# Prescription Drug Foreign Claim Reimbursement Form

(Must be submitted with the "Prescription Drug Reimbursement Claim Form")

☞ You may qualify for a vacation override on future foreign claims. For more information, call the Customer Service number located on the back of your BCBSM ID card.

**Instructions:**

- Complete a new claim form for each patient.
- Attach your itemized paid drug receipt.
- Complete the "Prescription Drug Reimbursement Form" and submit it with this claim form.
- **Complete all requested information. Your claim will be returned for missing or incorrect information.**

| Enrollee ID (numeric ONLY – located on BCBSM ID card) | Patient Name | Patient Date of Birth |
|---|---|---|
| | | |

☐ Country of Purchase:____________________ ☐ Currency Used: ____________________

Prescription Information

| | Date of Service (MM/DD/YYYY) | Name of Prescription | Form (ex: tablet, capsule, liquid) | Dose (ex: 500mg, 75mcg, 0.1%) | Quantity | Day Supply (ex: 30 day supply) | Amount Paid (per drug) |
|---|---|---|---|---|---|---|---|
| 1 | | | | | | | |
| 2 | | | | | | | |
| 3 | | | | | | | |
| 4 | | | | | | | |
| 5 | | | | | | | |
| 6 | | | | | | | |
| 7 | | | | | | | |
| 8 | | | | | | | |
| 9 | | | | | | | |
| 10 | | | | | | | |

**If your prescription does not have an FDA approved American Equivalent, the claim will not be paid.**

## Acknowledgment

I certify that the medication(s) described above was received for use by the patient listed above, and that I (or the patient, if not myself) am eligible for prescription drug benefits.

X________________________________________

Enrollee or Patient Signature - (REQUIRED) Date