4050-14423-0910
STANDARD

CVS CAREMARK

Prescription Reimbursement Claim Form

Important!

- Paper claims submitted to the PBM are processed within ten (10) business days, on average, of receiving a properly completed claim form.
- Keep a copy of all documents submitted for your records.
- Do not staple or tape receipts or attachments to this form.

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 insurance card)*

Group No./Group Name

Name *(Last Name)* *(First Name)* *(MI)*

Address

Address 2

City **State** **Zip**

Country

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

Name *(Last Name)* *(First Name)* *(MI)*

Date of Birth **Male** **Female** **Phone Number**

Relationship to Primary member

Member Spouse Child Other _____

Other Insurance Information

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 #_____

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 commiting 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 Member /Guardian **Date**

(Over)

STEP 2 ## Submission Requirements:

You MUST include all original receipts or a patient history printout from your pharmacy in order for your claim to process. Cash register receipts will only be accepted for diabetic supplies. The minimum information required is:

- Patient Name
- Prescription Number
- Medicine NDC number
- Date of Fill
- Quantity
- Days Supply
- Total Charge
- Pharmacy Name and Address or Pharmacy NABP Number

If Foreign Claim: Country:_____ **Currency:**_____ **Amount:**_____

Comment Section

STEP 3 ## Mail to:

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

IMPORTANT REMINDERS

To avoid having to submit a paper claim form:

- Always present your card 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.
- Claim form(s) must be signed
- Unsigned claim forms cannot be processed and will be returned
- Claims must be received within 365 days from the date of service.