

# Prescription Drug Claim Form



BlueCross BlueShield  
of Texas

## Member information (See other side for instructions)

ID number

Group number

Date of birth  /  /  ☐ Male ☐ Female

Name (First, Last)

Street address

City State Zip

Member's relationship to primary cardholder:

☐ Self ☐ Spouse/Domestic partner ☐ Dependent/Child

I certify that:

- The information on this form is correct
- The member named above is eligible for pharmacy benefits
- The member named above received the medicine(s) listed
- These benefits have not been assigned; any further assignment is void
- I give my permission to share the information on this form with Prime Therapeutics LLC

**X**

Member or legal representative signature

Is this medicine for an on-the-job-injury? ☐ Yes ☐ No

Do you have other insurance for this prescription medicine? ☐ Yes ☐ No

If yes, what is the other insurance company's name?

## Cardholder information (primary cardholder)

Name (First, Last)

**Why are you submitting this Prescription Drug Claim Form?**  
(check one)

- ☐ Did not have my pharmacy card with me when I bought this prescription
- ☐ Have not received my pharmacy card
- ☐ Picked up my medicine from a non-network pharmacy
- ☐ My other insurance is paying for part of this medicine (attach that company's Explanation of Benefits and an itemized receipt)
- ☐ Other (please explain) \_\_\_\_\_

\*If your plan has elected to cover OTC COVID-19 Home Test Kits, please use this form to be reimbursed. Please attach the itemized pharmacy receipt and submit to the address on the back of this form. Cash register receipts may not be accepted. **There is a limit of 8 At-Home Rapid tests per 30 days.**

## Pharmacy information

Pharmacy name

Pharmacy address

City State Zip

**X**

Pharmacist signature

Pharmacy NPI number

## Prescription (Rx) claim information\*

Was this prescription medicine purchased outside the U.S.? ☐ Yes ☐ No

All fields below must be completed. (See example on the back of this form.) Talk to your pharmacist if you need help.

Please attach itemized pharmacy receipts to the back of this form.

Claims are subject to your plan's limits, exclusions and provisions.

**1** Rx number

Date filled  /  /

Quantity \_\_\_\_\_ Days' supply

Name of medicine \_\_\_\_\_

NDC number

(Your pharmacist can provide the national drug code (NDC) and national provider identifier (NPI) numbers.)

Physician NPI number

Prescription cost \$  .

Balance due \$  .

**2** Rx number

Date filled  /  /

Quantity \_\_\_\_\_ Days' supply

Name of medicine \_\_\_\_\_

NDC number

(Your pharmacist can provide the national drug code (NDC) and national provider identifier (NPI) numbers.)

Physician NPI number

Prescription cost \$  .

Balance due \$  .

## Instructions

1. Use a separate claim form for each member and prescription. All information provided on or attached to this claim form must be for the same person/prescription.
2. Attach original itemized pharmacy receipts provided with your prescription. Be sure that all the required information is visible (staple to the top of the form, if necessary). Note: your claim will be sent back if required information is missing.

### Required information

- Member name
- ID number
- Group number
- Date of birth
- Pharmacy name and address
- Prescription cost
- Drug name and NDC number
- Physician NPI number
- Quantity
- Date filled
- Rx number
- Days' supply
- All compound drug information (if applicable)
- Pharmacy NPI number

3. Send this completed form with itemized receipts to:

Prime Therapeutics Commercial  
PO 25136  
Lehigh Valley, PA 18002-5136

### Questions?

- You can call the number on the back of your member ID card
- Your pharmacist may call 800-633-6196

### EXAMPLE

Rx number

Date filled  /  /

Quantity  Days' supply

Name of medicine "Drug Name"

NDC number   
(Your pharmacist can provide the national drug code (NDC) and national provider identifier (NPI) numbers.)

Physician NPI number

Prescription cost \$  .

Balance due \$  .

Is this prescription claim for a compound medicine?

☐ Yes ☐ No

Note: If yes, ask your pharmacist to complete the information below.

### Compound Information

Please enter all information for each drug used.

#### Compound Prescriptions

For pharmacy use only

NDC Number	Drug Ingredient	Quantity	Charge

## Rx Receipts

### Attach original itemized pharmacy receipts here

All required information must be visible (see step 2 above).

Keep a copy of this form and your receipt(s) for your records.

**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.



**BlueCross BlueShield**  
of Texas

# Pharmacy PPO Out-of-pocket Expense Credit Instructions

For member payments made directly to a pharmacy who is **not** in your health plan's network (an out-of-network pharmacy) and who does not file an insurance claim.

## What is it?

When you use insurance to pay for health care, the cost you pay applies to your deductible and/or out-of-pocket maximum.

A new Texas law lets you get credit toward your in-network deductible or out-of-pocket maximum for health care costs in certain situations. **This applies when you pay the out-of-network pharmacy directly and do not use your insurance.**

- This helps make sure that all your covered pharmacy costs apply to your in-network deductible and out-of-pocket maximum, even when insurance is not used.

## Who can claim it?

If you have an Individual/Family, Student or Group PPO Health plan that is regulated by the Texas Department of Insurance (TDI)\*, you may be able to submit a claim for PPO Out-of-pocket Expense Credit.

### All of the following must be true:

- You paid an out-of-network pharmacy for a service that's covered by your health plan.
- The pharmacy has not submitted a claim to Prime Therapeutics for the same service.
- The amount you paid the out-of-network pharmacy is **less than the average discounted rate** that Prime normally pays a pharmacy who **is** in your plan's network for the covered prescription drug.

## How does it work?

**Step 1: You** visit an out-of-network pharmacy and agree on a cost with them for your prescription drug.

**Step 2: You** submit a completed prescription drug claim form with an itemized pharmacy receipt.

**Step 3: Prime** reviews your claim and checks the amount you paid to make sure it's less than the average discounted rate they would pay a pharmacy who is in your plan's network for the same prescription drug.

**Step 4: Your** in-network deductible and out-of-pocket maximum amounts may be credited, if needed.

## How do I submit a claim?

You can print and mail the completed prescription drug claim form with the itemized pharmacy receipt to:

Prime Therapeutics Commercial  
PO Box 25136  
Lehigh Valley, PA 18002-5136

## What if I have questions?

For help with this form, please call the Customer Service number on your ID card.

\*To see if this applies to your plan, look for the TDI symbol on your ID card.

Prime Therapeutics is an independent company contracted by BCBSTX to provide pharmacy benefit management and related other services. BCBSTX, as well as several independent Blue Cross and Blue Shield Plans, has an ownership interest in Prime Therapeutics, LLC.

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

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**Health care coverage is important for everyone.**

We provide free communication aids and services for anyone with a disability or who needs language assistance. We do not discriminate on the basis of race, color, national origin, sex, gender identity, age, sexual orientation, health status or disability.

To receive language or communication assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator  
300 E. Randolph St.  
35th Floor  
Chicago, Illinois 60601

Phone: 855-664-7270 (voicemail)  
TTY/TDD: 855-661-6965  
Fax: 855-661-6960  
Email: [CivilRightsCoordinator@hcsc.net](mailto:CivilRightsCoordinator@hcsc.net)

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services  
200 Independence Avenue SW  
Room 509F, HHH Building 1019  
Washington, DC 20201

Phone: 800-368-1019  
TTY/TDD: 800-537-7697  
Complaint Portal: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>  
Complaint Forms: <http://www.hhs.gov/ocr/office/file/index.html>

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 855-710-6984.

Español Spanish	Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 855-710-6984.
العربية Arabic	إن كان لديك أو لدى شخص تساعد أسئلة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم فوري، اتصل على الرقم 855-710-6984.
繁體中文 Chinese	如果您，或您正在協助的對象，對此有疑問，您有權利免費以您的母語獲得幫助和訊息。洽詢一位翻譯員，請撥電話 號碼 855-710-6984。
Français French	Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 855-710-6984.
Deutsch German	Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 855-710-6984 an.
ગુજરાતી Gujarati	જો તમને અથવા તમે મદદ કરી રહ્યા હોય એવી કોઈ બાજી વ્યાકરણે એસ.બી.એમ. કાયદેક્રમ બાબતે પ્રશ્નો હોય, તો તમને વિના ખર્ચે, તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો હક્ક છે. દુભાષિયા સાથે વાત કરવા માટે આ નંબર 855-710-6984 પર કોલ કરો.
हिंदी Hindi	यदि आपके, या आप जिसकी सहायता कर रहे हैं उसके, प्रश्न हैं, तो आपको अपनी भाषा में निःशुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनुवादक से बात करने के लिए 855-710-6984 पर कॉल करें।
Italiano Italian	Se tu o qualcuno che stai aiutando avete domande, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare il numero 855-710-6984.
한국어 Korean	만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 통역사가 필요하시면 855-710-6984 로 전화하십시오.
Diné Navajo	T'áá ni, éí doodago la'da bika anáníwo'ígíí, na'idííkidgo, ts'idá bee ná ahóótí'i' t'áá níí'k'e níká a'doolwoł dóó bina'idííkidígíí bee níí h odoonih. Ata'dahalne'ígíí bich'i'í' hodíílnih kwe'e 855-710-6984.
فارسی Persian	اگر شما، یا کسی که شما به او کمک می کنید، سوالی داشته باشید، حق این را دارید که به زبان خود، به طور رایگان کمک و اطلاعات دریافت نمایید. جهت گفتگو با یک مترجم شفاهی، با شماره 855-710-6984 تماس حاصل نمایید.
Polski Polish	Jeśli Ty lub osoba, której pomagasz, macie jakiegokolwiek pytania, macie prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 855-710-6984.
Русский Russian	Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы связаться с переводчиком, позвоните по телефону 855-710-6984.
Tagalog Tagalog	Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa 855-710-6984.
اردو Urdu	اگر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کر رہے ہیں، کوئی سوال درپیش ہے تو، آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، 855-710-6984 پر کال کریں۔
Tiếng Việt Vietnamese	Nếu quý vị, hoặc người mà quý vị giúp đỡ, có câu hỏi, thì quý vị có quyền được giúp đỡ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, gọi 855-710-6984.