BlueCross BlueShield of Tennessee

www.bcbst.com

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

- CONFIDENTIAL -

Type or Print

Prescription Drug Statement

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. *Certification - I understand it is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.* Subscriber's Signature **X**		

This Section To Be Completed By **Subscriber Or Network Pharmacy**

Please attach prescription receipts. 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.

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**	

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Non-Network Pharmacy or No Reference Number

Please complete the following for all prescriptions purchased at non-network pharmacies and prescriptions without a reference number.

Pharmacy Name	NABP #	
Address	State	ZIP Code

Note To Pharmacy: The subscriber will file this claim for reimbursement of applicable benefits, payable to the subscriber.

Date Filled (MM/DD/YY)	RX Number	❑ New ❑ Refill	Metric Quantity	Days Supply	National Drug Code		
Medical Name, Strength, Dosage Form		Physician DEA		DAW Code	Amount Member Paid $		

Pharmacy Name	NABP #	
Address	State	ZIP Code

Note To Pharmacy: The subscriber will file this claim for reimbursement of applicable benefits, payable to the subscriber.

Date Filled (MM/DD/YY)	RX Number	❑ New ❑ Refill	Metric Quantity	Days Supply	National Drug Code		
Medical Name, Strength, Dosage Form		Physician DEA		DAW Code	Amount Member Paid $		

Pharmacy Name	NABP #	
Address	State	ZIP Code

Note To Pharmacy: The subscriber will file this claim for reimbursement of applicable benefits, payable to the subscriber.

Date Filled (MM/DD/YY)	RX Number	❑ New ❑ Refill	Metric Quantity	Days Supply	National Drug Code		
Medical Name, Strength, Dosage Form		Physician DEA		DAW Code	Amount Member Paid $		

Pharmacy Name	NABP #	
Address	State	ZIP Code

Note To Pharmacy: The subscriber will file this claim for reimbursement of applicable benefits, payable to the subscriber.

Date Filled (MM/DD/YY)	RX Number	❑ New ❑ Refill	Metric Quantity	Days Supply	National Drug Code		
Medical Name, Strength, Dosage Form		Physician DEA		DAW Code	Amount Member Paid $		

The pharmacist should complete this form. It is not necessary to attach receipts.

I hereby certify that my records show these drugs and medicines were dispensed in the quantities prescribed to the patient listed on the reverse side of this form by order of the patient's physician. I certify that the drug store or dispensary complies with Tennessee Code Annotated (State Law) 63-10-207.

Signature of Pharmacist X_____