

## Prescription Reimbursement Claim Form

### Important!



- Always allow up to 30 days from the time you send this form until 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 the 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

#### 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 \_\_\_\_\_ 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 Member

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:

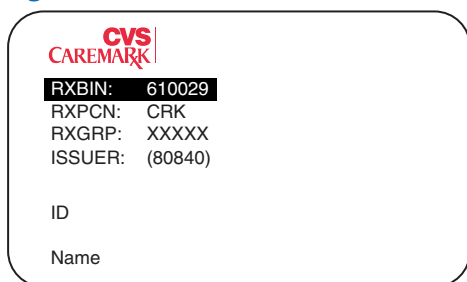
- Patient Name
- Prescription Number
- Medicine NDC number
- Date of Fill
- Metric Quantity
- Total Charge
- Days Supply for your prescription (you may need to ask your pharmacist for this “Days Supply” information)
- Pharmacy Name and Address or Pharmacy NABP Number

If the Prescribing Physician’s NPI (National Provider Identification) number is available, please provide: \_\_\_\_\_

If this claim is from a foreign country, please fill in below:

Country: \_\_\_\_\_ Currency: \_\_\_\_\_ Amount: \_\_\_\_\_

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 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 , 610475 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.