RxCare Wyoming™ PRESCRIPTION DRUG CLAIM FORM

1. Please type or print clearly. All information in each section must be provided. **Incomplete forms will be returned, causing a delay in payment.**
2. Attach original receipts to this form.
3. A separate form must be completed for each patient and for each pharmacy patronized.
4. The insured person must sign each claim form submitted.

Mail completed form and receipts to:

BlueCross BlueShield of Wyoming
P.O. Box 2266
Cheyenne WY 82003

SUBSCRIBER INFORMATION:

Carrier #: BCBSWY Name: _____

Street Address: _____ Contract #: _____

City: _____ State: ____ Zip: _____ Company Name: _____

I certify that the information is correct and that the patient indicated below is eligible for benefits. I have received the medication described hereon and authorize the release of all information contained on this claim form to RxCare Wyoming. I agree that any benefits payable hereunder for prescription drugs are not assignable and that any assignment thereof shall be void. I further represent that there has been no assignment of benefits hereunder.

Why were you unable to use your BCBSWY ID Card? _____

_____

SUBSCRIBER SIGNATURE: _____

PATIENT INFORMATION:

Patient Name: _____

Date of Birth: _____ ❑ Male ❑ Female

Patient's Relationship to the Insured: _____

❑ Self ❑ Spouse ❑ Dependent

PHARMACY INFORMATION:

Pharmacy Name: _____

Pharmacy Address: _____

City: _____ State: _____ Zip: _____

Pharmacy NABP Number*: _____

*You may need to call the pharmacy for this number

PRESCRIPTION CLAIM INFORMATION:

1- Prescription Number _____ Date Filled: _____

Name of Medication: _____ NDC Number*: _____

*You may need to call the pharmacy for this number

Prescription Cost: _____ Quantity: _____

Days Supply: _____

2- Prescription Number _____ Date Filled: _____

Name of Medication: _____ NDC Number*: _____

*You may need to call the pharmacy for this number

Prescription Cost: _____ Quantity: _____

Days Supply: _____