



BlueCross BlueShield of Tennessee

An Independent Licensee of the BlueCross BlueShield Association

BCBST Claims Service Center
P. O. Box 180150
Chattanooga, Tennessee 37401-7150

Prescription Drug Statement

Type or Print

This Section To Be Completed By Subscriber

1. Patient's Name (First, Middle Initial, Last)	2. Patient's Date of Birth	3. Subscriber's Name (First, Middle Initial, Last)
4. Subscriber's Identification No. or Medicare No.	5. Subscriber's Group No. (Or Group Name)	6. Subscriber's Address (Street, City, State, Zip Code)
7. Subscriber's Signature X		

This Section To Be Completed By Subscriber Or Network Pharmacy

Please transfer the following information from prescription receipts. It is not necessary to attach receipts. Pharmacist, you may place a "peel and stick" label if it contains the required information, including reference (authorization) number.

Reference (Authorization) No.	Date of Purchase	Amount Paid	Drug Store
A _____	_____	\$ _____	_____
A _____	_____	\$ _____	_____
A _____	_____	\$ _____	_____
A _____	_____	\$ _____	_____
A _____	_____	\$ _____	_____
A _____	_____	\$ _____	_____
A _____	_____	\$ _____	_____
A _____	_____	\$ _____	_____
A _____	_____	\$ _____	_____
A _____	_____	\$ _____	_____
A _____	_____	\$ _____	_____
A _____	_____	\$ _____	_____
		\$ _____	
		Total Charges	

This form must be fully completed by the member. Please use additional forms if needed. It is very important that the Reference (Authorization) number be included. If you do not have this number for each of your prescriptions, please contact your pharmacist.

