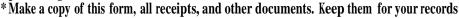
CVS caremark®

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 Pl	ase fill in this entire section. Incorrect or blank items can slow or stop 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)
D. (B) (I	DI V I
Date of Birth Male Female	Phone Number
Relationship to Enrollee	
Self Spouse/Domestic Partner Child	
Other Insurance Information	
COB (Coordination of Benef	ita)
)Yes)No
	Yes No
If yes, is the other plan your: Primary Secondary	3.10
If it's your primary, send in the plan's explanation of benef	its with this form.
Fill in the plan name	and your plan ID 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.

	oe included on your p • Patient Name	harmacy receipts is listed below • Prescription Number		
•	 Date of Fill 	 Metric Quantity 	• Total Charge	
		prescription (you need to ask your Address or Pharmacy NABP Numb	(you need to ask your pharmacist for this "Day Supply" information) Pharmacy NABP Number I (National Provider Identification) number is available, please provide:	
	•	•		
l	If the Prescribing Phy	•		

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