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 U S A

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

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 N/A 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 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 **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: _____

Prescribing physician's information (all fields required):

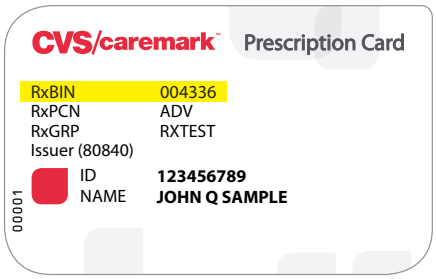
Name: _____

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 # 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

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.

Steps for Submitting a Paper Claim Reimbursement Form

NOTE – These may prevent you from having to submit a claim form:

- Use your ID card when obtaining prescriptions at a pharmacy.
- Use an in network pharmacy.
- Fill prescriptions for drugs on your approved drug list/formulary.

How to Submit a Paper Claim Reimbursement Form

1. Review the Dos and Don'ts.
2. Download, fully complete and print the Paper Claim Reimbursement Form.
3. Attach receipts to a separate piece of paper; please do not attach to the claim form.
4. Make copies of your submission and retain for your records.
5. Mail to the address indicated on claim form- Claims will be processed within 30 business days

Do's:

Do complete the Paper Claim Reimbursement Form that corresponds with the RxBIN number on your ID card.
Do make a copy of your prescription receipt(s) and include with the claim form.
Do ensure the following is included on your pharmacy receipts or provide on the claim form :

Date of Fill
Pharmacy information (NABP number, name, phone number, full address)
Prescriber's NPI number, DEA number and/or FULL name
Prescription number
NDC number
Total charge
Quantity
Days supply

If your plan has Coordination of Benefits (COB), you may submit a paper claim for consideration of your secondary benefit. Be sure to include primary claim payment information and EOB (explanation of benefits) to avoid delays in processing your claim.

Don'ts:

Do Not include Mail Service Order Form with your paper claim submission.
Do Not send in a cash register receipt except for diabetic supplies.
Do Not send medical or dental claims.
Contact us at the number on the back of your ID card if you have any questions regarding your claim(s).