**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.

**STEP 1** Card Holder/Patient Information  
This section must be fully completed to ensure proper reimbursement of your claim.

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identification Number (refer to your prescription card)</td>
<td></td>
</tr>
<tr>
<td>Name (Last Name)</td>
<td>(First Name) (MI)</td>
</tr>
<tr>
<td>Address</td>
<td></td>
</tr>
<tr>
<td>City</td>
<td>State Zip</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name (Last Name)</td>
<td>(First Name) (MI)</td>
</tr>
<tr>
<td>Date of Birth Male Female</td>
<td>Phone Number</td>
</tr>
<tr>
<td>Relationship to Primary member</td>
<td></td>
</tr>
<tr>
<td>Member Spouse Child Other</td>
<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>
</table>

**Important! A signature is REQUIRED**

NOTICE

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.

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 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 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
- Medication 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:___________

**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 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

**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.