

## 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.

**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 Plan Participant

Date

**STEP 2****Submission Requirements:**

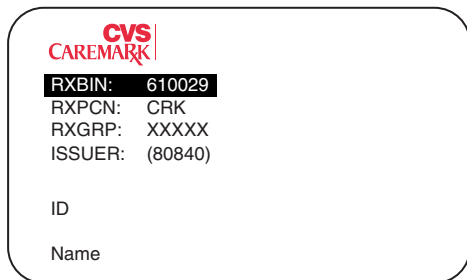
You **MUST** include all original receipts in order for your claim to process. Cash register receipts will only be accepted for diabetic supplies. The minimum information required is:

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

If Foreign Claim: Country: \_\_\_\_\_ Currency: \_\_\_\_\_ Amount: \_\_\_\_\_

Pharmacist's Signature: \_\_\_\_\_

**Comment Section**

**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.