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)
and with intent to defraud

Group No./Group Name
and with inte

Name *(Last Name)*
and with intent to defraud

(First Name)
and with inte

(MI)
a

Address
and with intent to defraud, injure,

Address 2
and with intent to defraud, injure,

City
and with intent to defrau

State
DL

Zip
97879

Country
and with intent to defrau

Patient Information–Use a separate claim form for each patient.

Name *(Last Name)*
and with intent to defraud

(First Name)
and with inte

(MI)
a

Date of Birth
06 07 24

Male
a

Female
a

Phone Number
9879846546

Relationship to Primary member

Member a Spouse a Child a Other and with intent to defraud, injure, or decei

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 and with intent to defraud, injure, or deceive any insurance company, submits a claim or applic ID# and with intent to defraud, injure, or deceive any insurance company, submits a

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 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

Signature of Plan Participant **Date**

(Over)

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: and with intent to defraud, injure, or dec

Prescribing physician's information (all fields required):

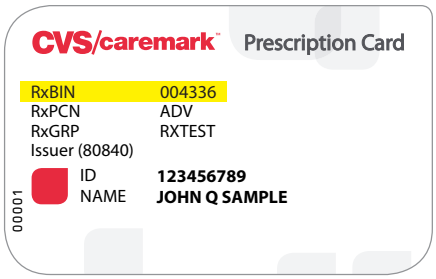
Name: and with intent to defraud, injure, or deceive any insurance company, submits a claim or application containing any materially false, deceptive, incomplete or misleading information pertaining to such claim may be committing a fraudulent insurance act wh

Address: 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

City, state, zip code: and with intent to defraud, injure, or deceive any insurance company, submits a claim or application contain **Phone number:** (898) 798-7987

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.