



**BlueCross BlueShield
of Tennessee**
www.bcbst.com

BCBST Claims Service Center
P. O. Box 180150
Chattanooga, Tennessee 37401-7150

Prescription Drug Statement

Type or Print

This Section To Be Completed By Subscriber

1. Patient's Name (First, Middle Initial, Last)	2. Patient's Date of Birth	3. Subscriber's Name (First, Middle Initial, Last)
4. Subscriber's Identification No. or Medicare No.	5. Subscriber's Group No. (Or Group Name)	6. Subscriber's Address (Street, City, State, Zip Code)
7. Certification - I understand it is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.		
Subscriber's Signature X		

This Section To Be Completed By Subscriber Or Network Pharmacy

Please attach prescription receipts. It is very important that the Reference (Authorization) number be included. If you do not have this number for each of your prescriptions, please contact your pharmacist.

Pharmacist, you may place a "peel and stick" label if it contains the required information, including reference (authorization) number.

Reference (Authorization) No.	Date of Purchase	Amount Paid	Drug Store
A _____	_____	\$ _____	_____
A _____	_____	\$ _____	_____
A _____	_____	\$ _____	_____
A _____	_____	\$ _____	_____
A _____	_____	\$ _____	_____
A _____	_____	\$ _____	_____
A _____	_____	\$ _____	_____
A _____	_____	\$ _____	_____
A _____	_____	\$ _____	_____
A _____	_____	\$ _____	_____
A _____	_____	\$ _____	_____
A _____	_____	\$ _____	_____
		\$ <u> </u>	
		Total Charges	

