P.O. Box 91059
Seattle, WA 98111-9159
800-722-1471
800-842-5357 TDD for the hearing impaired

PREMERA | BLUE CROSS

Secondary Insurance
Prescription Drug Claim Form

Please follow instructions carefully.
If all boxes are not completed, there could be a delay in processing.

1. Please list your prescription drugs below in date order and submit on a monthly basis.
2. All drugs listed must be for same person and same pharmacy. Please use a separate form for each person, each pharmacy.
3. Receipts must be attached to this form for all prescriptions. Please tape (do not staple) to reverse side or another sheet of paper.
4. Cash register receipts are not acceptable.
5. Explanation of benefits from primary insurance or pharmacy receipt indicating copay amount from primary coverage must be attached.

Subscriber (Employed) Name: _____	Patient Name: _____
_____	_____
ID Number: _____	Relationship to Subscriber: _____
Mailing Address: _____	Pharmacy Name: _____
_____	Pharmacy Address: _____
Subscriber's Employer: (Group Number) _____	_____

Please list your prescription drugs below in date order:

Date of Purchase	Amount Charged	Balance after Primary Ins. Benefits	Drug Quantity Units/Days	Name of Each Drug	Prescription Number	Prescribing Physician
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Keep copy for your records (form and attachments)

I hereby certify that the above drugs were necessary for treatment of the illness/injury reported and were purchased for the individual named above.

Signature (Subscriber) _____ Date _____/_____/_____

Please return this form to Premera Blue Cross, P.O. Box 91059, Seattle, WA 98111-9159.

If you have any questions, please call Premera Blue Cross Customer Service
Toll free at 800-722-1471 ● 800-842-5357 TDD for the hearing impaired

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