CAREMARK
It all starts with care®

Prescription Reimbursement Standard Claim Form

Important!

- * Always allow up to 21 days from the time you send this form until the time you receive the response to allow for mail time plus claims processing.
- * Make a copy of all documents submitted and do not staple or tape receipts or attachments to this form. No documents will be returned.

1 Primary Member/Patient Information

This section must be fully completed to ensure proper reimbursement of your claim.

Primary Member 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.

ID No. and Patient Codes will be found on your prescription card.

Name *(Last Name)* *(First Name)* *(MI)*

Date of Birth Male Female

Relationship to Primary member

Member Spouse Child Other_______________

Full-Time College Student

Yes No

I certify that I (or my eligible dependent) have received the medication described herein and that the patient named is eligible for drug benefits. I also certify that the medication received is not for treatment of an on-the-job injury or covered under another benefit plan. I authorize release of all information pertaining to this claim to Caremark, the plan administrator, insurance underwriter, plan sponsor, policyholder and/or employer. I certify that all the information entered on this form is correct.

X

Signature of Primary Member or Legal Representative Date

2 Prescription Claim Information

NOTE: If you are including all original receipts with the following information, it is not necessary to complete this section. **Exception: If submitting compound receipts, this section must be completed.** **ONLY INCLUDE** charges for prescription medications, original receipts and full itemized statements.

Rx

Rx #	Date Filled (m/d/y)	Prescriber's DEA No.	❍ New ❍ Refill ❍ DAW ❍ Compound	For office use only Prior Approval Code
N D C #	Drug Name and Strength	Metric Quantity	Days Supply	Total Charges

3 Pharmacy Information

NOTE: The pharmacist is to complete this section **ONLY** if original pharmacy receipts are not included or if there is a compound prescription.

Pharmacy Name

Pharmacy NABP No.

Pharmacy Phone Number

( )

I hereby certify that all the information listed below is correct and represents the actual charge(s) for prescription(s) dispensed. I further understand that all benefit payments as related to the charges listed below will be paid directly to the cardholder.

X

Signature of Pharmacist or Representative Date

(Over)

4 Mail This Completed Form To:

Please refer to your prescription card to ensure this form is mailed to the proper address.

IF 610415 IS THE RXBIN # ON YOUR CARD MAIL THE COMPLETED FORM TO:

Caremark
P.O. Box 52116
Phoenix, Arizona 85072-2116

IF 004336 IS THE RXBIN # ON YOUR CARD MAIL THE COMPLETED FORM TO:

Caremark
P.O. Box 52136
Phoenix, Arizona 85072-2136

Knowingly filing an insurance claim containing materially false information or concealing any material information with the intent to defraud an insurance company or other person is a fraudulent insurance act, which is a crime and subjects one to criminal and civil penalties.