

**Part 1
Cardholder/
Plan
Participant
Information**

Cardholder ID No. _____ Group No./Group Name _____
 Cardholder Name _____ Address _____
 City _____ State _____ ZIP _____ Phone () _____

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

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

Plan Participant Name _____ Date of Birth _____
 Plan Participant: Male Female Relationship: Plan Participant Spouse Child Other _____

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.
 Name of Insurance Company _____ ID # _____

Please type or print clearly.

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. I have indicated in the COB box above if there is primary prescription drug coverage under another medical 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! If you are including all original receipts with the following information, **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.

Please remember to include all original pharmacy receipts.

- Plan Participant Name
- Pharmacy Name and Address or NABP Number
- Prescription Number
- Date Purchased
- Total Charge
- Medicine Strength/or NDC Number
- Medicine Name
- Metric Quantity, Days Supply

Part 3 Pharmacy Information

• To ensure that the plan participant receives accurate and timely reimbursement for medicine purchases, please assist in completing the information below.
 • If compound prescription, please enter COMPOUND RX in the space for the NDC # and complete the Compound Prescriptions section on the reverse side.

Pharmacy Name _____ Pharmacy NABP No. _____
 Pharmacy Address _____ City _____
 State _____ ZIP _____ Phone () _____

Pharmacist to complete this section **ONLY** if original pharmacy receipts are not included.

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.

Signature of Pharmacist or Representative _____ **Date** _____
 (Required only if original pharmacy receipts are not included)

Rx 1	Rx #	Date Filled (mm/dd/yy)	Prescriber's DEA No.	<input type="radio"/> New <input type="radio"/> Refill <input type="radio"/> DAW <input type="radio"/> Compound	For office use only Prior Approval Code
	NDC #	Medicine Name and Strength		Metric Quantity	Days Supply
				Total Charges	

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
- Total Charge
- Original Pharmacy Receipts
- Pharmacist's Signature (only if original pharmacy receipts are not included)

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.

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