

Medicare Part D Prescription Claim Form

\bigcirc	This prescription was covered by a
	manufacturer patient assistance program

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.

ification Number (refer to your prescription card)	Group No./Group Name
e (Last Name)	(First Name)
<u>25S</u>	
	State Zip
e (Last Name)	(First Name) (i
of Birth Male Fema	ale Phone Number
ionship to Primary member per Spouse Child C	Other
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Any other prescription insurance? Ye If yes, select coverage: Pri If other coverage is Primary, include the expla Name of Insurance Company Any person who knowingly and with intent to application containing any materially false, de	NOTICE O defraud, injure, or deceive any insurance company, submits a claim eceptive, incomplete or misleding information pertaining to such cla
Any other prescription insurance? Ye If yes, select coverage: Pri If other coverage is Primary, include the expla Name of Insurance Company Any person who knowingly and with intent to application containing any materially false, de	NOTICE O defraud, injure, or deceive any insurance company, submits a claim eceptive, incomplete or misleding information pertaining to such clact which is a crime and may subject such person to criminal or company.
Any other prescription insurance? Yelf yes, select coverage: Print other coverage is Primary, include the explain Name of Insurance Company Any person who knowingly and with intent to application containing any materially false, do may be committing a fraudulent insurance a penalties, including fines, denial of benefits, a	NOTICE O defraud, injure, or deceive any insurance company, submits a claim ecceptive, incomplete or misleding information pertaining to such claic twhich is a crime and may subject such person to criminal or cond/or imprisonment.

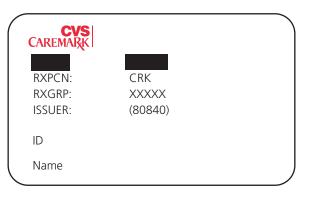
Submission Requirements:

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 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

STEP 3

Mailing Instructions:



CVS Caremark P.O. Box 52092

Phoenix, Arizona 85072-2092

CVS Caremark P.O. Box 52193

Phoenix, Arizona 85072-2193

CVS Caremark P.O. Box 52077 Phoenix, Arizona 85072-2077

CVS Caremark P.O. Box 52066 Phoenix, Arizona 85072-2066

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 .