

*An Independent Licensee of the Blue Cross and Blue Shield Association

MEDICATION CLAIM FORM

We are pleased to be your medical plan carrier. Please use the following guidelines when submitting reimbursement requests for medication.

1. Complete one form per patient.
2. Your reimbursement request must be received no later than one year from the date the medication is filled.
3. Complete the information below.
4. Write your identification number on the top of each page.
5. Tape your original receipts in the boxes marked for receipts. Receipts must include pharmacy name and address, full name of patient, date filled, quantity, physician name, name of medication or item, prescription number, and charge/copayment. **Cash register receipts do not provide enough information.**
6. Retain copies of receipts for your records.
7. Sign the completed form where indicated at the bottom of this page and mail to:
Attn: Customer Service Department
P. O. Box 30270
Salt Lake City, Utah 84130-0270
8. Additional forms may be obtained by calling 1 (800) 624-6519 or **www.ut.regence.com**.

When to use this form.

- ✓ During the period between the effective date of the plan and receipt of your identification card.
- ✓ If the patient has dual coverage and if we are secondary to the other coverage, receipts or Explanation of Benefits (EOB) from the primary insurance carrier must accompany this claim form. The retail cost of the medication and the amount you paid as a copayment are required to process secondary claims.

Identification Number _____

Patient's Name _____ Employee Name _____

Patient's Date of Birth _____ Daytime Phone _____

Employee's Address _____

Is this medication covered under any other group insurance policy? Yes No If yes, give name of insurance company and ID number.

CERTIFICATION STATEMENT:

I certify that the above information is correct and that the above checked person is eligible for benefits. I have received the medication described hereon and authorize release of all information contained on this voucher to my prescription medication plan and the underwriter. I agree that any benefits payable hereunder for prescription medications are not assignable and that any assignment or attempted assignment thereof shall be void. I further represent that there has been no assignment of benefits hereunder.

➤ _____
Signature Date

For Internal Use Only Prep/Log: _____ / _____ Key/Date: _____ / _____ Revd Date: _____ / _____ Claim Type: _____

ID Number _____

TAPE RECEIPT HERE
In date order

For Internal Use Only
ID#/Dep Code: _____
Customer/Client: _____
DOB/Sex/Rel: _____

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Please return this form to:

**Customer Service Department
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