



Prescription Reimbursement Claim Form

Part 1 Cardholder/Patient 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 drug claim.

Patient Information — Use a separate claim form for each family member

Patient Name Date of Birth
Patient: Male Female Relationship: Member Spouse Child Other

Please type or print clearly.

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

I certify that I (or my eligible dependent) have received the medication described herein and that the patient named is eligible for prescription benefits. I also certify that the medication received is not for treatment of an on-the-job injury or covered under another benefit plan.

Signature of Cardholder or Legal Representative Date

Part 2 Important!

Please remember to include all original pharmacy receipts.

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.

- Member Name Metric Quantity/Days Supply Total Charge Drug Strength or NDC Number
Date of Purchase Prescription Number Drug Name Pharmacy Name and Address or NABP Number

Part 3 Pharmacy Information

- To ensure that your patient receives accurate and timely reimbursement for medication purchases, please assist in completing the information below.
If compound prescription, please enter COMPOUND RX in the space designated for the NDC # and complete the Compound Prescriptions section on the reverse side.

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

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

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)

Table with 3 rows (Rx 1, Rx 2, Rx 3) and 7 columns: Rx #, Date Filled, Prescriber's DEA No., New/Refill/DAW/Compound, NDC #, Drug Name and Strength, Metric Quantity, Days Supply, Total Charges, and For office use only Prior Approval Code.

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.

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 patient
- Each pharmacy from which you purchase prescription drugs

CLAIM SUBMISSION

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

- Member Name
- Pharmacy Name and Address or NABP Number
- Prescription Number
- Drug Strength/NDC Number
- Date of Purchase
- Metric Quantity/Days Supply
- Drug Name
- Original Pharmacy Receipts
- Total Charge
- Pharmacist's Signature (only if original pharmacy receipts are not included)

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 / Patient Information Complete all cardholder and patient 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 space 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.

PHARMACY INFORMATION

Pharmacist to complete Part 3 of the form

- Indicate pharmacy name, NABP number, address and phone number.
- Include Rx number(s), drug name(s), strength(s) and date filled.
- Indicate prescriber's DEA number and whether the prescription is new, refill, DAW or compound.
- Include NDC number(s) for the drug(s) dispensed.
- If a compound prescription, enter the NDC number of the most expensive ingredient of the legend drug used.
- Indicate the drug ingredient(s) and quantity.
- Indicate the "metric quantity" expressed in number of tablets, grams or mls for liquids, creams, ointments and injectables.
- Indicate the "days supply" (the number of days the medication will last).
- Indicate the dollar amount paid by the patient.
- Sign and date the form.
- Pharmacist questions? Call Caremark at 1-800-364-6331.

COMPOUND PRESCRIPTIONS			
For pharmacy use only			
NDC #	Drug Ingredient	Quantity	Charge

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 1-877-252-3485.

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.

