ZOSTAVAX PRESCRIPTION DRUG CLAIM FORM

P.O. Box 890062 • Camp Hill, PA 17089-0062

TO BE COMPLETED BY MEMBER

SECTION I: MEMBER AND PATIENT INFORMATION

1. IDENTIFICATION NUMBER

2. GROUP NUMBER

3. PATIENT'S NAME (Last) (First) (MI)

4. PATIENT'S RELATIONSHIP TO MEMBER
☐ SELF ☐ SPOUSE ☐ CHILD

5. PATIENT'S BIRTHDATE
MONTH DAY YEAR

6. PATIENT'S SEX
☐ MALE ☐ FEMALE

7. DIAGNOSIS OR NATURE OF ILLNESS

8. MEMBER'S NAME (Last) (First) (MI)

9. MEMBER'S ADDRESS (Street)

(City) (State) (Zip Code)

10. 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. The signer agrees that any personally identifiable health information about the signer or signer's enrolled dependents is protected by the Health Insurance Portability and Accountability Act of 1996 and other privacy laws. In accordance with those laws, Highmark may use and disclose Protected Health Information for treatment, payment and health care operations as described in its Notice of Privacy Practices.

X MEMBER'S SIGNATURE _____ DATE _____

CLAIM FILING INSTRUCTIONS

1. **Complete Section I — Member and Patient Information — above.**
   - Your Identification and Group Numbers can be found on your Highmark Blue Shield Identification Card.
   - Please remember to sign and date the form where indicated.
   - You must use a separate claim form for each patient.
2. **Complete Section II — Attach Itemized Prescription Drug Expenses on the reverse side of this form.**

   You do not have to itemize prescription drug expenses if you receive an itemized printout from your pharmacy. The printout must include the pharmacist's stamp and signature.

Remember: Cancelled checks, cash register receipts or personal itemizations are not acceptable as itemized bills.

3. **Mail completed claim form with all attached itemized bills to:**

   Highmark Blue Shield
   P.O. Box 890062
   Camp Hill, PA 17089-0062

NOTE: YOU SHOULD MAKE A COPY OF YOUR COMPLETED CLAIM FORM AND ITEMIZED BILLS FOR YOUR RECORDS.

SECTION II: PRESCRIPTION DRUG EXPENSES

INSTRUCTIONS:

1. LIST YOUR APPROVED **ZOSTAVAX/ZOSTER PRESCRIPTION DRUG EXPENSES ONLY** FROM OLDEST TO MOST RECENT. IF ADDITIONAL SPACE IS REQUIRED, PLEASE SUBMIT ANOTHER CLAIM FORM.
2. ONLY DRUGS OR MEDICATIONS LEGALLY REQUIRING A PRESCRIPTION WILL BE CONSIDERED FOR PAYMENT. CALCULATION OF BENEFITS WILL BE BASED UPON EXPENSES LISTED BELOW.
3. ATTACH ALL RECEIPTS TO THIS FORM. (CLAIMS SUBMITTED WITHOUT ITEMIZED RECEIPTS WILL BE RETURNED.)

X IF GENERIC	BLUE SHIELD USE	DRUG NAME	DATE FILLED	BLUE SHIELD USE	PHARMACY NAME	RX NUMBER	CHARGE
Example X		ZOSTAVAX	1 - 2 - 2010		ORCHARD DRUGS	610317	143 00