

Prescription Drug Reimbursement Form

See the back for instructions. Complete all information.
An incomplete form may delay your reimbursement.



A Medicare Prescription Drug Plan
from Highmark Senior Resources Inc.
Highmark Blue Shield and Highmark Senior Resources are
Independent Licensees of the Blue Cross and Blue Shield Association



Member/Subscriber Information *See your Member ID card.*

Group No. **S P B L U E 2**

Member ID

Member Name (First, Last)

Street Address

City

State

Zip

Patient Date of Birth (Month/Day/Year)

Sex *Relation to Plan Member*

Female Self

Male

Pharmacy Information

Name of Pharmacy

Street Address

City

State

Zip

Telephone (include area code)

Acknowledgment

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.

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.

California: For your protection California law requires the following to appear on this form: Any person who knowingly presents 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.

Signature of Member

Claim Receipts

Tape claim receipts or itemized bills on the back.

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 NDC numbers and quantities for each ingredient on the back of this form and attach receipts. **Claim will be returned if incomplete.**

ONE CLAIM FORM PER COMPOUND SUBMISSION.

Was purchased outside the U.S.A.

If so, please indicate:

Country _____

Currency used _____

Is for treatment of an allergy.

Please tape receipts on the back

