Acknowledgment
I certify that the medication(s) described above was/were received for use by the patient listed above, and that I (and the patient, if not myself) am eligible for drug benefits. I also certify that the medication received was not for an on-the-job injury or covered under another benefit plan. I recognize that reimbursement will be paid directly to me, and that assignment of these benefits to a pharmacy or any other party is void.

Date / / 
Signature of Patient (or legal guardian if patient cannot legally consent to services)

If allowed by law, you may assign the payment of this claim to your pharmacy. If your pharmacy is willing to accept assignment, do not complete this form. Please request that your pharmacy contact Pharmacy Services at 1 800 922-1557 for assistance.

C100177 (05-2011)
Claim Receipts
Please tape your receipts here. Do not staple! Tape additional non-compound receipts on a separate piece of paper.

Tape receipt for prescription 1 here.

**Receipts must contain the following information:**
- Date prescription filled
- Name and address of pharmacy
- Doctor name or ID number
- NDC number (drug number)
- Name of drug and strength
- Quantity and days' supply
- Prescription number (Rx number)
- DAW (Dispense As Written)
- Amount paid

Tape receipt for prescription 2 here.

**Receipts must contain the following information:**
- Date prescription filled
- Name and address of pharmacy
- Doctor name or ID number
- NDC number (drug number)
- Name of drug and strength
- Quantity and days' supply
- Prescription number (Rx number)
- DAW (Dispense As Written)
- Amount paid

### PHARMACY INFORMATION (For Compound Prescriptions ONLY)

- List the VALID 11-digit NDC number for EACH ingredient used for the compound prescription.
- For each NDC number, indicate the "metric quantity" expressed in the number of tablets, grams, milliliters, creams, ointments, injectables, etc.
- For each NDC number, indicate cost per ingredient.
- Indicate the TOTAL charge (dollar amount) paid by the patient.
- Receipt(s) must be attached to claim form.

### Direct Reimbursement Claim Instructions
**Read carefully before completing this form.**

1. Always present your ID card at the participating retail pharmacy.
2. Only use this claim form when you have paid a pharmacy full price for a prescription drug order because you:
   - have not received your ID card.
   - did not have your ID card at the time of purchase.
3. You must complete a separate claim form for each pharmacy used and for each patient.
4. You must submit claims within one year of date of purchase or as required by your Plan.

5. **Be sure your receipts are complete.** In order for your request to be processed, all receipts must contain the information listed above. Your pharmacist can provide the necessary information if it is not itemized on your claim or bill.

6. You should read the Acknowledgment carefully, then sign and date this form.

7. Return the completed form and receipt(s) to:
   - Medco
   - P.O. Box 14711
   - Lexington, KY 40512

**Note:** See front of form for Secondary Prescription claims address.

---

† California: For your protection, California law requires the following to appear on this form:
Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Questions? Call the Premera Blue Cross Customer Service number listed on the back of your ID card or visit www.premera.com.