BlueCare Plus Tennessee

BlueCare Plus Tennessee, an Independent Licensee of the BlueCross BlueShield Association.

Instructions for Medicare Part D Prescription Drug Claim Form

PLEASE READ THE FOLLOWING INSTRUCTIONS AND CAREFULLY COMPLETE THE FORM.

Purpose

The Prescription Drug Claim Form is offered as a tool to assist in getting your claim paid as soon as possible. Please print clearly. Use of the form is not required. You may submit equivalent written documentation, but it must provide all of the requested information on this form. Please note that missing, incomplete or hard-to-read documentation can delay the successful processing of your claim.

When to Use This Form

This form can be used to request reimbursement for any of the following Medicare Part D prescription drug benefits:

- Routine Prescriptions – You purchased a prescription without using your member ID card.
- Hospital Observation – You were admitted to the hospital for up to three days for an observation and you were not allowed to bring your daily drugs from home. During the observation, the only drugs covered by Medicare Part D are those that are administered because you take them on a regular basis (ex. daily) at home.
- Medicare Part D Vaccines – You purchased or had administered a Part D-approved vaccine. Always check line **E.** in **Section 4** and follow these instructions for submitting vaccine claims:
  - If the vaccine was supplied and administered by your doctor or clinic, include the physician invoice, skip **Section 3,** skip **Section 6** and complete the rest of the form.
  - If the vaccine was purchased from and administered by a pharmacy, include the prescription receipt, skip **Section 5,** skip **Section 6** and complete the rest of the form.
  - If the vaccine was purchased from a pharmacy but administered by your doctor, include the prescription receipt from the pharmacy and the physician invoice from the doctor, skip **Section 6** and complete the rest of the form.
  - If the vaccine was free, but there was an administration fee, include the receipt showing the cost of the vaccine as zero dollars and the cost of the administration fee. Complete **Section 3** if administered at a pharmacy or **Section 5** if administered by a physician or at a clinic. Skip **Section 6** and complete the rest of the form.
- Compound Prescriptions – You purchased a compound prescription without using your member ID card. Please note that not all plans cover compound prescriptions. Special instructions for compound prescriptions include:
  - A compound prescription is composed of multiple ingredients combined to form a treatment that isn't readily available.
  - If you are not sure whether you have a compound prescription, ask your pharmacist.
  - The easiest way to submit a claim for a compound prescription is to request a receipt from the pharmacy that lists all of the ingredients. The list should include the National Drug Code (NDC), metric quantity and cost for each ingredient. The pharmacy receipt should be submitted with your claim. To submit your claim, include the receipt, skip **Section 6** and complete the rest of the form.
  - An alternative to providing the receipt is to have the pharmacist complete and sign **Section 6,** including the **Compound Prescriptions Only** part. You would complete the rest of the form.
  - Check your plan benefit materials or call Customer Service at the number on your member ID card if you have questions regarding your compound prescription.

Specific steps to complete the form begin on side 2.

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Section 1: Cardholder Information

Please fill in this section completely. This is critical information so that the claim is processed under the benefit to which you are entitled. The Cardholder Identification/ID number and Group number can be found on your member ID card.

Section 2: Other Prescription Drug Coverage

- If Medicare Part D is your primary prescription drug coverage, then skip this section.
- However, if Medicare Part D is your secondary prescription drug coverage, please be sure to complete **Section 2** *after* a claim for this prescription has been submitted to your primary insurance and you have received an *Explanation of Benefits* document detailing the outcome of that claim. In order to properly process your claim, please include a copy of the *Explanation of Benefits* from the primary insurance provider with your claim.

Section 3: Pharmacy Information

Skip this section if your doctor supplied and administered a vaccine. For all other situations, please supply as much information as possible about the pharmacy where the drug was purchased, including the National Provider Identifier (NPI) number, to ensure that your claim can be processed. If you cannot find the NPI on the prescription drug receipt, the pharmacy can provide it.

Section 4: Out-of-Network Purchase

Please check the reason that best applies to your situation.

Section 5: Physician Information

All of the information requested in this section is critical to successfully processing your claim per Medicare guidelines. Your claim may be denied if the physician information is not provided. You may have to contact the physician's office for his/her address, phone number, and National Provider Identifier (NPI) number.

Receipts

To be properly reimbursed for a Medicare Part D prescription drug claim, a receipt is required. Please note that a cash register receipt is not sufficient. Please tape your receipt(s) to an 8.5 x 11 sheet of paper or submit a clear photo copy.

Acceptable receipts include:

- Prescription Receipt – This receipt shows the pharmacy information, date of service, physician, Rx number, drug name, eleven-digit NDC, quantity, days supply and amount you paid. This is usually the receipt attached to the outside of the prescription envelope. As an alternative, you may request a prescription history report from your pharmacy for a given time period. As long as it shows all of the information noted in this paragraph and is signed by the pharmacist, this can serve as your pharmacy prescription receipt.
- Physician Invoice – This will normally come from your doctor if you have been administered a vaccine. It should provide the doctor's information (ex. name, address, and phone number), date of service, drug name, drug NDC, and amount you paid, including any administration fee.
- Hospital Invoice – This will be an itemized statement from the hospital resulting from an observation stay. It must include the hospital pharmacy NPI number, date of service, physician name, drug name, drug NDC, quantity, days supply and amount you paid. Please circle the drugs on the statement for which you are submitting a claim. Only circled drugs will be considered for reimbursement.

Section 6: Prescription Detail

Skip this section if you have a qualifying receipt as described above. If you cannot acquire any of the above receipts, have your doctor or pharmacist complete and sign this section.

Section 7: Cardholder Signature

Please sign the claim form. If someone is submitting the claim on the patient's behalf, an Authorization of Representation form (Form CMS-1696) or similar legal instrument must be included with the claim. Form CMS-1696 can be downloaded at www.cms.gov or obtained by calling the Customer Service number on your member ID card.

Section 8: Submit the Claim

The claim may be submitted via mail or fax to the address or phone number on the Medicare Part D Prescription Drug Claim Form. Reimbursement requests may be submitted up to 36 months from the date of service.

If you have any questions about filling out this form, please call 1-800-332-5762, TTY 711.

Hours of Operation

From Oct. 1 to March 31, you can call us 7 days a week from 8 a.m. to 9 p.m. ET. From April 1 to Sept. 30, you can call us Monday through Friday from 8 a.m. to 9 p.m. ET. If you call us outside these hours or on a holiday, our automated system will answer your call. You can leave a message for us, and we will call you back the next business day.

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Medicare Part D Prescription Drug Claim Form

Section 1 ➢ Cardholder Information

Cardholder Identification/ID #_____ Group #_____

Cardholder Name (*Last, First MI.*)_____

Street Address_____ Date of Birth_____

City_____ State_____ Zip_____

Section 2 ➢ Other Prescription Drug Coverage

Is the patient eligible for primary prescription drug coverage from another insurance company? Y ☐ N ☐

If yes, did the patient submit the claim to this other insurance company? Y ☐ N ☐
(If yes, include the Explanation of Benefits from the other insurance company.)

Did the other insurance company pay as the primary insurer? Y ☐ N ☐

Section 3 ➢ Pharmacy Information

Pharmacy Name_____ Pharmacy NPI _____

Address_____ Phone _____

City_____ State_____ Zip_____

Section 4 ➢ Out-of-Network Purchase

☐ A. I traveled outside my plan's service area and ran out of (or lost) my medication; or I became ill and could not access a network pharmacy.

☐ B. I was unable to obtain my medication in a timely manner within my service area (there was no network pharmacy within a reasonable driving distance that provides 24/7 service).

☐ C. My medication is not stocked regularly at an accessible network or mail-order pharmacy.

☐ D. While I was a patient in an emergency department, provider-based clinic, outpatient surgery or other outpatient facility, my medication was dispensed from an out-of-network pharmacy located in one of these institutions, and I could not get my medication filled at a network pharmacy.

☐ E. I received a vaccine at my doctor's office or pharmacy.

☐ F. I was evacuated or displaced from my residence due to a State or Federally declared disaster or health emergency.

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Section 5 ➢ Physician Information

Physician Name_____ Physician NPI _____

Physician Address_____ Phone _____

City_____ State _____ Zip _____

Section 6 ➢ Prescription Detail

To be completed and signed by physician or pharmacist if receipt is not attached

Date of Service _____ Rx #_____ NDC _____

Drug Name_____ Qty_____ Days Supply _____ Drug Cost _____

Medicare Part D Vaccine Claim Only *(if covered)*	Admin Fee_____ Total Paid by Cardholder_____

Compound Prescriptions Only *(if covered)*

11-digit NDC Number	Ingredient Name	Metric Quantity	Ingredient Cost
		Total Paid by Cardholder	

Physician or Pharmacist Signature _____ Date_____

Section 7 ➢ Cardholder Signature

Reimbursement of submitted claims is subject to your prescription benefit program and not guaranteed. Reimbursement will be made according to the limits of your prescription benefit plan and will be only for the amount your program would have paid on your behalf. The amount of reimbursement may be significantly lower than the original amount you paid. Claims that are hard to read or incomplete may be returned or payment denied. If someone is submitting the claim on the patient's behalf, an Authorization of Representation form (Form CMS-1696) must be attached. See the instructions for more information.

Signature _____ Date _____

Section 8 ➢ Submit the Claim

Via Mail:
BlueCross BlueShield of TN
Medicare Part D
Prescription Drug Claim Request
1 Cameron Hill Circle Ste 48
Chattanooga, TN 37402-0048

Via Fax: You may also fax your claim form to: 1.423.591.9495. Please use one claim form per fax. Do not combine claims for different members in the same fax submission. Reimbursement requests may be submitted up to 36 months from the date of service.

BlueCare Plus Tennessee

Nondiscrimination Notice

BlueCross BlueShield of Tennessee (BlueCross), including its subsidiaries SecurityCare of Tennessee, Inc. and Volunteer State Health Plan, Inc. also doing business as BlueCare Tennessee, complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. BlueCross does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

BlueCross:

Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as: (1) qualified sign language interpreters and (2) written information in other formats, such as large print, audio and accessible electronic formats.

Provides free language assistance services to people whose primary language is not English, such as: (1) qualified interpreters and (2) information written in other languages.

If you need these reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact Member Service at the number on the back of your Member ID card or call **1-800-332-5762**, TTY **711**. From **Oct. 1 to March 31**, you can call us 7 days a week from 8 a.m. to 9 p.m. ET. From **April 1 to Sept. 30**, you can call us Monday through Friday from 8 a.m. to 9 p.m. ET. Our automated phone system may answer your call outside of these hours and during holidays.

If you believe that BlueCross has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance ("Nondiscrimination Grievance"). For help with preparing and submitting your Nondiscrimination Grievance, contact Member Service at the number on the back of your Member ID card or call **1-800-332-5762**, TTY **711**. They can provide you with the appropriate form to use in submitting a Nondiscrimination Grievance. You can file a Nondiscrimination Grievance in person or by mail, fax or email. Address your Nondiscrimination Grievance to: Nondiscrimination Grievance; c/o Manager, Operations, Member Benefits Administration; 1 Cameron Hill Circle, Suite 0019, Chattanooga, TN 37402-0019; (423) 591-9208 (fax); Nondiscrimination_OfficeGM@bcbst.com (email).

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 ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD), 8:30 a.m. to 8 p.m. ET. Complaint forms are available at hhs.gov/ocr/office/file/index.html.

You can contact BlueCross's Nondiscrimination Coordinator at 423-535-1010 (phone) Nondiscrimination_CoordinatorGM@bcbst.com (email), or Corporate Compliance, 1 Cameron Hill Circle, 1.4, Chattanooga, TN 37402.

This notice is available at BlueCross's website: **bluecareplus.bcbst.com**

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Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-332-5762, TTY 711. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-800-332-5762, TTY 711. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-800-332-5762, TTY 711。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-800-332-5762, TTY 711。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-800-332-5762, TTY 711. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-332-5762, TTY 711. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-800-332-5762, TTY 711 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-332-5762, TTY 711. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-332-5762, TTY 711 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-332-5762, TTY 711. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-800-332-5762, TTY 711. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध है. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-800-332-5762, TTY 711 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-332-5762, TTY 711. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-800-332-5762, TTY 711. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-800-332-5762, TTY 711. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-800-332-5762, TTY 711. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、1-800-332-5762, TTY 711 にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。