Kansas City

Prescription Drug Program
Direct Member Reimbursement Form

Complete and return this form when you have purchased a covered prescribed prescription drug at retail cost and are seeking reimbursement. **Submit this form with the original prescription label receipt(s). Cash register and credit card receipts alone are not acceptable as proof of purchase. Reimbursement is not guaranteed.**

Claims will be subject to limitations, exclusions and other provisions of the Plan Benefit.

Patient Information (one form per patient)

Health Plan (Insurance) Name *(please print)*		
Name *(Last Name, First Name, MI)*	Birth Date	I.D. Number
Mailing Address *(Number, Street, City, State & Zip Code)*		
Prescribing Physician's Name		Physician's Telephone Number

Reason For Request

(At least one must be checked)

- ☐ Out of Area emergency medication
- ☐ Compound medication
- ☐ Non-emergency medication/vacation request
- ☐ Member not found in pharmacy system
- ☐ No identification card or identification number available
- ☐ Other: _____
- ☐ Coordination of Benefits (From Primary Insurance – complete section below)

Coordination of Benefits

(If your primary insurance has already paid for the attached prescription, please complete this section.)

Primary Health Plan/Insurance Company Name _____

Primary Member/Subscriber's Name *(Last Name, First Name, MI)* _____

Primary Member/Subscriber's ID

I certify that the patient for whom this claim is made is a covered person in this Prescription Drug Program and that the prescription is for the sole use of the named patient. I also certify that the claim(s) being submitted for payment are not eligible for payment under a no-fault automobile or workers compensation insurance program. I also authorize release of all information pertaining to this claim(s) to the plan administrator, underwriter, sponsored policy holder and/or employer.

X_____ _____

Member's/Subscriber's Signature — Date

Special Instructions:

Prescription Label receipt must have the following information clearly legible or reimbursement could be delayed or denied.

- Pharmacy Name
- Drug name, strength and quantity
- Prescribing physician's name
- Prescription number and date filled
- Member paid expense

The claim(s) will be returned if the member/subscriber's signature is not present.

Please mail label receipt(s) and this completed form to:

Blue Cross and Blue Shield of Kansas City
Pharmacy Services
P.O. Box 412735
Kansas City, MO 64141-2735

Reimbursement and correspondence will be issued to the primary member/subscriber.