STREET

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CITY

STATE

ZIP

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PATIENT'S NAME

|   |   |
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| / | / |
|---|---|

PATIENT'S DATE OF BIRTH (MM/DD/YY)

SEX:  MALE  FEMALE

RELATIONSHIP:

SUBSCRIBER  SPOUSE  CHILD

OTHER: \_\_\_\_\_

EXPLAIN RELATIONSHIP

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| ( ) |
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DAYTIME TELEPHONE

The undersigned certifies that the medication(s) described herein was received by the undersigned for the party(s) named below who is/are eligible for drug benefits, and that such medication(s) is/are not for an on the job injury or covered under another benefit plan. The undersigned authorizes release of all information to the plan administrator, underwriter, sponsor, policy holder, employer and their agents for use in connection with the benefit plan programs. Information may also be used for other reporting and analysis purposes without identification of the undersigned or the undersigned's family members. The undersigned further authorizes use of such person's subscriber identification number for identification purposes and further recognizes that reimbursement will be paid directly to the participant and assignment of these benefits to a pharmacy or otherwise is void.

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| X |
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SIGNATURE OF PATIENT, GUARDIAN OR LEGAL REPRESENTATIVE

## PART TWO: Pharmacy Information - To Be Filled Out By You or Your Pharmacist

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PHARMACY NAME

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ADDRESS - STREET

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PHARMACY NABP NUMBER

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CITY

STATE

ZIP

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| ( ) |
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PHARMACY TELEPHONE

| Rx 1                  | Rx 2                  |
|-----------------------|-----------------------|
| TAPE PHARMACY RECEIPT | TAPE PHARMACY RECEIPT |
| Rx 3                  | Rx 4                  |
| TAPE PHARMACY RECEIPT | TAPE PHARMACY RECEIPT |

|                      |
|----------------------|
| <b>FOR COMPOUNDS</b> |
|                      |

**For Compounds:** Pharmacist to identify the specific prescription by date of service and Rx number. Please list name, NDC# and metric quantities of each ingredient in box on left.

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| X |
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Signature of Pharmacist for Compounds

# Direct Reimbursement Claim

## INSTRUCTIONS

PLEASE WAIT UNTIL YOU RECEIVE YOUR BLUE SHIELD OF CALIFORNIA I.D. CARD BEFORE SENDING THIS CLAIM FOR REIMBURSEMENT. CLAIMS WITHOUT THE PROPER IDENTIFICATION NUMBER FROM YOUR BLUE SHIELD OF CALIFORNIA I.D. CARD WILL NOT BE PROCESSED. To avoid undue delay, please complete all required areas of information on the claim form.

Please be sure to copy your subscriber identification number exactly as it appears on the Blue Shield of California identification card. If this is not done, the claim form will be returned to you.

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## HOW TO COMPLETE THIS FORM

### PART ONE

#### Subscriber Information

1. Copy the 9 digit Subscriber Identification Number from the Blue Shield of California I.D. Card.
2. Subscriber name, address, and telephone number.
3. Patient Name: Person drug was prescribed for.
4. Patient Date of Birth: Month, Day, Year.
5. Patient Sex: Check Male or Female
6. Status: Patient's relationship to subscriber. If other, please write in type of relationship.
7. Please use separate claim form for each family member.

### PART TWO

#### Pharmacy Information

1. Pharmacy name, address, and telephone number where the prescription(s) were purchased.
2. Pharmacy NABP Number: Obtain the number from the pharmacy where prescriptions were purchased.
3. Tape pharmacy receipts to the form in the space provided. The receipts must indicate date of service, Rx number, NDC number, quantity, days supply and the amount paid.
4. Use a **separate claim form** for each pharmacy from which you purchase prescriptions.

**Note: Claim submission is not a guarantee of payment.**

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## WHERE TO MAIL THIS FORM

Blue Shield of CA  
Argus Health Systems  
PO BOX 419019, Dept. 191  
Kansas City, MO 64141

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IF THE CLAIM IS FOR A PRESCRIPTION PURCHASED IN A FOREIGN COUNTRY, PLEASE SUBMIT YOUR PRESCRIPTION RECEIPT WITH THE NAME OF THE DRUG(S), AND STATE THE FOREIGN CURRENCY USED. MARK THE "FOREIGN CLAIMS" BOX BELOW.

IF THE CLAIM IS FOR A VACATION SUPPLY, FILL OUT THIS FORM, ATTACH THE PRESCRIPTION RECEIPT, AND MARK THE "VACATION SUPPLY" BOX BELOW.

FOREIGN CLAIMS

VACATION SUPPLY

### MAIL PHARMACY FOREIGN CLAIMS AND VACATION SUPPLY CLAIMS TO:

Blue Shield of CA  
c/o Pharmacy Services  
PO BOX 7168  
San Francisco, CA 94120-7168

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**Any questions? Call Argus Member Services at 1-800-479-0031**