

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 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

Identification Number (refer to your prescription card)

[Input boxes for Identification Number]

Group Number/Group Name

[Input boxes for Group Number/Group Name]

Last Name

[Input boxes for Last Name]

First Name

[Input boxes for First Name]

MI

[Input boxes for MI]

Address

[Input boxes for Address]

Address 2

[Input boxes for Address 2]

City

[Input boxes for City]

State

[Input boxes for State]

Zip

[Input boxes for Zip]

Country

[Input boxes for Country]

Patient Information—Use a separate claim form for each patient

Last Name

[Input boxes for Last Name]

First Name

[Input boxes for First Name]

MI

[Input boxes for MI]

Date of Birth

[Input boxes for Date of Birth]

Male

Female

Phone Number

[Input boxes for Phone Number]

Relationship to Primary Member

Member Spouse Child Other

[Input boxes for Relationship to Primary Member]

Pharmacy Information

Pharmacy Name

[Input boxes for Pharmacy Name]

Address

[Input boxes for Address]

City

[Input boxes for City]

State

[Input boxes for State]

Zip

[Input boxes for Zip]

REQUIRED: Please check appropriate box for submitting a paper claim. Claim will be returned if incomplete. (tape receipts or itemized bills on the back)

Reason I am filing this form is:

- Out of the country
- Pharmacy does not accept insurance
- Compound
- No insurance coverage at the time
- Other—provide reason below

[Blank lines for other reasons]

Medication purchased outside of the United States (tape receipts or itemized bills on the back)

PLEASE INDICATE:

Country: _____

Currency used: _____



Pharmacy Information Continued

Phone Number

Is this an on-site nursing home pharmacy?

YES

NO

NCPDP/NPI Required

X

Signature of Pharmacist or Representative (REQUIRED)

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 Participant (REQUIRED)

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

A valid Prescribing Physician's NPI (National Provider Identification) number is required, please provide: _____

Prescribing physician's information (all fields required):

Name: _____

Address: _____

City, state, zip: _____

Phone: _____

Additional comments: _____

STEP 3 Mail completed forms with receipts to:

CVS Caremark
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.