BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association.

MAJOR MEDICAL POINT-OF-SALE
Participating Pharmacy
PRESCRIPTION DRUG CLAIM

Use this form for filing Major Medical Point-of-Sale Drugs from a Participating Pharmacy
* * * IMPORTANT: Please Read The Instructions On The Back Of This Form * * *

Section I. PATIENT/CONTRACT HOLDER INFORMATION

Patient's Name (Last Name, First Name, Middle Initial)	Patient's Birthdate	Sex M F	Contract Holder's Contract Number	Group #

Patient's Address (No., Street)

City | State

Zip Code | Telephone (Include Area Code) ( )

Patient's Relationship To Contract Holder
Self Child Spouse Other

Was Condition Related To Patient's Employment?
Yes No

Contract Holder's Name (Last Name, First Name, MIddle Initial)

Contract Holder's Address

City | State

Zip Code | Telephone (Include Area Code) ( )

Contract Holder Certification: I certify all information provided on this form to be true and correct to the best of my knowledge.

Signature Of Contract Holder | Date Signed

Section II. OTHER INSURANCE INFORMATION

Is the patient covered by other health insurance? Yes No	If yes, complete the following:	Policy Or Contract Number	Name of Policy Holder	Effective Date

Name and Address of Other Insurance Carrier:

PLEASE ATTACH A COPY OF THE OTHER INSURER'S BENEFIT PAYMENT NOTICE.

Section III. PRESCRIPTION DRUGS

Please see back page for instructions. It is not necessary to attach receipts if this form is filled out correctly.

Print Numbers Carefully As Shown

0	1	2	3	4	5	6	7	8	9

1	Claim Authorization Number			Date Filled
	Amount Charged $		Prescription Number (Rx#)	
2	Claim Authorization Number			Date Filled
	Amount Charged $		Prescription Number (Rx#)	
3	Claim Authorization Number			Date Filled
	Amount Charged $		Prescription Number (Rx#)	
4	Claim Authorization Number			Date Filled
	Amount Charged $		Prescription Number (Rx#)	
5	Claim Authorization Number			Date Filled
	Amount Charged $		Prescription Number (Rx#)	

INSTRUCTIONS

Remember to always show your Blue Cross and Blue Shield ID card and ask for the Claim Authorization Number when purchasing a prescription drug.

Please read these instructions carefully before entering your prescription drug claim information on the other side. Claims without the required information could be delayed or returned to you.

USE THIS FORM ONLY FOR DRUGS PURCHASED AT A PARTICIPATING PHARMACY

1. Please use a separate form for each patient. You can file up to 5 prescriptions for the same patient on one form.
2. Use a black pen to fill out the form. Do not use a pencil.
3. Write in designated areas only. Where boxes are provided, please print only one character or number per box. Please do not print outside of the boxes.
4. Complete all information in Sections I and II. Please note:
   - The Contract Holder's ID number and patient information must be valid.
   - The Contract Holder must sign this claim form.
5. Complete the information in Section III or attach pharmacy receipts.
   - The receipt provided by your Pharmacist should provide the following:
     - Claim Authorization Number
     - Date filled
     - Amount Charged
     - Prescription Number

   The Claim Authorization Number and Prescription Number fields may contain more boxes than are necessary.

   Do not attach prescription receipts if you complete this form in its entirety.
6. Mail this claim form to the address shown below:

Blue Cross and Blue Shield of Alabama
Attention: Prescription Drug Claims
P.O. Box 995
Birmingham, Alabama 35298-0001