CVS caremark

14423-CMU-0816

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

☐MEDICARE PART D

If other coverage is PRIMARY, include the Explanation of Benefits (EOB) with this form.

Name of Insurance Company:

_____

_____

ID#: _____

Continued

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