of Tennessee
1 Cameron Hill Circle
Chattanooga, TN 37402

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PRESCRIPTION DRUG CLAIM FORM

Section I – Subscriber's Information

Subscriber's Name (First, Middle, Last)	*Group Number*	*Identification Number*

Subscriber's Address (Street, City, State, Zip)

Section II – Patient's Information

Patient's Name (First, Middle, Last)	*Patient's Date of Birth*

Does this patient have prescription drug coverage with another insurance company? ☐ YES ☐ NO
If YES, please provide the following information:

Other Insurance Company Name and Address

Other Insurance Company Phone	*Identification/Contract No.*	*Group No.*

Section III – Subscriber's Signature

Acknowledgement – 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: _____ Date: _____

Section IV – Instructions

To avoid delays in processing your prescription drug claims, it is important that you read and follow these instructions carefully before submitting a claim.

- Complete a separate claim form for each patient.
- Complete all subscriber and patient information in **Sections I** and **II** and make sure the subscriber has signed in **Section III**.
- If the patient has other prescription drug coverage, complete the other insurance information in **Section II**. Submit a copy of the other insurance Explanation of Benefits with this claim form if the patient's other insurance is primary.
- **Securely attach the original prescription drug receipts or a pharmacy printout to this claim form. When submitting a pharmacy printout, make sure the pharmacist has signed the printout. Do not send photocopies.**
- Incomplete forms or prescription drug receipts and pharmacy printouts missing required information will be returned to the subscriber.
- If the amount you paid does not match the amount shown on the prescription drug receipt or the pharmacy printout, please attach a copy of your cash register receipt showing the amount you paid.
- Keep copies of completed claim forms and prescription drug receipts or pharmacy printouts for your records.
- Prescription drug claims must be filed by December 31 of the year following the date the prescription is filled. If your coverage is no longer in effect, you must file your claim within 9 months following the date coverage ended.

Prescription drug receipts and pharmacy printouts must contain the following information:

- Patient's name
- Name, address and NABP or NPI of pharmacy
- Name of prescribing physician
- Name of drug, strength, and dosage form
- NDC (National Drug Code)
- Quantity and days' supply
- Rx number
- Date prescription filled
- Amount patient paid
- Reference/authorization number (Network Pharmacy)

Mail completed claim form and original prescription drug receipts or pharmacy printout to:

BlueCross BlueShield of Tennessee Claims Service Center • 1 Cameron Hill Circle, Suite 0002 • Chattanooga, TN 37402-0002

For questions, contact Member Service at 1-800-565-9140.
For a list of Network Pharmacies, visit www.bcbst.com.