BLUE CROSS AND BLUE SHIELD MEDICARE PART D – PRESCRIPTION DRUG REIMBURSEMENT FORM
(To be used for Secondary Reimbursement under an American Airlines Group Health Plan)

BLUE CROSS AND BLUE SHIELD GROUP NUMBER: _____

A. GUIDELINES FOR SUBMITTING CLAIMS

1. Please return **this claim form, your pharmacy receipts, and your Part D Explanation of Medicare Benefits** to the following address (if this information is not provided, your claim will be denied):
   Blue Cross Blue Shield of Texas
   P.O. Box 660044
   Dallas, TX 75266-0044
2. Please indicate your member ID number on all documents (this is the number on your AA Medical ID card).
3. Be sure to notify your employer of all address changes.
4. Please call Blue Cross and Blue Shield at the number shown on your Medical ID Card with questions.

B. SUBSCRIBER/EMPLOYEE INFORMATION

Member ID:		Phone #:	
Last Name:	First Name:	M.I.:	Date of Birth: / /
Home Address:			New Address: Yes ❑ No ❑
City:		State:	Zip Code:
Spouse Last Name:	First Name:	M.I.:	Date of Birth: / /

C. PATIENT INFORMATION

Last Name:	First Name:	M.I.:	Date of Birth: / /
Home Address:			
City:		State:	Zip Code:
Sex: M ❑ F ❑	Relationship To Subscriber: Self ❑ Spouse/DP ❑		

D. DRUG INFORMATION

Enrolled in a Medicare Part D Prescription Drug Plan: Yes ❑ No ❑			
Name of Prescription Drug:			NDC#:
Days Supply:	Date Filled:		
Name of Prescription Drug:			NDC#:
Days Supply:	Date Filled:		
Name of Prescription Drug:			NDC#:
Days Supply:	Date Filled:		

ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY MISREPRESENTATION OR ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE GUILTY OF A CRIMINAL ACT PUNISHABLE UNDER LAW AND MAY BE SUBJECT TO CIVIL PENALTIES.

Member Signature:_____ Date:_____

D. DRUG INFORMATION – IF YOU NEED ADDITIONAL SPACE FOR YOUR PRESCRIPTIONS PLEASE USE THIS SECOND PAGE.			
Name of Prescription Drug:			NDC#:
Days Supply:	Date Filled:		
Name of Prescription Drug:			NDC#:
Days Supply:	Date Filled:		
Name of Prescription Drug:			NDC#:
Days Supply:	Date Filled:		
Name of Prescription Drug:			NDC#:
Days Supply:	Date Filled:		
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