



Use this form for filing Point-of-Sale Drugs from a Participating Pharmacy \*\*\* IMPORTANT: Please Read The Instructions On The Back Of This Form \*\*\*

Section I. PATIENT/CONTRACT HOLDER INFORMATION

Form section for patient/contract holder information including fields for name, birthdate, sex, contract number, group #, address, and relationship to contract holder.

Contract Holder Certification: I certify all information provided on this form to be true and correct to the best of my knowledge.

Signature Of Contract Holder

Date Signed

Section II. OTHER INSURANCE INFORMATION

Form section for other insurance information including fields for coverage status, policy number, name of policy holder, and effective date.

PLEASE ATTACH A COPY OF THE OTHER INSURER'S BENEFIT PAYMENT NOTICE.

Section III. PRESCRIPTION DRUGS

Please see back page for instructions. It is not necessary to attach receipts if this form is filled out correctly.

Print Numbers Carefully As Shown

Numbered grid for printing numbers 0-9

Table with 5 rows for prescription drug claims, each containing fields for claim authorization number, amount charged, prescription number, and date filled.

# INSTRUCTIONS

**Remember to always show your Blue Cross and Blue Shield ID card and ask for the Claim Authorization Number when purchasing a prescription drug.**

**Please read these instructions carefully before entering your prescription drug claim information on the other side. Claims without the required information could be delayed or returned to you.**

## **USE THIS FORM ONLY FOR DRUGS PURCHASED AT A PARTICIPATING PHARMACY**

1. Please use a separate form for each patient. You can file up to 5 prescriptions for the same patient on one form.
2. Use a black pen to fill out the form. Do not use a pencil.
3. Write in designated areas only. Where boxes are provided, please print only one character or number per box. Please do not print outside of the boxes.
4. Complete all information in Sections I and II. Please note:
  - The Contract Holder's ID number and patient information must be valid.
  - The Contract Holder must sign this claim form.
5. Complete the information in Section III or attach pharmacy receipts.
  - The receipt provided by your Pharmacist should provide the following:
    - Claim Authorization Number
    - Date filled
    - Amount Charged
    - Prescription Number

**The Claim Authorization Number and Prescription Number fields may contain more boxes than are necessary.**

**Do not attach prescription receipts if you complete this form in its entirety.**

6. Mail this claim form to the address shown below:

Blue Cross and Blue Shield of Alabama  
Attention: Prescription Drug Claims  
P.O. Box 830280  
Birmingham, Alabama 35283-0280