CVS CAREMARK | CAREMARK®

SECONDARY CLAIM FORM

Do not staple or tape receipts or attachments to this form.

Instructions This form should be used ONLY if you are submitting claims for secondary prescription coverage.

AFTER you have submitted your claim to the primary carrier:

- Pharmacy receipt(s), Explanation of Benefits (EOBs), or denial letter from primary insurer MUST be included.
- Please provide all information requested.
- Contact your pharmacist, if necessary, to provide the detailed drug information requested.

Always allow up to 21 days from the time you send this form until the time you receive the response to allow for mail time plus claims processing.

Part 1 Cardholder/ Plan Participant Information

Part 1 must be fully completed to ensure proper reimbursement of your drug claim.

Please type or print clearly.

Cardholder ID No. _____ Group No./Group Name _____

Please submit the appropriate ID number for your Secondary coverage.

Cardholder Name _____ Address _____

City _____ State _____ ZIP _____ Phone ( )

Plan Participant Information — Use a separate claim form for each family member

Plan Participant Name _____ Date of Birth _____

Plan Participant: ❍ Male ❍ Female Relationship: ❍ Self ❍ Spouse ❍ Child ❍ Other _____

Are any of these medications being taken for an on-the-job injury? ❍ Yes ❍ No

Important! A signature is REQUIRED in both A and B.

A

Fraud Prevention Regulation: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

x _____

Signature of Plan Participant **Date**

B

Release of Information: I certify that I (or my eligible dependent) have received the medicine described herein and that the plan participant named is eligible for prescription benefits. I also certify that the medicine received is not for treatment of an on-the-job injury or covered under another benefit plan. I authorize release of all information pertaining to this claim to Caremark, the prescription benefit manager; insurance underwriter; sponsor; policyholder; and/or employer. I certify that all the information entered on this form is correct.

x _____

Signature of Plan Participant **Date**

Part 2 Important!

Please remember to include all original pharmacy receipts or primary carrier's EOB.

If you are including your primary carrier's EOB or original pharmacy receipts, STOP HERE and submit the claim. It is not necessary to complete Part 3. **NOTE:** Do not staple or tape receipts or attachments to this form. When submitting a claim, the following information must be included.

- Plan Participant Name
- Prescription Number
- Date of Purchase
- Metric Quantity/Days Supply
- Pharmacy Name and Address or NABP Number
- Medicine Strength/or NDC Number
- Medicine Name
- Amount Paid by Plan Participant

Part 3 Pharmacy Information

Pharmacy Name _____ Pharmacy NABP No. _____

Pharmacy Address _____ City _____

State _____ ZIP _____ Phone ( )

Rx 1

Rx #	Date Filled (mm/dd/yy)	❍ New ❍ Refill	Compound ❍ Yes ❍ No	For office use only Prior Approval Code
NDC #	Medicine Name and Strength	Metric Quantity	Days Supply	Total Paid by Primary	Amount Paid by Plan Participant

Rx 2

Rx #	Date Filled (mm/dd/yy)	❍ New ❍ Refill	Compound ❍ Yes ❍ No	For office use only Prior Approval Code
NDC #	Medicine Name and Strength	Metric Quantity	Days Supply	Total Paid by Primary	Amount Paid by Plan Participant

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INSTRUCTIONS

To avoid delays in handling your claim, be sure all information is complete and correct.

A separate claim form must be completed for:

- Each plan participant/family member
- Each pharmacy from which you purchase prescription medicines

Obtain additional claim forms from your company or association and mail directly to the Caremark claims department.

CLAIM SUBMISSION

When submitting a claim, the following information must be included:

- Pharmacy Name and Address or NABP Number
- Prescription Number
- Date of Purchase
- Medicine Name
- Medicine Strength/or NDC Number
- Metric Quantity/Days Supply
- Amount Paid by Plan Participant
- Original Pharmacy Receipts or Your Primary Carrier's EOB

DO NOT include charges for durable medical equipment that required a prescription to obtain. No benefits will be provided under this plan for such items.

DO NOT submit canceled checks, cash register slips or personal itemization. These are not acceptable as substitutes for original receipts.

DO NOT submit statements with "balance" amounts only.

HOW TO COMPLETE THIS FORM

Cardholder / Plan Participant Information

Complete all cardholder and plan participant information in Part 1 on reverse side.

- The cardholder ID number can be found on your ID card.
- The group is the name of your company or association through which you have coverage.
- Sign and date in the spaces provided. Your signature certifies that the information is correct and complete.
- Please make a copy of all documents and receipts before you send them to Caremark. No documents will be returned.

MAIL THIS FORM TO:

Please refer to your prescription card to ensure this form is mailed to the proper address.

If 610415 is the RXBIN # on your card mail the completed form to:

Caremark
P.O. Box 52116
Phoenix, Arizona 85072-2116

If 004336 is the RXBIN # on your card mail the completed form to:

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

If you have questions, please contact: Caremark toll-free at 1-800-929-2524
Monday–Friday, 7 a.m.–10 p.m. CST / Saturday, 8 a.m.–8 p.m. CST / Sunday, 8 a.m.–4:30 p.m. CST
Closed on national holidays.