BlueCross BlueShield of Florida
An Independent Licensee of the Blue Cross and Blue Shield Association

Instructions for Completing the Prescription Drug Program Subscriber Claim Form

Please note: One pharmacy and one subscriber per claim form

I. **Subscriber and Patient Information:** This section must be filled out in its entirety for claims to be processed. The ID Number can be found on the subscriber's Blue Cross and Blue Shield of Florida ID card.

II. **Patient Information:** This section must also be filled out in its entirety for claims to be processed.

III. **Pharmacy Information:** The Pharmacy NABP number is a unique ID number assigned to each pharmacy and is required for claims processing. If this number is not found on the subscriber's receipt, it may be obtained from the pharmacy.

IV. **Prescription Information:** Prescription Receipts are required for claims processing. Cash register receipts are not acceptable. Balance due field should be filled in when other insurance has paid as primary and a balance due is being requested.

V. **Subscriber Certification:** The subscriber must sign the Subscriber Certification for claims to be processed.

Mail completed claim form and receipts to:
Prime Therapeutics LLC
Mail Route – BCBSFL
P.O. BOX 14430
Lexington, KY 40512-4430

BlueCross BlueShield of Florida
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PRESCRIPTION DRUG PROGRAM SUBSCRIBER CLAIM FORM

SEND COMPLETED FORM & PHARMACY RECEIPTS TO:

PRIME THERAPEUTICS LLC
Mail Route – BCBSFL
P.O. BOX 14430
Lexington, KY 40512-4430

Instructions
(see back of form for detailed instructions)
1. Sections I through IV – Complete sections in their entirety.
2. Section V – Be sure to sign.

I. SUBSCRIBER INFORMATION (MUST BE COMPLETED)

SUBSCRIBER NAME	LAST	FIRST	M.I.	DATE OF BIRTH
				/ /

SUBSCRIBER ADDRESS	STREET	CITY	STATE	ZIP

SUBSCRIBER ID # H **GROUP #**

II. PATIENT INFORMATION (MUST BE COMPLETED)

PATIENT NAME			DATE OF BIRTH			PLEASE CHECK APPROPRIATE BOXES	SEX		RELATIONSHIP TO SUBSCRIBER (Check One)			
LAST	FIRST	M.I.	MO	DAY	YEAR		M	F	SELF	SPOUSE	CHILD	OTHER
							☐	☐	☐	☐	☐	☐

Was condition related to an accident? ☐ Yes ☐ No Accident Date / /

If yes, was it related to: ☐ Auto Accident ☐ Worker's Comp ☐ Other

Is other insurance applicable to charge? ☐ Yes ☐ No

If yes, complete the information below, and attach explanation of benefits.

Other Carrier Name _____ Policy # _____

Name of Subscriber _____

III. PHARMACY INFORMATION

PHARMACY NAME _____ **PHONE** ( )

STREET _____ **CITY, STATE, ZIP** _____

PHARMACY NABP # _____

Prescription Receipts Required for Processing

IV. PRESCRIPTION INFORMATION

DATE RX FILLED			RX NUMBER	QUANTITY	DAYS SUPPLY	NATIONAL DRUG CODE (NDC)	DRUG NAME	PRESCRIPTION COST	BALANCE DUE
MO	DAY	YR							

V. SUBSCRIBER CERTIFICATION

I Certify all information provided on this form and on the attached itemized statement to be true and correct to the best of my knowledge:

SUBSCRIBER SIGNATURE _____ DATE / /

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Form No. BCBS 13177-1006R SR

Reset