Drug Claim Form

Member Information

First Name	Last Name	ID Number
Date of Birth	Gender ☐ Male ☐ Female	
Street Address		
City	State	Zip

Member's Relationship to Primary Insurance 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
- ☐ I give my permission to share the information on this form with Prime Therapeutics LLC

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?

Insurance Cardholder Information *(Primary Insurance Cardholder)*

First Name	Last Name

Pharmacy Information

Pharmacy Name

Pharmacy Address

City	State	Zip

Prescription (Rx) Claim Information

Did you buy this medicine outside the U.S.? ☐ Yes ☐ No

All fields must be completed. If outside the U.S., the Rx and NDC number may be left blank if not available (*See example on page 3*). Talk to your pharmacist if you need help. Also, please attach original itemized pharmacy receipts. A cash register receipt is not acceptable. Claims are subject to your plan's limits, exclusions and provisions.

Rx Number	Date Filled
Quantity	Days' Supply

Name of Medicine

29380151 • 8-20

Prescription (Rx) Claim Information *(Continued)*	
1. Prescription (Rx) Claim Information	
NDC Number *(Your pharmacist can provide the national drug code (NDC))*	
Total Prescription Charge	Amount Member Paid
2. Prescription (Rx) Claim Information	
Rx Number	Date Filled
Quantity	Days' Supply
Name of Medicine	
NDC Number *(Your pharmacist can provide the national drug code (NDC))*	
Total Prescription Charge	Amount Member Paid

Instructions

1. Use a separate claim form for each member. All information provided on or attached to this claim form must be for the same person.
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
   - Date of birth
   - Pharmacy name and address (not required for claims outside the U.S.)
   - Total charge
   - NDC Number (not required for claims outside the U.S.)
   - Drug name
   - Date filled
   - Days' supply
   - Rx number (not required for claims outside the U.S.)
   - All compound drug information

   Questions?
   You can call the number on the back of your member ID card.

3. Keep a copy of this form and pharmacy receipts for your records. Send the original form and pharmacy receipts to:

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

Example	
Rx Number 000006011481	Date Filled 01/12/2019
Quantity 30	Days' Supply 30
Name of Medicine "Drug Name"	
NDC Number *(Your pharmacist can provide the national drug code (NDC))* 00123456731	
Total Prescription Charge $205.14	Amount Member Paid $XXX.XX

29380151 • 8-20

Compound Information *(Please enter all information for each drug used)*

Is this prescription claim for a compound medicine? ☐ Yes ☐ No

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

Compound Prescriptions *(For pharmacy use only)*

NDC Number	Drug Ingredient	Quantity	Charge

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.

Blue Cross Blue Shield of North Dakota is an independent licensee of the Blue Cross Blue Shield Association. Prime Therapeutics LLC is an independent company that assists in the administration of BCBSND's pharmacy benefits management on behalf of Blue Cross Blue Shield of North Dakota.

29380151 • 8-20

In accordance with federal regulations, Blue Cross Blue Shield of North Dakota is required to provide you the following disclosure:

Blue Cross Blue Shield of North Dakota complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, gender identity, sexual orientation or sex. Blue Cross Blue Shield of North Dakota does not exclude people or treat them differently because of race, color, national origin, age, disability, gender identity, sexual orientation or sex.

Blue Cross Blue Shield of North Dakota:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, please call Member Services at 1-844-363-8457 (toll-free) or through the North Dakota Relay at 1-800-366-6888 or 711.

If you believe that Blue Cross Blue Shield of North Dakota has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, gender identity, sexual orientation or sex, you can file a grievance with:

Civil Rights Coordinator
4510 13th Ave S
Fargo, ND 58121
701-297-1638 or North Dakota Relay at 800-366-6888 or 711
701-282-1804 (fax)
CivilRightsCoordinator@bcbsnd.com (email) (Communication by unencrypted email presents a risk.)

You can file a grievance in person or by mail, fax, or email within 180 days of the date of the alleged discrimination. Grievance forms are available at http://www.bcbsnd.com/report or by calling 1-844-363-8457. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW.
Room 509F, HHH Building
Washington, DC 20201
800-368-1019 or 800-537-7697 (TDD)

Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*

Español (Spanish)

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-363-8457 (TTY: 1-800-366-6888 o 711).

Deutsch (German)

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-844-363-8457 (TTY: 1-800-366-6888 oder 711).

中文 (Chinese)

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-844-363-8457（TTY：1-800-366-6888 或 711）。

Oroomiffa (Oromo)

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-844-363-8457 (TTY: 1-800-366-6888 ykn 711).

Tiếng Việt (Vietnamese)

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn.
Gọi số 1-844-363-8457 (TTY: 1-800-366-6888 hoặc 711).

Ikirundi (Bantu – Kirundi)

ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu.
Woterefona 1-844-363-8457 (TTY: 1-800-366-6888 canke 711).

العربية (Arabic)

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-844-363-8457 (رقم هاتف الصم والبكم: 1-800-366-6888 أو711).

Kiswahili (Swahili)

KUMBUKA: Ikiwa unazungumza Kiswahili, unaweza kupata, huduma za lugha, bila malipo.
Piga simu 1-844-363-8457 (TTY: 1-800-366-6888 au 711).

Русский (Russian)

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода.
Звоните 1-844-363-8457 (телетайп: 1-800-366-6888 или 711).

日本語 (Japanese)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-844-363-8457
（TTY: 1-800-366-6888 または 711）まで、お電話にてご連絡ください。

नेपाली (Nepali)

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस्
1-844-363-8457 (टिटिवाइ: 1-800-366-6888 वा 711) ।

Français (French)

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement.
Appelez le 1-844-363-8457 (ATS : 1-800-366-6888 ou 711).

한국어 (Korean)

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-844-363-8457
(TTY: 1-800-366-6888 또는 711)번으로 전화해 주십시오.

Tagalog (Tagalog – Filipino)

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-844-363-8457 (TTY: 1-800-366-6888 o 711).

Norsk (Norwegian)

MERK: Hvis du snakker norsk, er gratis språkassistansetjenester tilgjengelige for deg. Ring 1-844-363-8457 (TTY: 1-800-366-6888 eller 711).

Diné Bizaad (Navajo)

Díí baa akó nínízin: Díí saad bee yáníłti'go **Diné Bizaad**, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 1-844-363-8457 (TTY: 1-800-366-6888 éí doodagó 711.)