



## INSTRUCTIONS

PLEASE WAIT UNTIL YOU RECEIVE YOUR BLUE SHIELD I.D. CARD BEFORE SENDING THIS CLAIM FOR REIMBURSEMENT. CLAIMS WITHOUT THE PROPER IDENTIFICATION NUMBER FROM YOUR BLUE SHIELD I.D. CARD WILL NOT BE PROCESSED.

To avoid undue delays, complete all required areas of information on the claim form.

Be sure to copy the last nine letters and digits from your subscriber identification number (ID#) exactly as it appears on the Blue Shield identification card. If this is not done, the claim form will be returned to you.

Keep a copy of your receipt(s) for your records. © A registered mark of the Blue Shield Association

## HOW TO COMPLETE THIS FORM

### PART ONE

#### Subscriber Information



Medicare Part D subscribers, do **not** use this form!

1. Copy the last 9 letters and digits from the Subscriber Identification Number on the Blue Shield I.D. Card.
2. Subscriber name, address, and telephone number.
3. Patient Name: Person for whom the drug was prescribed.
4. Patient Date of Birth: Month, Day, Year.
5. Patient Sex: Check Male or Female.
6. Status: Patient's relationship to subscriber. If "other" is selected, please write in the type of relationship.
7. Please use a separate claim form for each family member.

### PART TWO

#### Pharmacy Information

1. Pharmacy name, address, and telephone number where the prescription(s) were purchased.
2. Pharmacy ID (NCPDP/NPI): Obtain this number from the pharmacy where prescriptions were purchased.
3. Tape a copy of pharmacy label receipts to the form in the space provided. The receipts must indicate date of service, Rx number, NDC number, quantity, days supply, and the amount paid. For foreign claims, state the currency used.
4. For medications compounded by the pharmacy, the pharmacist must complete and sign the sections titled, "**Medications compounded by Pharmacy**" and "**Compounded Medications**" on page one of this form.
5. Use a **separate claim form** for the different pharmacies from which you have purchased prescriptions.

**Note: Claim submission is not a guarantee of payment.**

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| <b>Reason for Claim Submission:</b><br><input type="checkbox"/> Your Blue Shield membership was loaded late.<br><input type="checkbox"/> Your Blue Shield ID Card was missing when you purchased your medication.<br><input type="checkbox"/> Prior Authorization was approved after you purchased your medication.<br><input type="checkbox"/> You did not use a pharmacy in the Blue Shield Pharmacy Network.<br><input type="checkbox"/> The pharmacy was unable to process your prescription online due to system unavailability.<br><input type="checkbox"/> Your medication was compounded especially for you by your pharmacy. | <b>Submit to:</b><br><b>Blue Shield of California</b><br><b>Argus Health Systems, Inc.</b><br><b>P.O. Box 419019,</b><br><b>Dept 191</b><br><b>Kansas City, MO 64141</b> |
| <b>FOREIGN CLAIMS:</b><br>Include your prescription receipt with the name of the drug(s) and state the foreign currency used.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | <b>Submit to:</b><br><b>Blue Shield of California</b><br><b>Attn: Foreign Claims</b><br><b>PO BOX 272550</b><br><b>Chico, CA 95927-2550</b>                              |
| <b>OTHER REASON:</b><br><input type="checkbox"/> You obtained more medications than your plan covers because you required a vacation supply.<br><input type="checkbox"/> Other reason: _____                                                                                                                                                                                                                                                                                                                                                                                                                                          | <b>Submit to:</b><br><b>Blue Shield of California</b><br><b>c/o Pharmacy Services</b><br><b>PO BOX 7168</b><br><b>San Francisco, CA 94120-7168</b>                       |