

# 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/Patient 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

### Patient Information—Use a separate claim form for each patient

Last Name

First Name MI Date of Birth Phone Number

Relationship to Primary Member  
Member Spouse Child Other

### Pharmacy Information

Pharmacy Name

Address

City State Zip/Postal Code

### Pharmacy Information (Cont.)

**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*

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.

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 Patient (REQUIRED) 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 diabetes supplies. The minimum information that must be included on your pharmacy receipts is listed below:**

- Patient 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.

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Your privacy is important to us. Our employees are trained regarding the appropriate way to handle your private health information.

**Prescription Claim Information**

<b>Prescription (Rx) Number</b>	<b>Drug Name</b>	
<b>National Drug Code (NDC) Number</b>	<b>Date Filled (MM/DD/YY)</b>	<b>Total Paid (Cost)</b>
<b>Prescriber's NPI Number</b>	<b>Quantity of Drug</b>	<b>Days Supply</b>
<b>Prescription (Rx) Number</b>	<b>Drug Name</b>	
<b>National Drug Code (NDC) Number</b>	<b>Date Filled (MM/DD/YY)</b>	<b>Total Paid (Cost)</b>
<b>Prescriber's NPI Number</b>	<b>Quantity of Drug</b>	<b>Days Supply</b>
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<b>Prescriber's NPI Number</b>	<b>Quantity of Drug</b>	<b>Days Supply</b>
<b>Prescription (Rx) Number</b>	<b>Drug Name</b>	
<b>National Drug Code (NDC) Number</b>	<b>Date Filled (MM/DD/YY)</b>	<b>Total Paid (Cost)</b>

Prescriber's NPI Number Quantity of Drug Days Supply

## Allergy Claim Information

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

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

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