blue california
Promise Health Plan

Medicare Part D Prescription Drug Reimbursement Form

Instructions

To avoid undue delays, complete all required steps (*) on the claim form.

Note: Claim submission is not a guarantee of payment.

Step 1: Reason for claim

Indicate reason for claim using checkboxes provided.

Step 2: Member information*

- **Make sure you have your Blue Shield of California Promise Health Plan ID card before submitting this form for reimbursement.**
- **We will not process claims without the proper identification number from your Blue Shield of California Promise Health Plan ID card.**
- Copy the last nine letters and digits from the member identification number on your Blue Shield of California Promise Health Plan ID card.
- Member name, address, and telephone number.
- Patient name: Person for whom the drug was prescribed.
- Patient date of birth: Month, day, year.
- Patient sex: Check male or female.
- Status: Patient's relationship to member. If "other" is selected, please write in the type of relationship.
- **Please submit a separate claim form for each family member.**
- **Claims must be submitted within one year of the prescription fill date.**

If you need assistance filling out this form or have questions about your pharmacy benefits, call the Member Services number on your Blue Shield of California Promise Health Plan member ID card.

Step 3: Pharmacy information*

- Pharmacy name, address, and telephone number where the prescription(s) were purchased.
- **Pharmacy ID (NCPDP/NPI)**: Obtain this number from the pharmacy where prescriptions were purchased.
- Tape a copy of pharmacy label receipts to the form in the space provided. The receipts must indicate **date of service, prescriber name and ID (NPI), Rx number, NDC number, quantity, days supply, and the amount paid**. For foreign claims, state the currency used.
- For medications compounded by the pharmacy, the pharmacist must complete and sign the sections titled, "**Medications compounded by pharmacy**" and "**Compounded medications**" on page one of this form.
- Use a separate claim form for the different pharmacies from which you have purchased prescriptions.

Step 4: Sign and complete form

- **Keep a copy of your receipt(s) for your records.**
- **Sign form confirming accuracy of data.**

Step 1: Reason for claim submission*

- ☐ You obtained more medications than your plan covers because you required a vacation supply.
- ☐ Prior authorization was approved after you purchased your medication.
- ☐ The pharmacy was unable to process your prescription online due to system unavailability.
- ☐ Foreign claims: Include your prescription receipt with the name of the drug(s) and state the foreign currency used.
- ☐ Your Blue Shield of California Promise Health Plan ID was missing when you purchased your medication.
- ☐ You did not use a pharmacy in the Blue Shield of California Promise Health Plan Pharmacy Network.
- ☐ Your medication was compounded especially for you by your pharmacy.
- ☐ Other reason: _____

Submit to:

SS&C Health Solutions

P.O. Box 419019

For Medicare: Dept. 780

Kansas City, MO 64141

Step 2: Member information* (to be completed by member)

Member name

Address

City | State | ZIP

Phone | Member ID#

/ /

Date of birth

Sex: ☐ Male ☐ Female

Relationship:

☐ Self ☐ Spouse ☐ Child ☐ Other:

Explain relationship _____

Step 3: Pharmacy information* (to be completed by you or your pharmacist)

Pharmacy name

Address

City | State | ZIP

Pharmacy telephone | Pharmacy ID (NCPDP/NPI)

Medication #1	Medication #2	Medication #3
Tape pharmacy label receipt (receipt must include all the bold items listed in **Step 3: Pharmacy information** on the front of this form)	Tape pharmacy label receipt (receipt must include all the bold items listed in **Step 3: Pharmacy information** on the front of this form)	Tape pharmacy label receipt (receipt must include all the bold items listed in **Step 3: Pharmacy information** on the front of this form)

Medications compounded by pharmacy	**Compounded medications:** Pharmacist to identify the specific medications by date of service and Rx number. Please list all medication names, prescriber name and NPI, all NDC numbers, cost per ingredient, metric quantities of each ingredient, total amount paid, and compounding fee (if applicable) in box on left.

Pharmacist signature _____ Date _____

Step 4:

By signing this form, I certify that I have received the prescription drugs, listed in step 3, for which reimbursement is being requested. I have read and understood this form and all the information entered on this form is true and correct to the best of my knowledge.

Signature of patient, guardian, or legal representative _____ Date _____

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