CVS CAREMARK | Part D Services

Medicare Part D
Prescription Claim Form

○ This prescription was covered by a manufacturer patient assistance program

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.

STEP 1 Card Holder/Patient Information

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

Card Holder 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.

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

Date of Birth **Male** **Female** **Phone Number**

Relationship to Primary member

Member ☐ Spouse ☐ Child ☐ Other ________

Other Insurance Information

COB (Coordination of Benefits)

Any other prescription insurance? ❍ Yes ❍ No

If yes, select coverage: ❍ Primary ❍ Secondary

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

Name of Insurance Company ID #

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 misleding information pertaining to such claim may be commiting 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.

x ______________________________

Signature of Plan Participant **Date**

STEP 2 Submission Requirements:

You MUST include all original pharmacy 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
- Date of Fill
- Total Charge
- Prescription Number
- Metric Quantity
- Pharmacy Name and Address or Pharmacy NABP Number
- Medicine NDC number
- Days Supply

STEP 3 Mailing Instructions:

PLEASE SUBMIT TO MEDICARE PART D ADDRESS:

CVS Caremark
P.O. Box 52066
Phoenix, Arizona 85072-2066

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 .