Prescription Drug Reimbursement Form for Microsoft

PREMERA | BLUE CROSS

You may submit your claim electronically without completing this form. From the Microsoft Benefits Site, select Refill a Prescription. Then, on the ESI website, select Benefits > Forms. Under the Request reimbursement section choose Start a Claim.

Subscriber information *See your Premera ID card*

Premera identification #

Rx Group # **BCWAPDP**

Name:
(*Member first and last name*)
Street address:

City: State: ZIP:

Note that this shipping address will be visible to other family members on the Web (as the last-used shipping address for your household). If, on this website, you would like to block your shipping address from the view of other family members, please contact Premera about filing a nondisclosure request.

Patient information

Name:
(*Patient First and Last Name*)

Date of birth: (MM/DD/YYYY)

Gender:

*Relation to Plan subscribe*r:

Pharmacy information

Name of pharmacy:

Street address:

City: State: ZIP:

Telephone:
(include area code)

Any person who knowingly and with intent to defraud, injure, or deceive any insurance company submits a claim or application containing any materially false, deceptive, incomplete, or misleading information pertaining to such claim may be committing a fraudulent insurance act, which is a crime and may subject such person to criminal or civil penalties, including fines and/or imprisonment or denial of benefits.†

* A compounded medicine is a blend of ingredients that the pharmacist prepares especially for you at your prescriber's request. To be covered under your pharmacy benefit, a compounded medicine must have at least one ingredient that is a prescription drug with an FDA-approved therapeutic indication.

Claim receipts

Tape claim receipts or itemized bills on page two.
Do not staple!

Check the appropriate box if any of the receipts are for a medication that:

☐ **Is a compound prescription.***
Make sure your pharmacist lists ALL the VALID 11-digit NDC numbers and quantities for each ingredient on page two of this form and attach receipts. Claim will be returned if incomplete.

ONE CLAIM FORM PER COMPOUND PRESCRIPTION.

☐ **Was purchased outside the USA.**
If so, please indicate:
Country:
Currency used:

Important: Foreign claims MUST include:
1) Name of drug 2) Strength 3) Quantity
Claim will be returned if incomplete.

☐ **Is for treatment of an allergy.**

Other Prescription drug coverage

Medicare supplement members need not complete this section.

☐ **Submitting Secondary Coverage – Prescription Claim for reimbursement.**

Check one:

☐ Receipt indicates the total price paid for the prescription.

☐ Receipt indicates the copayment amount paid under primary plan or other health insurance carrier.

☐ Explanation of Benefits from primary plan or other health insurance carrier attached.

For Secondary Coverage – Prescription Claim submission only

Return the completed form and receipt(s) to:

Premera Blue Cross
PO Box 91059, Seattle, WA 98111-9159

Please tape receipts on the second page.

Acknowledgement

I certify that the medication(s) described above was/were received for use by the patient listed above, and that I (and the patient, if not myself) am eligible for drug benefits. I also certify that the medication received was not for an on-the-job injury or covered under another benefit plan. I recognize that reimbursement will be paid directly to me, and that assignment of these benefits to a pharmacy or any other party is void.

X_____ **Date** _____

Signature of Patient (or legal guardian if patient cannot legally consent to services)

If allowed by law, you may assign the payment of this claim to your pharmacy. If your pharmacy is willing to accept assignment, do not complete this form. Please request that your pharmacy contact Pharmacy Services at 1 800 922-1557 for assistance.

Claim receipts

Please tape your receipts here. **Do not staple!** Tape additional non-compound receipts on a separate piece of paper.

Tape receipt for prescription 1 here.

Receipts must contain the following information:

- Date prescription filled
- Name and address of pharmacy
- Doctor name or ID number
- NDC number (drug number)
- Name of drug and strength
- Quantity and days' supply
- Prescription number (Rx number)
- DAW (Dispense As Written)
- Amount paid

Tape receipt for prescription 2 here.

Receipts must contain the following information:

- Date prescription filled
- Name and address of pharmacy
- Doctor name or ID number
- NDC number (drug number)
- Name of drug and strength
- Quantity and days' supply
- Prescription number (Rx number)
- DAW (Dispense As Written)
- Amount paid

PHARMACY INFORMATION (For Compound Prescriptions ONLY)

- List the **VALID 11-digit NDC** number for **EACH** ingredient used for the compound prescription. **(A)**
- For each NDC number, indicate the "metric quantity" expressed in the number of tablets, grams, milliliters, creams ointments, injectables, etc. **(B)**
- For each NDC number, indicate cost per ingredient. **(C)**
- Indicate the **TOTAL** charge (dollar amount) paid by the patient. **(D)**
- **Receipt(s)** must be attached to claim form**.**

RX#		Date Filled (mm/dd/yy)		Days Supply (###)	

(A) VALID 11- digit NDC#	(B) Quantity	(C) Price
Total Quantity		
(D) Total Charge		

Instructions Read carefully before completing this form. An incomplete form may delay reimbursement.

1. Always present your Premera ID card at the participating retail pharmacy.
2. Only use this claim form when you have paid a pharmacy full price for a prescription drug order and are seeking reimbursement.
3. You must complete a **separate** claim form for **each pharmacy** used and for **each patient.**
4. You must submit claims within 1 year of date of purchase or as required by your Plan.

†California: For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

5. **Be sure your receipts are complete.** In order for your request to be processed, all receipts must contain the information listed above. Your pharmacist can provide the necessary information if it is not itemized on your claim or bill.
6. You should read the Acknowledgement carefully, then sign and date this form.

For PRIMARY claim submission

7. **Return the completed form and receipt(s) to:**

Express Scripts
P.O. Box 14711
Lexington, KY 40512

Note: *See front of form for Secondary Coverage – Prescription Claims address.*

Questions? Call the Premera Blue Cross Microsoft-dedicated Customer Service Team at 800-676-1411.

Notice of availability and nondiscrimination **800-722-1471 | TTY: 711**

Call for free language assistance services and appropriate auxiliary aids and services.
Llame para obtener servicios gratuitos de asistencia lingüística, y ayudas y servicios auxiliares apropiados.
呼吁提供免费的语言援助服务和适当的辅助设备及服务。
呼籲提供免費的語言援助服務和適當的輔助設備及服務。
Gọi cho các dịch vụ hỗ trợ ngôn ngữ miễn phí và các hỗ trợ và dịch vụ phụ trợ thích hợp.
무료 언어 지원 서비스와 적절한 보조 도구 및 서비스를 신청하십시오.
Звоните для получения бесплатных услуг по переводу и других вспомогательных средств и услуг.
Tumawag para sa mga libreng serbisyo ng tulong sa wika at angkop na mga karagdagang tulong at serbisyo.
Звертайтесь за безкоштовною мовною підтримкою та відповідними додатковими послугами.
សូមហៅទូរសព្ទទៅសេវាជំនួយភាសាដោយឥតគិតថ្លៃ ព្រមទាំងសេវាកម្ម និងជំនួយចាំបាច់ដែលសមរម្យផ្សេងៗ។
無料言語支援サービスと適切な補助器具及びサービスをお求めください。
ለነፃ የቋንቋ እርዳታ አገልግሎቶች እና ተገቢ ድጋፍ ሰጪ አጋዥ መሳሪያዎችን እና አገልግሎቶችን ለማግኘት በስልክ ቁጥር
Tajaajiloota deeggarsa afaan bilisaa fi gargaarsaa fi tajaajiloota barbaachisaa ta'an argachuuf bilbilaa.
મુફત ભાષા સહાયિતા સેવાવાં અને ઉચિત સહાયિક ચીજાં અને સેવાવાં વાસતે કાલ કરો।
Fordern Sie kostenlose Sprachunterstützungsdienste und geeignete Hilfsmittel und Dienstleistungen an.
ໂທເພື່ອຮັບການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ແລະ ການບໍລິການ ແລະ ການຊ່ວຍເຫຼືອພິເສດທີ່ເໝາະສົມແບບບໍ່ເສຍຄ່າ.
Rele pou w jwenn sèvis asistans lengwistik gratis ak èd epi sèvis oksilyè ki apwopriye.
Appelez pour obtenir des services gratuits d'assistance linguistique et des aides et services auxiliaires appropriés.
Zadzwoń, aby uzyskać bezpłatną pomoc językową oraz odpowiednie wsparcie i usługi pomocnicze.
Ligue para serviços gratuitos de assistência linguística e auxiliares e serviços auxiliares adequados.
Chiama per i servizi di assistenza linguistica gratuiti e per gli ausili e i servizi ausiliari appropriati.
اتصل للحصول على خدمات المساعدة اللغوية المجانية والمساعدات والخدمات المناسبة.
برای خدمات کمک زبانی رایگان و کمک‌ها و خدمات امدادی مقتضی، تماس بگیرید.

Discrimination is against the law. Premera Blue Cross (Premera) complies with applicable Federal and Washington state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex characteristics, intersex traits, pregnancy or related conditions, sexual orientation, gender identity, and sex stereotypes. Premera does not exclude people or treat them less favorably because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. Premera provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). Premera provides free language assistance services to people whose primary language is not English, which may include qualified interpreters and information written in other languages. If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact our Civil Rights Coordinator. If you believe that Premera has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity, you can file a grievance with: Civil Rights Coordinator — Complaints and Appeals, PO Box 91102, Seattle, WA 98111, Toll free: 855-332-4535, TTY: 711, Fax: 425-918-5592, Email AppealsDepartmentInquiries@Premera.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Ave SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html. You can also file a civil rights complaint with the Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint Portal available at https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status, or by phone at 800-562-6900, 360-586-0241 (TDD). Complaint forms are available at https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx.

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