Blue Shield of California
An Independent Member of the Blue Shield Association

ARGUS™

Blue Shield of California Prescription Drug Benefit*

Direct Reimbursement Claim

*Applies to outpatient prescription drug benefits available through plans underwritten by Blue Shield of California and Blue Shield of California Life & Health Insurance Company.

PART ONE: To Be Filled Out By You

SUBSCRIBER IDENTIFICATION NUMBER

CUSTOMER NUMBER: 0 1 9 1 0 0 0 0

SUBSCRIBER NAME

MAIL ADDRESS – STREET

CITY STATE ZIP

PATIENT'S NAME

PATIENT'S DATE OF BIRTH (MM/DD/YY) / /

SEX: ☐ MALE ☐ FEMALE

RELATIONSHIP:

☐ SUBSCRIBER ☐ SPOUSE ☐ CHILD

☐ OTHER:_____ EXPLAIN RELATIONSHIP

( ) DAYTIME TELEPHONE

The undersigned certifies that the medication(s) described heron was received by the undersigned for the party(s) named below who is/are eligible for drug benefits, and that such medication(s) is/are not for an on the job injury or covered under another benefit plan. The undersigned authorizes release of all information to the plan administrator, underwriter, sponsor, policy holder, employer and their agents for use in connection with the benefit plan programs. Information may also be used for other reporting and analysis purposes without identification of the undersigned or the undersigned's family members. The undersigned further authorizes use of such person's subscriber identification number for identification purposes and further recognizes that reimbursement will be paid directly to the participant and assignment of these benefits to a pharmacy or otherwise is void.

X

SIGNATURE OF PATIENT, GUARDIAN OR LEGAL REPRESENTATIVE

PART TWO: Pharmacy Information - To Be Filled Out By You or Your Pharmacist

PHARMACY NAME | ADDRESS – STREET | **PHARMACY NABP NUMBER**

CITY | STATE | ZIP | ( ) PHARMACY TELEPHONE

Rx 1	Rx 2
TAPE PHARMACY RECEIPT	TAPE PHARMACY RECEIPT
Rx 3	**Rx 4**
TAPE PHARMACY RECEIPT	TAPE PHARMACY RECEIPT

FOR COMPOUNDS

For Compounds: Pharmacist to identify the specific prescription by date of service and **Rx** number. Please list name, NDC# and metric quantities of each ingredient in box on left.

X

Signature of Pharmacist for Compounds

C-14352 (10/03)

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INSTRUCTIONS

PLEASE WAIT UNTIL YOU RECEIVE YOUR BLUE SHIELD I.D. CARD BEFORE SENDING THIS CLAIM FOR REIMBURSEMENT. CLAIMS WITHOUT THE PROPER IDENTIFICATION NUMBER FROM YOUR BLUE SHIELD I.D. CARD WILL NOT BE PROCESSED.

To avoid undue delay, please complete all required areas of information on the claim form.

Please be sure to copy your subscriber identification number exactly as it appears on the Blue Shield identification card. If this is not done, the claim form will be returned to you.

HOW TO COMPLETE THIS FORM

PART ONE
Subscriber Information

1. Copy the 9 digit Subscriber Identification Number from the Blue Shield I.D. Card.
2. Subscriber name, address, and telephone number.
3. Patient Name: Person drug was prescribed for.
4. Patient Date of Birth: Month, Day, Year.
5. Patient Sex: Check Male or Female
6. Status: Patient's relationship to subscriber. If other, please write in type of relationship.
7. Please use separate claim form for each family member.

PART TWO
Pharmacy Information

1. Pharmacy name, address, and telephone number where the prescription(s) were purchased.
2. Pharmacy NABP Number: Obtain the number from the pharmacy where prescriptions were purchased.
3. Tape pharmacy receipts to the form in the space provided. The receipts must indicate date of service, Rx number, NDC number, quantity, days supply and the amount paid.
4. Use a **separate claim form** for each pharmacy from which you purchase prescriptions.

Note: Claim submission is not a guarantee of payment.

Reason for Claim Submission:

- ☐ Member not eligible in system
- ☐ Member in Cobra group
- ☐ No Rx Card presented
- ☐ Pharmacy online system down
- ☐ Other (explain) _____

Submit to:

Blue Shield
Argus Health Systems, Inc.
PO BOX 419019, Dept. 191
Kansas City, MO 64141

Other Reason:	**Instructions:**
☐ Foreign Claims	Include your prescription receipt with the name of the drug(s), and state the foreign currency used.
☐ Vacation Supply	Fill out this form, attach the prescription receipt.
☐ Compound	Fill in boxes at bottom of form on the other side.

Submit to:

Blue Shield
c/o Pharmacy Services
PO BOX 7168
San Francisco, CA 94120-7168