Bristol-Myers Squibb

Direct Reimbursement Claim

ARGUS™

PART 1 To be filled out by you

Member Identification Number

Member Date of Birth (mm/dd/yyyy) / /

Customer Number 0 5 3 8 0 0 0 0

Sex: ☐ Male ☐ Female

Member Name

Daytime Telephone ( )

Member Mailing Address

Street Address City State ZIP Code

The undersigned certifies that the medication(s) described herein was received by the undersigned for the party(s) named below who is/are eligible for drug benefits. The undersigned further authorizes use of such person's subscriber identification number for identification purposes and further recognizes that reimbursement will be paid directly to the participant and assignment of these benefits to a pharmacy or otherwise is void.

X

Signature of patient, guardian, or legal representative

PART 2 To be filled out by you or your pharmacist

Pharmacy Name

Pharmacy Street Address

Pharmacy NCPDP Number

City State ZIP Code

Pharmacy Telephone ( )

Rx 1	Rx 2
Tape Pharmacy Receipt Here	Tape Pharmacy Receipt Here
Rx 3	**Rx 4**
Tape Pharmacy Receipt Here	Tape Pharmacy Receipt Here

Cash register receipts are not acceptable for any prescriptions.

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