of Tennessee

bcbst.com

BCBST Claims Service Center
1 Cameron Hill Circle, Suite 0002
Chattanooga, Tennessee 37402-0002

# Prescription Drug Statement

**-- Confidential --**

***Please Print.***

## *This Section To Be Completed By Subscriber*

| 1. Patient's Name *(First, Middle Initial, Last)* | 2. Patient's Date of Birth | 3. Subscriber's Name *(First, Middle Initial, Last)* |
|---|---|---|
| 4. Subscriber's Identification No. or Medicare No. | 5. Subscriber's Group No. *(Or Group Name)* | 6. Subscriber's Address *(Street, City, State, Zip Code)* |
| 7. **Certification** - ***I understand it is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.*** **Subscriber's Signature X** | | |

## *This Section To Be Completed By Subscriber OR Network Pharmacy*

***Please attach prescription receipts. It is very important that the Reference (Authorization) number be included. If you do not have this number for each of your prescriptions, please contact your pharmacist.***

***Pharmacist**, you may place a "peel and stick" label if it contains the required information, including reference (authorization) number.*

| Reference *(Authorization)* No. | Date of Purchase | Amount Paid | Drug Store |
|---|---|---|---|
| A | | $ | |
| A | | $ | |
| A | | $ | |
| A | | $ | |
| A | | $ | |
| A | | $ | |
| A | | $ | |
| A | | $ | |
| A | | $ | |
| A | | $ | |
| A | | $ | |
| A | | $ | |
| | | $ **Total Charges** | |

BlueCross BlueShield of Tennessee, Inc., an Independent Licensee of the BlueCross BlueShield Association

# Non-Network Pharmacy or No Reference Number

***Please complete the following for all prescriptions purchased at non-network pharmacies and prescriptions without a reference number.***

| Pharmacy Name | | | | | | NABP # | |
|---|---|---|---|---|---|---|---|
| Address | | | | | | State | ZIP Code |
| **Note To Pharmacy:** ***The subscriber will file this claim for reimbursement of applicable benefits, payable to the subscriber.*** | | | | | | | |
| Date Filled *(MM/DD/YYYY)* | RX Number | ❑ New ❑ Refill | Metric Quantity | Days Supply | National Drug Code | | |
| Medical Name, Strength, Dosage Form | | | Physician DEA | | DAW Code | Amount Member Paid $ | |

| Pharmacy Name | | | | | | NABP # | |
|---|---|---|---|---|---|---|---|
| Address | | | | | | State | ZIP Code |
| **Note To Pharmacy:** ***The subscriber will file this claim for reimbursement of applicable benefits, payable to the subscriber.*** | | | | | | | |
| Date Filled *(MM/DD/YYYY)* | RX Number | ❑ New ❑ Refill | Metric Quantity | Days Supply | National Drug Code | | |
| Medical Name, Strength, Dosage Form | | | Physician DEA | | DAW Code | Amount Member Paid $ | |

| Pharmacy Name | | | | | | NABP # | |
|---|---|---|---|---|---|---|---|
| Address | | | | | | State | ZIP Code |
| **Note To Pharmacy:** ***The subscriber will file this claim for reimbursement of applicable benefits, payable to the subscriber.*** | | | | | | | |
| Date Filled *(MM/DD/YYYY)* | RX Number | ❑ New ❑ Refill | Metric Quantity | Days Supply | National Drug Code | | |
| Medical Name, Strength, Dosage Form | | | Physician DEA | | DAW Code | Amount Member Paid $ | |

| Pharmacy Name | | | | | | NABP # | |
|---|---|---|---|---|---|---|---|
| Address | | | | | | State | ZIP Code |
| **Note To Pharmacy:** ***The subscriber will file this claim for reimbursement of applicable benefits, payable to the subscriber.*** | | | | | | | |
| Date Filled *(MM/DD/YYYY)* | RX Number | ❑ New ❑ Refill | Metric Quantity | Days Supply | National Drug Code | | |
| Medical Name, Strength, Dosage Form | | | Physician DEA | | DAW Code | Amount Member Paid $ | |

***The pharmacist should complete this form. It is not necessary to attach receipts.***

***I hereby certify that my records show these drugs and medicines were dispensed in the quantities prescribed to the patient listed on the reverse side of this form by order of the patient's physician. I certify that the drug store or dispensary complies with Tennessee Code Annotated (State Law) 63-10-207.***

**Signature of Pharmacist X**________________________________________