

IT IS TO YOUR ADVANTAGE TO ALWAYS USE YOUR PRESCRIPTION DRUG CARD TO AVOID FILING PAPER CLAIMS, WHICH DELAYS PAYMENT OF YOUR BENEFITS.

INSTRUCTIONS

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

CLAIM SUBMISSION

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

- Pharmacy name
- Prescription number
- Date of purchase
- Drug name
- Drug strength
- Quantity
- Drug Charge
- Computer print-out
- Pharmacist's signature and/or original pharmacy receipt(s)
- DO NOT include charges for durable medical equipment.
- DO NOT submit canceled checks or cash register slips. These are not acceptable as substitutes for original receipts.
- DO NOT submit statements with balance amounts only.

HOW TO COMPLETE THIS FORM

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.bcbsnm.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.

PHARMACY INFORMATION

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**.

COMPOUND PRESCRIPTIONS

For pharmacy use only

NDC number	Drug ingredient	Quantity	Charge

MAILING INSTRUCTIONS

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

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