



PRESCRIPTION DRUG CLAIM FORM

INSTRUCTIONS:

1. Prescription Drug Claim Forms are not required if submitting a **pharmacy computer printout with the pharmacist's signature and license number.**
2. Only ONE PATIENT'S prescriptions per form.
3. Only ONE PRESCRIPTION per line. No more than eight prescriptions per form.
4. Complete, sign, and date form.
5. Make a copy of completed form for your records.
6. Enclose receipts for each item listed.
7. Mail the completed original copy with the receipts to Blue Cross and Blue Shield of Montana, P.O. Box 5004, Great Falls, MT 59403

OR

Drop them off at 600 Smelter Avenue, Great Falls, Montana OR 560 North Park Avenue, Helena, Montana.

Subscriber ID Number			Patient's Name		Date of Birth	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Relationship to Member <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child
Member's Name (Last, First, MI)			Member's Address				Do you have Medicare coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No
Date Filled	OFFICE USE ONLY	Prescription Charges	Drug Name	Quantity	Strength	Prescribing Physician	Pharmacy Name and City
1		\$					
2		\$					
3		\$					
4		\$					
5		\$					
6		\$					
7		\$					
8		\$					

TOTAL \$ _____

By signing, I am acknowledging the above information to be true and accurate.

FOR PLAN USE ONLY

Signature of Person Completing This Form

Date

Please check this box if you need additional prescription drug claim forms.

Forms are available at Blue Cross and Blue Shield of Montana offices or by contacting your local representative.