BlueCross BlueShield of Arizona

An Independent Licensee of the Blue Cross and Blue Shield Association

Prescription Drug Reimbursement Form

Mail completed form and original receipts to: Blue Cross Blue Shield of Arizona
Mail Stop A228
P.O. Box 13466
Phoenix, AZ 85002-3466

1. Please type or print clearly. All information in each section must be provided.
Incomplete forms will be returned, causing a delay in payment.
2. Tape **original** receipts to the back of this form.
3. A separate form must be completed for **each** patient and for **each** pharmacy patronized.
4. The employee/contractholder must sign each claim form submitted.

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.

EMPLOYEE/CONTRACTHOLDER & PATIENT INFORMATION

Group Name	Group Number
Employee/Contractholder Name (Last, First, Middle Initial)	Employee/Contractholder I.D. Number
Address	Daytime Phone ( )
City	State Zip

Patient Name (Last, First, Middle Initial)	Sex	Relationship to Employee/Contractholder	Date of Birth
	☐ Male ☐ Female	☐ Self ☐ Spouse ☐ Dependent	

Does the patient have other prescription drug coverage? ☐ Yes ☐ No

If yes, please provide the name of coverage

Did the patient submit this claim to the other coverage? ☐ Yes ☐ No If yes, please attach explanation of benefits.

To the best of my knowledge the above information is correct and the patient named is eligible for benefits.

Employee/Contractholder's Signature Date

PHARMACY INFORMATION

Pharmacy Name	NABP Number
Address	Phone Number ( )
City	State Zip

PRESCRIPTION RECEIPTS

	Rx Number	Date Filled	Check One: ☐ New ☐ Refill	Quantity	Days' Supply	National Drug Code	Claimed Amount
1	Prescribing Physician Name (Last, First)			Medication Name, Strength, Form			DAW Code
2	Rx Number	Date Filled	Check One: ☐ New ☐ Refill	Quantity	Days' Supply	National Drug Code	Claimed Amount
	Prescribing Physician Name (Last, First)			Medication Name, Strength, Form			DAW Code
3	Rx Number	Date Filled	Check One: ☐ New ☐ Refill	Quantity	Days' Supply	National Drug Code	Claimed Amount
	Prescribing Physician Name (Last, First)			Medication Name, Strength, Form			DAW Code