Prescription Drug Claim Form

of Tennessee

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Contract Number

Last Name	First Name	Middle Initial	Telephone Number
Address		Date of Birth	
City	State	Zip Code	Does Contract Holder have other Insurance? ☐ Yes ☐ No
If YES; Name of the Other Insurance Company			
Other Insurance Coverage Effective Date:	Please attach a copy of of the other insurer's benefit payment notice.		Other Insurance Contract Number
Address of Insurance Company	City	State	Zip Code

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

Signature of the Contract Holder ______________________ Date Signed ______________

PRESCRIPTION DRUGS

- See filing instructions on back
- Manual submission of claims does not guarantee reimbursement
- Attach original receipt OR have the pharmacist complete and sign this form.
- Claim forms and/or receipts without the required information cannot be processed and will be returned to you.

1.	Prescription Number (Rx#)	Date Filled	Amount Charged	Quantity	Days Supply
	Doctor	National Drug Code		Drug Name, Strength, Form	

2.	Prescription Number (Rx#)	Date Filled	Amount Charged	Quantity	Days Supply
	Doctor	National Drug Code		Drug Name, Strength, Form	

3.	Prescription Number (Rx#)	Date Filled	Amount Charged	Quantity	Days Supply
	Doctor	National Drug Code		Drug Name, Strength, Form	

CONTINUED →

PRESCRIPTION DRUGS

Pharmacy Name	Pharmacy/NABP Number/NPI	Telephone Number	
Street Address	City	State	Zip

I certify that the prescriptions listed above are legend drugs which require a prescription and must be dispensed by a Registered Pharmacist. I further certify that they were ordered by the Patient's attending physician for his/her use.

Signature of Registered Pharmacist ______________________ Date Signed ______________

Filing Your Claim is Easy if you Follow These Instructions:

- Indicate the reason for manually filing these claims:
  - ☐ Coordination of Benefits
  - ☐ I had not received my Blue Advantage Part D Card
  - ☐ Pharmacy not participating in network - **provide explanation below, or on separate sheet**
  - ☐ Pharmacy unable to process claim electronically
  - ☐ Emergency - If emergency, describe emergency below, or on a separate sheet

  Manual submission of claims does not guarantee reimbursement of claim.

Describe Emergency or Provide Explanation

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- Use a separate claim form if you use more than one pharmacy.
- Complete the top portion—Contract Holder Information completely. We prefer that you use black ink.
- Make sure you sign this form in the Contract Holder's Certification space.
- Attach original pharmacy receipts for each prescription, or have the pharmacist complete the form and sign it.
- If you attach the original pharmacy receipts you **do not** have to have the **pharmacist's signature**.
- Mail or fax this claim form to the address or fax number shown below:

Prescription Drug Claims
P.O. Box 12046
Birmingham, Alabama 35202-2046

Fax Number 1 866-432-9591

BlueRx is a Regional Medicare Prescription Drug Plan provided by Blue Cross and Blue Shield of Alabama and BlueCross BlueShield of Tennessee, Independent Licensees of the Blue Cross and Blue Shield Association.BlueRx contracts with CMS as a regional Medicare prescription drug plan.