

Bluegrass Family Health

Prescription Claim Form

Instructions for use: Please use a separate claim form for each member requesting a reimbursement. Attach all pharmacy receipts to the claim form. Mail to: BFH 651 Perimeter Drive, Suite 300, Lexington, Ky. 40517 Attn: Pharmacy. All claims will be reviewed upon receipt. Process time is 6-8 weeks. The following information must be provided in order for a claim to be considered for reimbursement by BFH:

Primary Cardholder's Information

Name of Insured: _____

ID Number: _____

Insured's Address: _____
(Street Address)

(City) _____ (State) _____ (Zip) _____

Insured's Telephone number: (_____) _____

Other insurance/policy number _____

Prescription Information

Name on Prescription: _____

Date of Birth: _____

Relationship to insured if not insured: _____

***Please include Original receipt from dispensing Pharmacy with the following information:**

- ◀ Name of the medication
- ◀ National Drug code (NDC Number)
- ◀ NABP number of the dispensing pharmacy (National Pharmacy Code)
- ◀ Date of service
- ◀ Quantity Dispensed/Days supply
- ◀ Amount of purchase

The completion of this form is not a guarantee of payment. Requests for reimbursement are subject to all Plan rules and requirements. Before mailing your request, please make copies for your records.