

Standard Claim Form

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

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

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 853901
Richardson, Texas 75085-3901

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.

Secondary Claim Form

Instructions: This form should be used ONLY if you are submitting claims for secondary prescription coverage.

AFTER you have submitted your claim to the primary carrier:

- Please provide all information requested.
- Contact your pharmacist, if necessary, to provide the detailed drug information requested.
- Pharmacy receipt(s), Explanation of Benefits (EOBs), or denial letter from primary insurer **MUST** be included.

Part 1

**Cardholder/
Plan**

Cardholder ID No. _____ Group No./Group Name _____

Please submit the appropriate ID number for your Secondary coverage.

**Participant
Information**

Cardholder Name _____ Address _____

City _____ State _____ ZIP _____ Phone () _____

Part 1 must be fully completed to ensure proper reimbursement of your drug claim.

Plan Participant Information — Use a separate claim form for each family member

Plan Participant Name _____ Date of Birth _____

Plan Participant: Male Female Relationship: Member Spouse Child Other _____

Are any of these medications being taken for an on-the-job injury? Yes No

Important! A signature is REQUIRED in both A and B.

Fraud Prevention Regulation: Any person who knowingly and with intent to defraud 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 subjects such person to criminal and civil penalties.

A

Signature of Plan Participant _____ Date _____

Release of Information: I certify that I (or my eligible dependent) have received the medicine described herein and that the plan participant named is eligible for prescription benefits. I also certify that the medicine 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 prescription benefit manager; insurance underwriter; sponsor; policyholder; and/or employer. I certify that all the information entered on this form is correct.

B

Signature of Plan Participant _____ Date _____

Part 2

Important! Please remember to include all original pharmacy receipts or primary carrier's EOB.

If you are including your primary carrier's EOB or original pharmacy receipts, **STOP HERE** and submit the claim. It is not necessary to complete Part 3. **NOTE:** Do not staple or tape receipts or attachments to this form. When submitting a claim, the following information must be included.

- Plan Participant Name
- Prescription Number
- Date of Purchase
- Metric Quantity/Days Supply
- Pharmacy Name and Address or NABP Number
- Medicine Strength/or NDC Number
- Medicine Name
- Amount Paid by Plan Participant

Part 3

**Pharmacy
Information**

Pharmacy Name _____ Pharmacy NABP No. _____

Pharmacy Address _____ City _____

State _____ ZIP _____ Phone () _____

Rx 1	Rx #	Date Filled (mm/dd/yy)	<input type="radio"/> New <input type="radio"/> Refill	Compound <input type="radio"/> Yes <input type="radio"/> No	For office use only Prior Approval Code	
	NDC #	Medicine Name and Strength	Metric Quantity	Days Supply	Total Paid by Primary	Amount Paid by Plan Participant

Rx 2	Rx #	Date Filled (mm/dd/yy)	<input type="radio"/> New <input type="radio"/> Refill	Compound <input type="radio"/> Yes <input type="radio"/> No	For office use only Prior Approval Code	
	NDC #	Medicine Name and Strength	Metric Quantity	Days Supply	Total Paid by Primary	Amount Paid by Plan Participant

INSTRUCTIONS

To avoid delays in handling your claim, be sure all information is complete and correct.

A separate claim form must be completed for:

- Each plan participant/family member
- Each pharmacy from which you purchase prescription medicines

Obtain additional claim forms from your company or association and mail directly to the Caremark claims department.

CLAIM SUBMISSION

When submitting a claim, the following information must be included:

- Pharmacy Name and Address or NABP Number
- Prescription Number
- Date of Purchase
- Medicine Name
- Medicine Strength/or NDC Number
- Metric Quantity/Days Supply
- Amount Paid by Plan Participant
- Original Pharmacy Receipts or Your Primary Carrier's EOB

DO NOT include charges for durable medical equipment that required a prescription to obtain. No benefits will be provided under this plan for such items.

DO NOT submit canceled checks, cash register slips or personal itemization. These are not acceptable as substitutes for original receipts.

DO NOT submit statements with "balance" amounts only.

HOW TO COMPLETE THIS FORM

Cardholder / Plan Participant Information

Complete all cardholder and plan participant information in Part 1 on reverse side.

- The cardholder ID number can be found on your ID card.
- The group is the name of your company or association through which you have coverage.
- Sign and date in the spaces provided. Your signature certifies that the information is correct and complete.
- Please make a copy of all documents and receipts before you send them to Caremark. No documents will be returned.

MAIL THIS FORM TO:

Caremark Claims Department / P.O. Box 52136 / Phoenix, AZ 85072-2136

If you have questions, please contact: Caremark toll-free at 1-800-929-2524

Monday–Friday, 7 a.m.–10 p.m. CST / Saturday, 8 a.m.–8 p.m. CST / Sunday, 8 a.m.–4:30 p.m. CST

Closed on national holidays.