

## Prescription Reimbursement Claim Form

### Important!



- Always allow up to 30 days from the time you receive the response to allow for claims processing and delivery.
- Keep a copy of all documents submitted for your records.
- Do not staple receipts or attachments to this form.
- Reimbursement is not guaranteed and other contractor will review the claims subject to limitations, exclusions and provisions of the plan.

#### STEP 1

#### Card Holder/Member Information

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

##### Card Holder Information

Identification Number (refer to your ID card)

Group Number/Group Name

Last Name

First Name

MI

Address

Address 2

City

State

Zip/Postal Code

Country

##### Member Information—Use a separate claim form for each member

Last Name

First Name

MI

Date of Birth

Phone Number

##### Pharmacy Information

Pharmacy Name

Address

City

State

Zip/Postal Code

**REQUIRED:** Please check appropriate box for submitting a paper claim. Claim will be returned if incomplete. (Tape receipts and/or itemized bills on another sheet of paper)

#### Reason I am filing this form is:

Allergy/Allergen Clinic

Pharmacy does not accept insurance

Compound

No insurance coverage at the time

Other—provide reason below

Medication purchased outside of the United States (Tape receipts and/or itemized bills on another sheet of paper)

PLEASE INDICATE:

Country/Region: \_\_\_\_\_

Currency used: \_\_\_\_\_

#### Other Insurance Information

##### Coordination of Benefits (COB)

Are any of these medicines being taken for an on-the-job injury? YES NO

Is the medicine covered under any other group insurance? YES NO

If YES, is other coverage:

PRIMARY

SECONDARY

MEDICARE PART D

If other coverage is PRIMARY, include the Explanation of Benefits (EOB) with this form.

Name of Insurance Company:

ID#: \_\_\_\_\_

*continued*

## Pharmacy Information (Cont.)

Phone Number

Is this an on-site nursing home pharmacy?

YES

NO

NCPDP/NPI

☐☐

X

Signature of Pharmacist or Representative

## 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.

(New York Members Only) Any person who knowingly and with intent to defraud, injure, or deceive 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

(California Members Only) For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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 Member (REQUIRED)

Date

## STEP 2 Submission Requirements

**Claim Receipts-** Proof of purchase must be included along with the following information either on the claim form or receipt. (Proof of purchase can be pharmacy receipt or cash register receipt).

- Member 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 NCPDP Number

Number of prescriptions you are submitting for reimbursement: \_\_\_\_\_

Prescribing physician's national provider identification (NPI) number: \_\_\_\_\_

Prescribing physician's information (all fields required):

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip/Postal Code: \_\_\_\_\_

Phone: \_\_\_\_\_

Additional comments:

## STEP 3

**Mail completed forms with receipts to:**

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

### IMPORTANT REMINDER—To avoid having to submit a paper claim form:

- Always have your ID 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 ID card.

# Prescription Claim Information

Prescription 1	Prescription (Rx) Number	Drug Name	
	National Drug Code (NDC) Number	Date Filled (MM/DD/YY)	Total Paid (Cost)
	Prescriber's NPI Number	Quantity of Drug	Days Supply
Prescription 2	Prescription (Rx) Number	Drug Name	
	National Drug Code (NDC) Number	Date Filled (MM/DD/YY)	Total Paid (Cost)
	Prescriber's NPI Number	Quantity of Drug	Days Supply
Prescription 3	Prescription (Rx) Number	Drug Name	
	National Drug Code (NDC) Number	Date Filled (MM/DD/YY)	Total Paid (Cost)
	Prescriber's NPI Number	Quantity of Drug	Days Supply
Prescription 4	Prescription (Rx) Number	Drug Name	
	National Drug Code (NDC) Number	Date Filled (MM/DD/YY)	Total Paid (Cost)
	Prescriber's NPI Number	Quantity of Drug	Days Supply
Prescription 5	Prescription (Rx) Number	Drug Name	
	National Drug Code (NDC) Number	Date Filled (MM/DD/YY)	Total Paid (Cost)
	Prescriber's NPI Number	Quantity of Drug	Days Supply
Prescription 6	Prescription (Rx) Number	Drug Name	
	National Drug Code (NDC) Number	Date Filled (MM/DD/YY)	Total Paid (Cost)
	Prescriber's NPI Number	Quantity of Drug	Days Supply

## Allergy Claim Information

Allergy 1	Date of Purchase (MM/DD/YY) <input type="text"/>	Number of Vials <input type="text"/>	Charge per treatment for professional immunotherapy in your office. (Cost) <input type="text"/>
	Number of Treatments <input type="text"/> Single Dose      Multidose	Days Supply <input type="text"/>	Charge for preparation of allergenic extract in location other than your office. (Cost) <input type="text"/>
	Vial Contains Single Antigen Multiantigen	Administered By Physician Nurse Self	Total charge for allergenic extract only. (Cost) <input type="text"/>
	Directions		
	Ingredients		
Allergy 2	Date of Purchase (MM/DD/YY) <input type="text"/>	Number of Vials <input type="text"/>	Charge per treatment for professional immunotherapy in your office. (Cost) <input type="text"/>
	Number of Treatments <input type="text"/> Single Dose      Multidose	Days Supply <input type="text"/>	Charge for preparation of allergenic extract in location other than your office. (Cost) <input type="text"/>
	Vial Contains Single Antigen Multiantigen	Administered By Physician Nurse Self	Total charge for allergenic extract only. (Cost) <input type="text"/>
	Directions		
	Ingredients		
Allergy 3	Date of Purchase (MM/DD/YY) <input type="text"/>	Number of Vials <input type="text"/>	Charge per treatment for professional immunotherapy in your office. (Cost) <input type="text"/>
	Number of Treatments <input type="text"/> Single Dose      Multidose	Days Supply <input type="text"/>	Charge for preparation of allergenic extract in location other than your office. (Cost) <input type="text"/>
	Vial Contains Single Antigen Multiantigen	Administered By Physician Nurse Self	Total charge for allergenic extract only. (Cost) <input type="text"/>
	Directions		
	Ingredients		