Prescription Reimbursement Claim Form

Please note:

* It may take up to 30 days from when you sent this form to get a response back. This allows for mail and processing time
* Make a copy of this form, all receipts, and other documents. Keep them for your records
* Don't staple or tape any receipts or other documents to this form
* Submitting this claim doesn't mean you will be reimbursed. The contractor will review your request which must meet certain plan rules, limits, and exclusions

STEP 1 Card Holder/Patient Information

Please fill in this entire section. Incorrect or blank items can slow or stop your claim.

Card Holder Information

Identification Number **Group No./Group Name**

Name *(Last Name)* *(First Name)* *(MI)*

Address

Address 2

City **State** **Zip**

Country

Patient Information Use a separate claim form for each patient.

Name *(Last Name)* *(First Name)* *(MI)*

Date of Birth **Male** **Female** **Phone Number**

Relationship to Enrollee

Self Spouse/Domestic Partner Child

Other Insurance Information

COB (Coordination of Benefits)

Were any of these medicines for an on-the-job injury? Yes No

Are any covered by another group insurance plan? Yes No

If yes, is the other plan your: Primary Secondary

If it's your primary, send in the plan's explanation of benefits with this form.

Fill in the plan name_____and your plan ID number_____

Important! A signature is REQUIRED

NOTICE

Any person who knowingly and with intent to defraud, injure, or deceive any insurance company, submits a claim or application containing any materially false, deceptive, incomplete or misleading information pertaining to such claim may be committing a fraudulent insurance act which is a crime and may subject such person to criminal or civil penalties, including fines, denial of benefits, and/or imprisonment.

I certify that I (or my eligible dependent) have received the medicine described herein. I certify that I have read and understood this form, and that all the information entered on this form is true and correct.

X

Signature of Plan Enrollee **Date**

STEP 2 Submission Requirements:

You MUST include all original "pharmacy" receipts in order for your claim to process. The minimum information that must be included on your pharmacy receipts is listed below:

- Patient Name
- Prescription Number
- Medicine NDC number
- Date of Fill
- Metric Quantity
- Total Charge
- Days Supply for your prescription (you need to ask your pharmacist for this "Day Supply" information)
- Pharmacy Name and Address or Pharmacy NABP Number

If the Prescribing Physician's NPI (National Provider Identification) number is available, please provide: _____

If this is from a foreign country, please fill in below:

Country:_____ Currency:_____ Amount:_____

Additional Comments

STEP 3 Mailing Instructions:

Please mail your completed claim form and supporting receipt to the address below:

CVS Caremark
P.O. Box 52136
Phoenix, Arizona 85072-2136

IMPORTANT REMINDER

You can avoid having to submit paper claim forms by:

- Always having your prescription ID card with you
- Always using in-network pharmacies (find them at Caremark.com)
- Using covered medicine (see plan's drug list)

- Calling the number on the back of your ID card if there are issues at the pharmacy