**Prescription Reimbursement Claim Form**

**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.
- Reimbursement is not guaranteed and the 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.

<table>
<thead>
<tr>
<th>Identification Number (refer to your prescription card)</th>
<th>Group No./Group Name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name (Last Name)</th>
<th>(First Name)</th>
<th>(MI)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Address 2</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Country</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

**Patient Information—Use a separate claim form for each patient.**

<table>
<thead>
<tr>
<th>Name (Last Name)</th>
<th>(First Name)</th>
<th>(MI)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date of Birth</th>
<th>Male</th>
<th>Female</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Relationship to Primary member</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member</td>
</tr>
<tr>
<td>--------</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

**Other Insurance Information**

**COB (Coordination of Benefits)**

- 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
- If other coverage is Primary, include the explanation of benefits (EOB) with this form.

<table>
<thead>
<tr>
<th>Name of Insurance Company</th>
<th>ID #</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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.

**Signature of Member**

**Date**
Step 2

Submission Requirements:

You MUST include all original 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

If Foreign Claim: Country:__________________________ Currency:__________________________ Amount:__________________________

Pharmacist’s Signature: ___________________________

Comment Section

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 52116
Phoenix, Arizona 85072-2116

**RXBIN # 004336, 012114** mail to:

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

**RXBIN # 610029** mail to:

CVS Caremark
P.O. Box 52196
Phoenix, Arizona 85072-2196

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

CVS Caremark
P.O. Box 52010
Phoenix, Arizona 85072-2010

**RXBIN # 610473, 610475** mail to:

CVS Caremark
P.O. Box 53992
Phoenix, Arizona 85072-3992

Submission Requirements:

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

If Foreign Claim: Country:__________________________ Currency:__________________________ Amount:__________________________

Pharmacist’s Signature: ___________________________

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Phoenix, Arizona 85072-3992

**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.