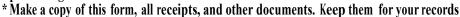
CVS caremark®

Prescription Reimbursement Claim Form



Please note:

* It may take up to 30 days from when you sent this form to get a response back. This allows for mail and processing time







- * Don't staple or tape any receipts or other documents to this form
- * Submitting this claim doesn't mean you will be reimbursed. The contractor will review your request which must meet certain plan rules, limits, and exclusions

STEP 1 Card Holder/Patient Information Please fill in this entire section. In	correct or blank	items can	slow or st	op your	claim.	
Card Holder Information						
Identification Number 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 Nun Relationship to Enrollee	nber					
Self Spouse/Domestic Partner Child						
Other Insurance Information						
COD (Coordination of Domofita)						
Were any of these medicines for an on-the-joh injury? Ves					l	
Were any of these medicines for an on-the-job injury? Yes No Are any covered by another group insurance plan? Yes No						
Were any of these medicines for an on-the-job injury? Yes No Are any covered by another group insurance plan? Yes No If yes, is the other plan your: Primary Secondary						
Were any of these medicines for an on-the-job injury? Yes No Are any covered by another group insurance plan? Yes No If yes, is the other plan your: Primary Secondary If it's your primary, send in the plan's explanation of benefits with this form.						
Were any of these medicines for an on-the-job injury? Yes No Are any covered by another group insurance plan? Yes No If yes, is the other plan your: Primary Secondary	number					

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.

STEP 2

Submission Requirements:

You MUST include all original "pharmacy" receipts in order for your claim to process. 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

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

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

Country:	Currency:	Amount:
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Additiona	l Comments
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STEP 3

Mailing Instructions:

Please mail your completed claim form and supporting receipt to the address below:

CVS Caremark
P.O. Box 52136
Phoenix, Arizona 85072-2136

IMPORTANT REMINDER

You can avoid having to submit paper claim forms by:

- Always having your prescription ID card with you
- Always using in-network pharmacies (find them at Caremark.com)
- Using covered medicine (see plan's drug list)
- Calling the number on the back of your ID card if there are issues at the pharmacy