Prescription Reimbursement Claim Form

* 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.

Important!

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

CARD HOLDER INFORMATION

Identification Number (refer to your prescription card)

Group Number/Group Name

Last Name

First Name

MI

Address

Address 2

City

State

Zip Code

Country

PATIENT INFORMATION—Use a separate claim form for each patient

Last Name

First Name

MI

Date of Birth

Gender: ◯ M ◯ F

Daytime Phone #

Relationship to Primary Member: ◯ Member ◯ Spouse ◯ Child ◯ Other: _____

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 the other coverage: ◯ Primary ◯ Secondary

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

Name of insurance: _____ 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 a 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 Participant _____ Date _____

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 _____

STEP 3 Mailing Instructions:

CVS Caremark
RXBIN# 004336
P.O. Box 52136
Phoenix, Arizona 85072-2136

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.