CVS CAREMARK | Part D Services

# Medicare Part D
## Prescription Claim Form

○ 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.

**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 misleding information pertaining to such claim may be commiting 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

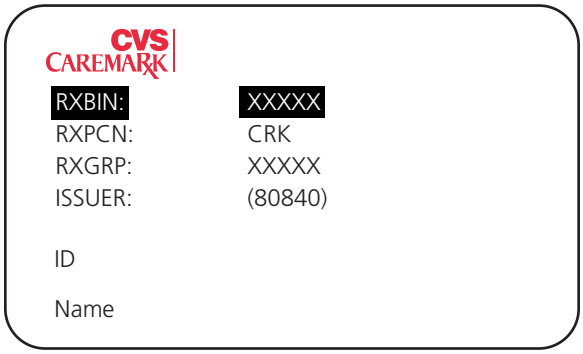
(Over)

## 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 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:




**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 52092
Phoenix, Arizona 85072-2092

### RXBIN # 610029 mail to:

CVS Caremark
P.O. Box 52193
Phoenix, Arizona 85072-2193

### RXBIN # 610474 , 610468 , 004245 or 610449 mail to:

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

### RXBIN # 004336 mail to:

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 .