LINCS RX™

PRESCRIPTION DRUG CLAIM

SEE BACK OF FORM FOR INSTRUCTIONS

BlueCross BlueShield of Oklahoma

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www.bcbsok.com

P.O. Box 3283 • Tulsa, OK 74102-3283

PATIENT INFORMATION - A separate claim form must be completed for each patient. Please print in ink or type

PATIENT'S NAME (LAST, FIRST, MIDDLE INITIAL)	SEX M ☐ F ☐	RELATIONSHIP TO MEMBER	DATE OF BIRTH MO. DAY YR.

MEMBER INFORMATION

MEMBER'S NAME (LAST, FIRST, MIDDLE INITIAL)	MEMBER'S EMPLOYER

MEMBER'S ADDRESS (STREET, CITY, STATE, ZIP CODE)

IDENTIFICATION NUMBER - Copy this from your Blue Cross and Blue Shield Identification Card

IDENTIFICATION NUMBER (FROM BLUE CROSS AND BLUE SHIELD I.D. CARD)	GROUP NUMBER

Attach receipt for each prescription here.

PRESCRIPTION DRUG INFORMATION

Rx NUMBER	NAME OF DRUG		QUANTITY	DAYS SUPPLY	NATIONAL DRUG CODE NO.
DATE WRITTEN	DATE FILLED	NEW ☐ REFILL ☐	NAME OF PRESCRIBING PHYSICIAN		COST
Rx NUMBER	NAME OF DRUG		QUANTITY	DAYS SUPPLY	NATIONAL DRUG CODE NO.
DATE WRITTEN	DATE FILLED	NEW ☐ REFILL ☐	NAME OF PRESCRIBING PHYSICIAN		COST
Rx NUMBER	NAME OF DRUG		QUANTITY	DAYS SUPPLY	NATIONAL DRUG CODE NO.
DATE WRITTEN	DATE FILLED	NEW ☐ REFILL ☐	NAME OF PRESCRIBING PHYSICIAN		COST

PHARMACY INFORMATION

NOTE: If you need to file a claim for prescriptions filled at more than one pharmacy, please use a separate claim form for each pharmacy.

NAME OF PHARMACY

ADDRESS OF PHARMACY (STREET) (CITY) (STATE) (ZIP CODE)

REASON FOR PAPER CLAIM

In most cases, your claims for prescription drug benefits are filed automatically. So that we may improve our service to you, please indicate your reason for filing this paper claim. (Check one box only)

1. ☐ Used a pharmacy outside the participating network.
2. ☐ Did not have my Blue Cross and Blue Shield of Oklahoma prescription drug card.
3. ☐ Pharmacist was unable to process the claim electronically.
4. ☐ Other (please explain) _____

AGREEMENT AND SIGNATURE OF MEMBER - claim will not be accepted without signature of member

I certify that the above information is correct and that the bills attached were incurred by the patient listed above. I authorize any medical or medically related facility, pharmacy, government agency, insurance company, or other person or firm to provide Blue Cross and Blue Shield information, including copies of records, concerning advice, care or treatment provided the patient above including, without limitation, information relating to mental illness, use of drugs or alcohol, upon presentation of a photocopy of this signed authorization. I understand that such information will be used by Blue Cross and Blue Shield for the purpose of evaluating a claim for insurance benefits for services provided to the patient named above. I understand that I or any authorized representative will receive a copy of this authorization upon request. The authorization is valid from the date signed until revoked in writing.

MEMBER'S SIGNATURE	MEMBER'S DAYTIME PHONE NUMBER ( )	DATE SIGNED MO. DAY YR.

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of any insurance policy containing any false, incomplete or misleading information is guilty of a felony.

8.775 (3/02)

LINCS$_{RX}$™ *Claim Form Instructions*

WHEN TO USE THIS FORM

A. *This claim form is to be used only by those persons with a Blue Cross and Blue Shield of Oklahoma* **LINCS$_{RX}$**™ *identification card. This form should be used only when it is necessary to purchase a prescription because you did not have your ID card at the time your prescription was filled, or because the pharmacy which filled your prescription was a non-participating pharmacy.*

Submit this form as soon as you have your prescription filled in order to receive prompt payment. If you have more than three prescriptions, call a Customer Service Representative at the number listed below for additional claim forms.

Please use a separate claim form for each patient. You will also need to use a separate claim form if you need to file a claim for prescriptions from more than one pharmacy.

HOW TO COMPLETE THIS FORM

B. *Complete all sections of this form, including:*

- ***PATIENT INFORMATION*** *(Use a separate form for each patient.)*
- ***MEMBER INFORMATION***
- ***IDENTIFICATION NUMBER*** *(from your Blue Cross and Blue Shield of Oklahoma ID card.)*
- ***PRESCRIPTION DRUG INFORMATION*** *(Complete the information requested and attach a pharmacy receipt for each prescription. Your claim cannot be processed without a receipt from the pharmacy.)*

  The following information must appear on each prescription receipt: Drug quantity, drug name, drug strength and price.

- ***PHARMACY INFORMATION*** *(Use a separate form for each pharmacy.)*
- ***REASON FOR PAPER CLAIM*** *(So that we may improve service to you, please check the box in this section that best describes why you need to file a paper claim.)*
- ***AGREEMENT AND SIGNATURE OF MEMBER*** *(Please don't forget to sign and date the claim form.)*

WHERE TO SEND THIS FORM

C. ***Send this completed form to:***
LINCS$_{RX}$™ Prescription Drug Program
P.O. Box 3283
Tulsa, Oklahoma 74102-3283