

# 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)

Group Number/Group Name

Last Name

First Name

MI

Address

Address 2

City

State

Zip

Country

#### Patient Information—Use a separate claim form for each patient

Last Name

First Name

MI

Date of Birth

Male

Female



Phone Number

Relationship to Primary Member

Member

Spouse

Child

Other

#### Pharmacy Information

Pharmacy Name

Address

City

State

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

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

PLEASE INDICATE:

Country: \_\_\_\_\_

Currency used: \_\_\_\_\_

#### Other Insurance Information

##### Coordination of Benefits (COB)

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#: \_\_\_\_\_

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

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