Regence BlueCross BlueShield of Utah | Regence ValueCare | Regence HealthWise

Regence BlueCross BlueShield of Utah, Regence ValueCare and Regence HealthWise are Independent Licensees of the Blue Cross and Blue Shield Association

DIRECT MEMBER REIMBURSEMENT FORM

DIRECTIONS: Please read and fill out entire form

1.) This form **must** be completely filled out in order to process your claim(s). **Please be thorough**.

2.) Attach all prescription receipt(s) to the back of this form.

3.) Prescription receipts must contain all of the following information: Rx number, date filled, physician, drug name, NDC#, days supply, quantity, and prescription charge.

*** *Store cash register receipts will not be accepted; pharmacy receipt(s)* ***MUST*** *contain the above information.*

4.) Sign form and mail receipts to:

Attention: Member Reimbursement
Regence BlueCross BlueShield of Utah
P. O. Box 30270
Salt Lake City, Utah 84130-0270

If you have questions or concerns, please call Pharmacy Customer Service at **1 (800) 572-0316**
Monday — Friday, 8:00 a.m. to 6:00 p.m. (MST)

EMPLOYEE (MEMBER) INFORMATION: (This is the individual whose name is on the I.D. Card)
Please Print

Employee Name: _____

Mailing Address: _____

_____
City State ZIP Code

_____
Employee Identification Number:

_____
Employer's Name:

PATIENT INFORMATION:

Patient Name: _____ Sex: Male/Female Date of Birth: _____/_____/_____

Prescription(s) are for: Employee ☐ Spouse ☐ Child ☐

PRESCRIPTION INFORMATION:

Rx Number	Date Rx was Filled	Doctor's Name	Drug Name and NDC #	Quantity	Days Supply	Pharmacy Charge

***** **ARE THESE REIMBURSEMENT(S) FOR DOUBLE COVERAGE?** *(Please check)* ☐ YES ☐ NO

If yes, please supply second contract number _____

I hereby certify that the above statements, including accompanying statements, are to the best of my knowledge true, correct, and complete. I hereby authorize any physician or service provided to furnish and disclose all known facts concerning this claim, upon request from the claim administrator. I will reimburse the fund for any overpayment made to me or on my behalf due to error on this form.

EMPLOYEE SIGNATURE: _____ DATE: _____

(Please see helpful hints to speed up your reimbursement)

HELPFUL HINTS
TO SPEED UP YOUR REIMBURSEMENT

DID YOU INCLUDE THE FOLLOWING NECESSARY INFORMATION?

1. Cardholder ID number (usually the identification number)
2. Actual pharmacy receipts and/or pharmacy printouts
3. The Dr.'s name for each prescription
4. The Quantity and Days Supply for each prescription
5. The Drug NDC# (National Drug Code) — (Can be found on the pharmacy receipt in most cases. If not, please ask pharmacist.)

ALSO ...

1. Did you complete the entire front section of this form including:
   - Your Employer's name?
   - Whether your claim is for double coverage or not?
   - Your correct mailing address?

FACT TO KNOW ...

✔ MEMBER REIMBURSEMENTS TAKE APPROXIMATELY **2 - 4 WEEKS** TO PROCESS.

✔ USE THIS FORM EACH TIME YOU ARE SUBMITTING CLAIM(S) FOR REIMBURSEMENT.

✔ SAVE TIME BY MAKING COPIES OF THIS FORM FOR FUTURE MEMBER REIMBURSEMENTS.

✔ CUSTOMER SERVICE HOURS OF OPERATION ARE:

8:00 AM — 6:00 PM, MONDAY — FRIDAY (MST)

PHONE: 1 (800) 572-0316