CVS/caremark Prescription Reimbursement Claim Form



STEP 1

- **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.

Card Holder/Patient Information

* Reimbursement is not guaranteed and other contractor will review the claims subject to limitations, exclusions and provisions of the plan.

This section must be fully completed to ensure proper reimbursement of your claim.

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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.

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Signature of Plan Participant

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 Metric Quantity Date of Fill 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 Card CVS/caremark Prescription ID card. Please see RxBIN XXXXX highlighted area to the left for reference. Match **RxPCN** CRK RxGRP xxxx your RXBIN # to the addresses below. Issuer (80840) 9151014609 123456789 ID NAME JOHN Q. SAMPLE **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 RXBIN # 610474 , 610468 , 004245 or 610449 mail to: CVS/caremark P.O. Box 52010 Phoenix, Arizona 85072-2010 RXBIN # 610473 , 601475 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.