

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 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.

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

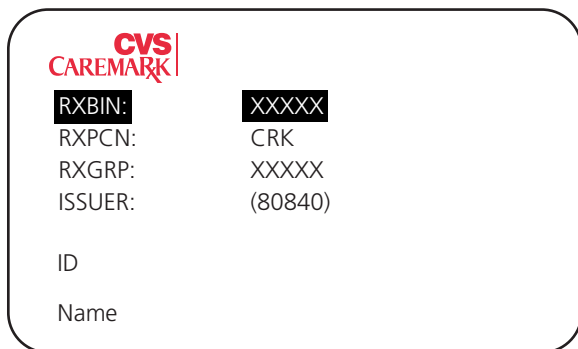
Signature of Plan Participant

Date

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
- Date of Fill
- Total Charge
- Prescription Number
- Metric Quantity
- Pharmacy Name and Address or Pharmacy NABP Number
- Medicine NDC number
- Days Supply

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 .