

CVS/caremark™ Prescription Reimbursement Claim Form

Important!

- » Always allow up to 30 days from the time you receive the response to allow for mail time plus claims processing.
- » Keep a copy of all documents submitted for your records.
- » Do not staple or tape receipts or attachments to this form.
- » Reimbursement is not guaranteed and other contractor will review the claims subject to limitations, exclusions and provisions of the plan.



STEP 1 Card Holder/Patient Information This section must be fully completed to ensure proper reimbursement of your claim.

Card Holder Information

<p>Identification Number (refer to your prescription card)</p> <div style="border: 1px solid black; height: 20px; width: 100%;"></div> <p>Name (Last Name)</p> <div style="border: 1px solid black; height: 20px; width: 100%;"></div> <p>Address</p> <div style="border: 1px solid black; height: 20px; width: 100%;"></div> <p>Address 2</p> <div style="border: 1px solid black; height: 20px; width: 100%;"></div> <p>City</p> <div style="border: 1px solid black; height: 20px; width: 100%;"></div> <p>Country</p> <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<p>Group No./Group Name</p> <div style="border: 1px solid black; height: 20px; width: 100%;"></div> <p>(First Name) (MI)</p> <div style="border: 1px solid black; height: 20px; width: 100%;"></div> <p>State Zip</p> <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
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Patient Information—Use a separate claim form for each patient.

<p>Name (Last Name)</p> <div style="border: 1px solid black; height: 20px; width: 100%;"></div> <p>Date of Birth</p> <div style="border: 1px solid black; height: 20px; width: 100%;"></div> <p>Relationship to Primary member</p> <p>Member <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____</p>	<p>(First Name) (MI)</p> <div style="border: 1px solid black; height: 20px; width: 100%;"></div> <p>Male <input type="checkbox"/> Female <input type="checkbox"/></p> <p>Phone Number</p> <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
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Other Insurance Information

COB (Coordination of Benefits)

Are any of these medicines being taken for an on-the-job injury? Yes No

Is the medicine covered under any other group insurance? Yes No

If yes, is other coverage: Primary Secondary

If other coverage is Primary, include the explanation of benefits (EOB) with this form.

Name of Insurance Company _____ ID# _____

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.

<p>X Signature of Plan Participant</p>	<p>Date</p>
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STEP 2**Submission Requirements:**

You **MUST** include all original “pharmacy” receipts in order for your claim to process. “Cash register” receipts will **only** be accepted for diabetic supplies. The minimum information that must be included on your pharmacy receipts is listed below:

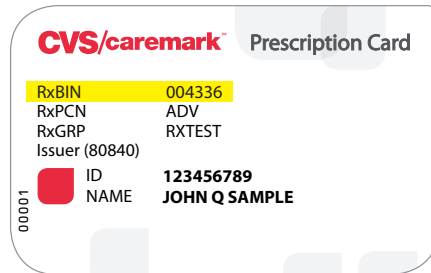
- Patient Name
- Prescription Number
- Medicine NDC number
- Date of Fill
- Metric Quantity
- Total Charge
- Days Supply for your prescription (you need to ask your pharmacist for this “Day Supply” information)
- Pharmacy Name and Address or Pharmacy NABP Number

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:**

The RXBIN # is located on front of your CVS/caremark Prescription ID card. Please see highlighted area to the left for reference. Match your RXBIN # to the addresses below.

RXBIN # 610415 mail to:

CVS/caremark
P.O. Box 52116
Phoenix, Arizona 85072-2116

RXBIN # 004336 , 012114 or if you are unable to locate your bin # mail to:

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

RXBIN # 610029 mail to:

CVS/caremark
P.O. Box 52196
Phoenix, Arizona 85072-2196

RXBIN # 610474 , 610468 , 004245 or 610449 mail to:

CVS/caremark
P.O. Box 52010
Phoenix, Arizona 85072-2010

RXBIN # 610473 , 601475 mail to:

CVS/caremark
P.O. Box 53992
Phoenix, Arizona 85072-3992

IMPORTANT REMINDER—To avoid having to submit a paper claim form:

- Always have your card available at time of purchase.
- Always use pharmacies within your network.
- Use medication from your formulary list.
- If problems are encountered at the pharmacy, call the number on the back of your card.