

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

City

State

Zip

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)

Any other prescription insurance? Yes No

If yes, select 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 “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:

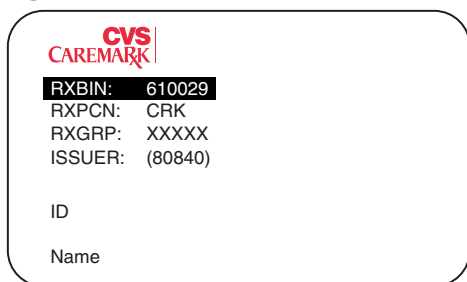
- Patient Name
- Prescription Number
- Medicine NDC number
- Date of Fill
- Metric Quantity
- Total Charge
- Days Supply for your prescription (you may need to ask your pharmacist for this “Days Supply” information)
- Pharmacy Name and Address or Pharmacy NABP Number

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.