



PLAN CODE

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WELLPOINT PHARMACY MANAGEMENT For the Blue Cross of California Prescription Drug Program P.O. Box 4165, Woodland Hills, CA 91365-4165

CERTIFICATE/SUBSCRIBER ID NUMBER (THIS NUMBER IS ON YOUR ID CARD)

PRESCRIPTION DRUG CLAIM FORM

INSURED: PLEASE RETURN COMPLETED FORM TO THE ADDRESS SHOWN ON THE REVERSE SIDE.

Insured Name (PLEASE PRINT) First Middle Last
Insured Mailing Address Street City State ZIP Code

PRESCRIPTIONS WERE DISPENSED TO: (Use a separate claim form for each individual patient.)

PATIENT NAME (PLEASE PRINT) First Middle Last
PATIENT BIRTHDATE M / D / Y SEX M F RELATIONSHIP TO INSURED (CHECK ONE BOX) SELF SPOUSE CHILD

NOTE: USE A SEPARATE CLAIM FORM FOR EACH PATIENT. DO NOT SEND IN COMPUTER PRINTED RECEIPTS OR PHOTOCOPIES OF THE COMPLETED CLAIM FORM.

DOES THAT PATIENT HAVE OTHER HEALTH INSURANCE COVERAGE? YES NO IF YES, YOU MUST COMPLETE THE FOLLOWING:
DOES THE OTHER COVERAGE INCLUDE: MAJOR MEDICAL DRUG OTHER MEDICAL
INSURED'S NAME
SPOUSE'S BIRTHDATE M / D / Y INSURED'S ID NUMBER EFFECTIVE DATE
INSURANCE COMPANY NAME
ADDRESS Street City State ZIP Code

HAVE YOU BEEN TREATED WITHIN THE PAST 24 MONTHS FOR THE SAME CONDITION FOR WHICH ANY OF THESE DRUGS HAVE BEEN PRESCRIBED? YES NO
IF YES, INDICATE DATE FIRST TREATED M / D / Y IF YES, INDICATE THE CONDITION BEING TREATED

I certify that the above information is correct and that I have received the drugs described below. I also certify that the patient for whom this claim is made is eligible for benefits. The drugs listed below are not for treatment of an occupational injury or disease, for which the Employer has accepted liability. The medication is not covered under any other group insurance plan or other employer.

I authorize the pharmacy to furnish the administrator with any information it requests relating to the prescription(s) listed below.

THIS FORM MUST BE SIGNED: SIGNATURE Patient or Parent if a Minor Date

YOUR PHARMACIST MUST COMPLETE THIS SECTION: WE CANNOT PROCESS THIS FORM WITHOUT THIS INFORMATION.

Pharmacist: When using a Pharmacy computer or Point of Service device, you need to record only THE SHADED AREAS OF THE CLAIM FORM.

SECTION "A"

Table with 8 columns: RX NUMBER, DATE FILLED, CHECK ONE (NEW RX, REFILL RX), METRIC QUANTITY, DAYS SUPPLY, PRESCRIBING PHYSICIAN DEA NUMBER OR NAME, IS Rx: (NO DAW, MD DAW, PATIENT DAW, RPH DAW, NO GENERIC, BRAND DISPENSED AS GENERIC), RX PRICE. Contains 4 rows of prescription data.

PHARMACIST MUST COMPLETE:

Pharmacy Name
Street Address
City State ZIP Code
Phone #

PHARMACY NABP NUMBER
Total number of Prescriptions
TOTAL PRICE \$

SEE REVERSE SIDE FOR NABP NUMBER INSTRUCTIONS IF DISPENSED BY PHYSICIAN USE ALL 9 SPACES FOR TIN NUMBER

THIS FORM MUST BE SIGNED BY PHARMACIST Pharmacist Date

NOTE: Payment for the above claim(s) will be made directly to the insured. Any assignment of these benefits must include the signature of the insured and is subject to approval.

PATIENT MUST COMPLETE THIS SECTION

PHARMACIST REVIEW REVERSE SIDE FOR INSTRUCTIONS

## INSTRUCTIONS

Please read this carefully before completing the claim form.

**Claim forms without the required information cannot be processed.  
Incomplete claim forms will be returned to you.**

### SUBSCRIBER:

- a. Bring this claim form **to the pharmacy** when you obtain prescription drugs.
- b. Use a **separate** claim form for each family member.
- c. You must complete the top portion of the claim form (certificate/subscriber ID number, name, address, etc.) before presenting it to the pharmacist.
- d. Give the claim form **to your pharmacist** to complete the lower portion (Rx number, drug dispensed, etc.)
- e. A cash register tape is **not** considered satisfactory evidence of purchase.
- f. A computer printout of the prescriptions from the pharmacy cannot be processed. The claim form must be completed on the reverse side. Your pharmacist may complete a Prescription Drug Universal Claim Form (UCF) and attach it to this form instead of completing the lower portion of this claim form.
- g. Mail the claim form directly to the address below:

**REMEMBER: The certificate/subscriber ID number and patient information must be valid and correct.  
The pharmacist must complete the lower portion of the claim form.**

**IF YOU HAVE QUESTIONS CALL:  
1 (800) 678-DRUG**

### PHARMACIST:

When using a pharmacy computer or Point-of-Service (P.O.S.) device: **YOU NEED TO RECORD ONLY THE REFERENCE NUMBER, PHARMACY NAME AND ADDRESS, NABP NUMBER AND YOUR SIGNATURE ONTO THE CLAIM FORM.**

If you are not using a pharmacy computer or P.O.S. device:

- a. You should complete the lower portion in detail (Rx number, drug dispensed, etc.).
- b. You must provide the complete name and address of the pharmacy, NABP number, and authorized signature. The first six digits of your seven digit NABP number is the same as the provider number used for many other pharmaceutical administrators. If you have questions regarding your NABP number, please call the toll-free number listed below for instructions.
- c. You may complete a Universal Claim Form (UCF) instead of completing the lower portion of this claim form. **THE UCF MUST BE ATTACHED TO THIS CLAIM FORM AND MUST BE SUBMITTED BY THE SUBSCRIBER.** The pharmacy NABP number must be written on the front of the claim form or on the Universal Claim Form. Do not attach more than 4 prescriptions per Prescription Drug Claim Form.  
Do not include both reference number and non-reference number items on the same claim form. Claims that could not be placed on the Point-of-Service system should be entered on a separate Prescription Drug Claim Form.
- d. The DAW field indicates a situation where a generic drug could have been dispensed. If the physician requires that the brand drug be dispensed, the box marked MD DAW should be checked. The other boxes should be checked accordingly if the employee or pharmacist requests a brand name drug or if there is no generic drug available at the pharmacy.

**TO THE PHARMACIST – IF YOU HAVE QUESTIONS CALL: 1-800-678-DRUG**

Blue Cross of California prescription drug benefits are administered by WellPoint Pharmacy Management.

MAIL TO:

WellPoint Pharmacy Management  
Attn: BLUE CROSS OF CALIFORNIA  
P.O. Box 4165  
Woodland Hills, CA 91365-4165