

IT IS TO YOUR ADVANTAGE TO ALWAYS USE YOUR PRESCRIPTION DRUG CARD TO AVOID FILING PAPER CLAIMS, WHICH DELAYS PAYMENT OF YOUR BENEFITS. Reminder: DO NOT use this form for BlueSCRIPT reimbursement.

To avoid delays in handling your claim, be sure all information is complete and correct.

A separate claim form must be completed for:

- Each patient
- Each pharmacy from which you purchase prescription drugs, if original receipt(s) is not attached

When submitting a claim, the following information must be included:

- | | |
|-----------------------|--|
| ■ Pharmacy name | ■ Quantity |
| ■ Prescription number | ■ Drug Charge |
| ■ Date of purchase | ■ Computer print-out |
| ■ Drug name | ■ Pharmacist's signature and/or original pharmacy receipt(s) |
| ■ Drug strength | |

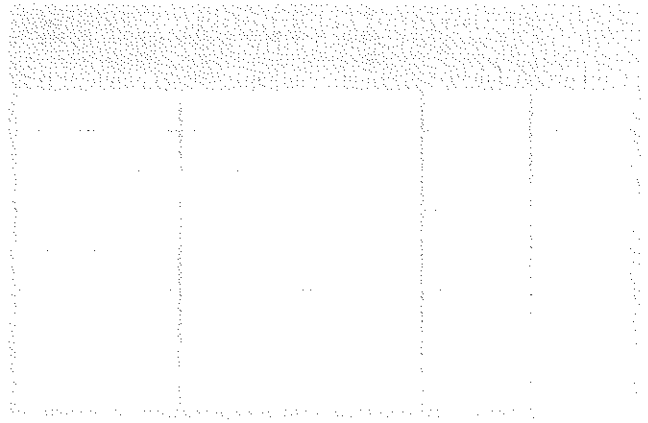
- DO NOT include charges for durable medical equipment which required a prescription to obtain.
- DO NOT submit canceled checks or cash register slips. These are not acceptable as substitutes for original receipts.
- DO NOT submit statement with balance amounts only.

Member/Patient Information — Complete all member and patient information in Part 1 on reverse side.

- The member ID number, group number and PCN number can be found on your member ID card.
- Sign and date in the space provided. Your signature certifies that the information is correct and complete.
- Complete a separate form for each family member and for each pharmacy.
- See your benefit administrator for additional claim forms, or log on to our Web site at www.bcbsil.com to download additional forms. Mail your completed form to the address shown below.
- Please make a copy of all documents and receipts before you send in your claim(s) as no documents will be returned.

Pharmacist to complete Part 3 of the form

- Include Rx number(s), drug name(s), strength(s) and date filled.
- Include NDC number(s) for the drug(s) dispensed.
- Indicate NABP number, pharmacy address and phone number.
- If a compound prescription, enter the NDC number of the most expensive ingredient of the legend drug used.
- Indicate the drug ingredient(s) and quantity.
- Indicate the "metric quantity" expressed in number of tablets, grams or mls for liquids, creams, ointments and injectables.
- Indicate the days supply (number of days the medication will last).
- Indicate the amount paid by the patient.
- Sign and date the form.
- Pharmacist questions? Call Prime Therapeutics' Contact Center at **800.821.4795**.



Mail this form and your original paid pharmacy receipt(s) to:

Blue Cross and Blue Shield of Illinois
P.O. Box 64812
St. Paul, MN 55164-0812