WYOMING

An independent licensee of the Blue Cross and Blue Shield Association

PRESCRIPTION DRUG CLAIM FORM

Mail completed form and receipts to:
Blue Cross Blue Shield of Wyoming
P.O. Box 2266
Cheyenne WY 82003

1. Please type or print clearly. All information in each section must be provided.
   Incomplete forms will be returned and cause 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.

SUBSCRIBER INFORMATION

Carrier #: **BCBSWY** Name: _____

Street Address: _____ Contract Number: _____

City: _____ State: _____ ZIP: _____ Company: _____

I certify that the information is correct and that the patient indicated below is eligible for benefits. I have received the medication described herein and authorize the release of all information contained on this claim form to Blue Cross Blue Shield of 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? _____

_____

NOTE: If you are requesting reimbursement for a COVID home test kit, a cash register receipt is valid. There may not be an RX number for these kits; if so, please leave blank. The rest of the information is required. A UPC or NDC can also be used.

IMPORTANT: Your required signature attests that these test kits are not being used for testing required by your employer, return to work, travel, attending recreational event requirements and will not be resold if seeking COVID test reimbursement.

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: _____

Name of Medication: _____

Prescription Cost: _____

Days Supply: _____

Date Filled: _____

Quantity: _____

NDC Number*: _____

**You may need to call the pharmacy for this number*

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2. Prescription Number: _____

Name of Medication: _____

Prescription Cost: _____

Days Supply: _____

Date Filled: _____

Quantity: _____

NDC Number:* _____

**You may need to call the pharmacy for this number.*