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							
Identification Number (refer to your prescription card) Group No./Group Name							
Name (Last Name		(First Name) (MI)					
Address							
Address 2							
City		State Zip					
Country							
Patient In	nformation—Use a separate claim form for ea	ach patient.					
Name (Last Name	·						
Name (Lust Nume		(MI)					
Date of Birth	Male Female	Phone Number					
Date of biftii	Male reliidle						
	Primary member						
Member	Spouse Child Other						
Other Ins	urance Information						
C							
	OB (Coordination of Benefits)						
	any of these medicines being taken for an on-the-job injury?	○ Yes ○ No					
	he medicine covered under any other group insurance?	○ Yes ○ No					
	es, is other coverage: O Primary O Secondary						
If other coverage is Primary, include the explanation of benefits (EOB) with this form.							
Nan	ne of Insurance Company	ID#					
	ALA : A PENUDED						

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.

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Signature of Plan Participant	Date	(Over)
		(0101)

STEP 2

Submission Requirements:

You MUST include all original "pharmacy" receipts in order for your claim to process. "Cash register" receipts will <u>only</u> 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:

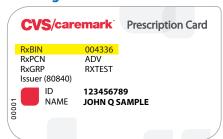
City, state, zip code:

Phone number:

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 # <u>004336</u>, <u>012114</u> 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

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.