

CLAIM FORM

Please print clearly with black ink or type.

Pharmacist's Name		NPI Number	
Provider Number (include any letters, if applicable)			
Address	City	State	Zip
Phone	Fax	Email Address	

Patient's Date of Birth

M	M	D	D	Y	Y	Y	Y
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Patient's Sex: Male Female

Patient's Name _____														
Last	First	Middle Initial												
Patient's Contract Number														
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SERVICE PROVIDED : (CHECK ONE)

- 0115T – Initial Consultation
 0116T – Subsequent Visit

LOCATION OF SERVICES RENDERED : (CHECK ONE)

- Retail Pharmacy Patient's Home Long Term Care Facility
 Long Term Care Facility Pharmacist Clinic Other: _____

I, the undersigned, furnished the above information to enable Blue Cross and Blue Shield of Alabama to consider this claim for payment, and I certify that such information is true and correct and that the expenses were incurred by the above named patient. **I understand that any payment will be made to me. I certify that I have completed the required information on InfoSolutions (www.infosolutions.net)**

Signature _____ Date _____

NOTE: Claim payment is pending verification that the required information has been entered on InfoSolutions (www.infosolutions.net).

FILING YOUR CLAIM IS EASY

Fill out the Medication Therapy Management Claim form (include all requested information).

- Pharmacist Information • Patient's full name • Date of service
- Place of treatment (i.e. retail pharmacy, long term care facility, patient's home, etc.)

THIS INFORMATION IS NEEDED TO PROPERLY FILE MEDICATION THERAPY MANAGEMENT CLAIMS.

Mail or fax the completed claim to:
Blue Cross and Blue Shield of Alabama
 Medication Therapy Management
 Post Office Box 12485
 Birmingham, Alabama 35202-2485
 Fax: 1 205 220-2939

For additional forms, call: Customer Service

1 877 878-8668

or on the web at: www.bcbsal.com

**Ask for Medication Therapy Management Claim,
 stock number MBG-220.**