Pharmacy Benefit Claim Form

Capital

Section 1: 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 Capital Blue Cross' pharmacy benefit manager.

X

Member or legal representative signature

Is this pharmacy benefit for an on-the-job-injury? ❑ Yes ❑ No

Do you have other insurance for this pharmacy benefit? ❑ Yes ❑ No

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

Cardholder information (primary cardholder)

Name (First, Last)

Why are you submitting this Pharmacy Benefit Claim Form? (check one)

☐ Did not have my ID card with me when I bought this drug or item.

☐ Have not received my ID card.

☐ Picked up this drug or item from an out-of-network pharmacy.

☐ My other insurance is paying for part of this purchase (attach that company's Explanation of Benefits and an itemized receipt).

☐ Other (please explain).

Section 2: Pharmacy claim information

Pharmacy name

Pharmacy address

City State Zip

X

Pharmacist signature

Pharmacy NPI number

Was this prescription 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.

Rx number

Date filled / /

Quantity Days' supply

Name of drug

NDC number

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

Provider NPI number

Prescription cost $.

Balance due $.

Section 3: Over-the-counter (OTC) COVID-19 at-home test kit claim

To be reimbursed for COVID-19 at-home test kits, please attach itemized receipts to the back of this form. Please enter the NDC or UPC number from the cash register receipt. All information below is required. **There is a limit of eight at-home rapid tests per 30 days per member. Reimbursement may be limited to no more than $12 per test.**

Test kit name

NDC or UPC number

Date purchased / / Quantity of tests

Test kit cost $.

IMPORTANT: You must sign the form, confirming that the test kit was not used for testing required by your employer and will not be resold.

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

Signature

Sections 1 and 2: Instructions for pharmacy claims

1. Use a separate claim form for each member and prescription. Complete Section 1 and Section 2 on the front of this form and Section 4 below if applicable. 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.
3. Required information
   - Member name.
   - ID number.
   - Group number.
   - Date of birth.
   - Pharmacy name and address.
   - Prescription cost.
   - Drug name and NDC number.
   - Provider NPI number.
   - Quantity.
   - Date filled.
   - Rx number.
   - Days' supply.
   - All compound drug information (if applicable).
   - Pharmacy NPI number.
4. Send this completed form with itemized receipts to:

   Pharmacy Services
   PO Box 25136
   Lehigh Valley, PA 18002-5136

Questions?

- You can call the number on the back of your ID card (TTY: 711).
- Your pharmacist may call 800.821.4795.

Sections 1 and 3: Instructions for over-the-counter COVID-19 at-home test kit claims

1. For OTC COVID-19 test kits, each member is allowed reimbursement for up to eight tests per 30 days. Reimbursement may be limited to no more than $12 per test. To use one receipt for multiple family members, a separate claim form and a copy of the receipt must be submitted for each family member with the number of tests claimed per family member.
2. Attach original itemized receipts provided with your purchase. 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.
3. Required information
   - Member name.
   - ID number.
   - Group number.
   - Date of birth.
   - Test kit cost.
   - NDC/UPC number.
   - Quantity of tests claiming.
   - Date purchased.
4. Send this completed form with itemized receipts to:

   Pharmacy Services
   PO Box 25136
   Lehigh Valley, PA 18002-5136

Questions?

- You can call the number on the back of your ID card (TTY: 711).

EXAMPLE

Rx number 0 0 0 0 0 6 0 1 1 4 8 1

Date filled 0 1 / 1 2 / 2 2

Quantity 30 Days' supply 3 0

Name of drug "Drug Name"

NDC number 0 0 1 2 3 4 5 6 7 3 1

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

Provider NPI number 0 1 2 3 4 5 6 7 8 9

(Does not apply for COVID-19 home tests)

Prescription cost $ 2 0 5 . 1 4

Balance due $ 2 0 5 . 1 4

Section 4: Compound information

Is this claim for a compound drug?

❑ Yes ❑ No

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

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.

Healthcare benefit programs issued or administered by Capital Blue Cross and/or its subsidiaries, Capital Advantage Insurance Company®, Capital Advantage Assurance Company®, and Keystone Health Plan® Central. Independent licensees of the Blue Cross Blue Shield Association. Communications issued by Capital Blue Cross in its capacity as administrator of programs and provider relations for all companies.

