Capital

Questions about completing this form?
Please call the number on the back of your ID card (TTY: 711).
Call 24 hours a day, seven days a week.

Mail your completed claim form(s) and original, detailed pharmacy receipts to:
Medicare Claims
PO Box 20970
Lehigh Valley, PA 18002-0970

Medicare claim form

Please complete each section of this form.

MEMBER INFORMATION

First name	
Last name	
Date of birth	__ __ / __ __ / __ __ __ __
Member ID number	
Phone number	
Street address	
City	
State	ZIP Code

Your ID number is listed on your ID card.

PHARMACY/CLINIC/HOSPITAL INFORMATION

Name	
Phone #	
Federal tax ID	---
Street Address	
City	
State	ZIP Code

The federal tax ID number is a nine-digit number assigned to your pharmacy, clinic, or hospital that provided your drug/product.

OTHER HEALTH INSURANCE INFORMATION

If you have other pharmacy benefit insurance (for example, auto) that covers this drug/product, please send copies of:

1. Both sides of your other health insurance card.
2. The Explanation of Benefits (EOB) page that shows the amount paid, or the reason why coverage was denied.

WHY ARE YOU SENDING THIS CLAIM?

Please check any of the reasons shown below or write your own reason.

❑ I couldn't choose an in-network pharmacy because I received the covered drug/product while in an ER department, medical clinic, or other outpatient setting (for example, self-administration of drug for same-day surgery).

❑ I became sick or ran out of my drug while traveling outside of my plan's service area (but still within the U.S.).

❑ I couldn't get a covered drug/product when I needed it because I couldn't find a 24-hour network pharmacy near me.

❑ The covered drug/product I needed is not usually stocked at an in-network retail (local) or home delivery pharmacy service.

❑ I couldn't use an in-network pharmacy because I was evacuated or displaced due to a federally declared disaster or health emergency.

❑ Other (explain)_____

_____

INSTRUCTIONS FOR COMPLETING THIS FORM

- Medicare payment rules say that your provider must:

  a. Have a valid 10-digit National Provider Identifier (NPI) number, *and*

  b. Accept Medicare claims, *or*

  c. Have filed forms to show they have asked for Medicare's approval to write prescriptions.

- Use one claim form for each member and each pharmacy/clinic/hospital.

  For example:
  - One member + two pharmacies = two forms.
  - One member with multiple drugs received on the same date or during the same hospital stay = one form.
  - Two members who each use two pharmacies = four forms.
- When submitting a pharmacy, clinic, or hospital claim with multiple drugs, attach the billing statement.
- Pharmacy, clinic, or hospital receipts or bills are required. Not accepted: canceled checks or receipts that only show the amount paid.
- Before you send in your claim(s), be sure to make a copy of all forms and receipts.

CLAIM INFORMATION

Original pharmacy receipts or bills are required. Please do not staple them to this form.

Receipts must show:

❑ Pharmacy/clinic/hospital name.	❑ Date purchased.	❑ NDC number.
❑ Strength.	❑ Quantity.	❑ Days' supply.
❑ Drug/product name.	❑ Drug/product cost.	❑ NPI number.

All of the fields on the next page must be completed in order to process your claim. If you need help finding the information, please ask your pharmacist.

CLAIM FORM

Example claim				
Date filled	1 0 / 0 1 / 2 0 2 0			*Your pharmacist/healthcare provider can give you the national drug code (NDC) and your doctor's national provider identifier (NPI) numbers.*
Quantity	60	Days' supply	30	
Drug/product name	Name of drug/product			
NDC number	0 0 1 8 6 5 0 2 2 2 8			◀ **National drug code**
NPI number	9 2 1 5 2 4 1 1 6 3			◀ **National provider identifier**
Total cost of drug/product	$146.04	Amount you paid	$36.57	

Claim 1

Date filled	__ __ / __ __ / __ __ __ __			*Your pharmacist/healthcare provider can give you the national drug code (NDC) and your doctor's national provider identifier (NPI) numbers.*
Quantity		Days' supply		
Drug/product name				
NDC number	__ __ __ __ __ __ __ __ __ __ __			◀ **National drug code**
NPI number	__ __ __ __ __ __ __ __ __ __			◀ **National provider identifier**
Total cost of drug/product		Amount you paid		

Claim 2

Date filled	__ __ / __ __ / __ __ __ __			*Your pharmacist/healthcare provider can give you the national drug code (NDC) and your doctor's national provider identifier (NPI) numbers.*
Quantity		Days' supply		
Drug/product name				
NDC number	__ __ __ __ __ __ __ __ __ __ __			◀ **National drug code**
NPI number	__ __ __ __ __ __ __ __ __ __			◀ **National provider identifier**
Total cost of drug/product		Amount you paid		

Claim 3

Date filled	__ __ / __ __ / __ __ __ __			*Your pharmacist/healthcare provider can give you the national drug code (NDC) and your doctor's national provider identifier (NPI) numbers.*
Quantity		Days' supply		
Drug/product name				
NDC number	__ __ __ __ __ __ __ __ __ __ __			◀ **National drug code**
NPI number	__ __ __ __ __ __ __ __ __ __			◀ **National provider identifier**
Total cost of drug/product		Amount you paid		

Claim 4

Date filled	__ __ / __ __ / __ __ __ __			*Your pharmacist/healthcare provider can give you the national drug code (NDC) and your doctor's national provider identifier (NPI) numbers.*
Quantity		Days' supply		
Drug/product name				
NDC number	__ __ __ __ __ __ __ __ __ __ __			◀ **National drug code**
NPI number	__ __ __ __ __ __ __ __ __ __			◀ **National provider identifier**
Total cost of drug/product		Amount you paid		

COMPOUND DRUG INFORMATION

A compound drug is made of two or more drugs that are combined. If you are taking a compound drug, your pharmacist needs to enter the NDC numbers for all the ingredients used.

NDC number	Drug ingredient	Quantity	Cost

MEMBER CERTIFICATION

Your signature below certifies that:

- The information on this form is correct.
- The member named above is eligible for pharmacy benefits.
- The member named above received the drug(s)/product(s) listed.
- These benefits have not been assigned; any further assignment is void.
- I give my permission to share the details of this form with Capital Blue Cross.

Member or legal representative signature* _____ Date _____

*If you are not the member, the member's prescribing physician, or other prescriber, you must provide a signed Appointment of Representative Form (or equivalent notice) along with this request. For information on how to appoint a representative, please refer to your plan benefit materials or call the number on the back of your ID card.

OTHER RESOURCES

Medicare Help Line:
1.800.MEDICARE (1.800.633.4227)
TTY/TDD: 1.877.486.2048
Calls answered 24 hours/day,
7 days/week, except on federal holidays.

Healthcare Insurance Fraud Hotline:
1.800.706.4071
TTY/TDD 1.800.693.3816
Monday through Friday, 9:00 AM to
6:00 PM ET.

It is a crime to knowingly give false information or submit a fraudulent claim to get paid for a benefit. It is a crime to give false information on an insurance application. If convicted, the person may have to do any or all of the following: pay the money back, pay a fine, and/or serve time in prison.

Fraud increases the cost of healthcare for all of us. If you know of (or suspect) any type of health insurance fraud, please call one of the hotline numbers listed above. You don't need to give your name; all calls are confidential.

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