

Prescription Reimbursement Claim Form

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.

	1 Card Holder/Patient Information							This section must be fully completed to ensure proper reimbursement of your claim.																				
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Identifica	lentification Number (refer to your prescription card)												Group No./Group Name															
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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 misleding 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 Member	Date

STEP 2 Submission Requirements:

You MUST include all original receipts in order for your claim to process. Cash register receipts will <u>only</u> be accepted for diabetic supplies. The minimum information required is:

• Patient Name

• Prescription Number

• Medicine NDC number

Date of Fill

Metric Quantity

Days Supply

Total Charge

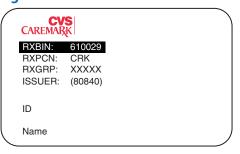
• Pharmacy Name and Address or Pharmacy NABP Number

If Foreign Claim: Country:_____ Currency:____ Amount:____

Pharmacist's Signature:

Comment Section

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.