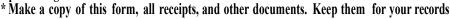


Prescription Reimbursement Claim Form



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







* 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

meet certuin plan ruie	5, 1111105, 4114	Cherusions					
STEP 1 Card Holder/Patient Info	rmation	Please fill in this ex	ntire section. Incorrect or	blank items can	slow or stop yo	our claim.	
Card Holder Information							
Identification Number Name (Last Name)			Group No./Group (First Name)	Name			(MI)
Address	-			_			
Address 2							
City				State	Ziţ)	
Country	-						
Patient Information Use a separate	claim form	n for each	oatient.				
Name (Last Name)			(First Name)				(MI)
Date of Birth Male Relationship to Enrollee Self Spouse/Domestic Partner Child	Female		Phone Number	-			
Other Insurance Information							
Were any of these medicines for an on-th Are any covered by another group insurar If yes, is the other plan your: Primary If it's your primary, send in the plan's exp Fill in the plan name	e-job injury? nce plan? y >Seconda	Yes Yes ary nefits with this f	> No > No orm. our plan ID number_				
Important! A signature is REQUIRE	D						
		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.

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 8

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