INSTRUCTIONS:
- This form is to provide direct reimbursement for prescriptions that were purchased outside the United States.
- In order to process your claim(s) in the most timely manner, you must provide all information requested below in English.
- Do not submit this claim form until you receive your Caremark® card (from which you will obtain your identification numbers).
- Receipts must be enclosed.
- Please use a separate claim form for each plan participant.
- Do not staple receipts or attachments to this form.

CARDHOLDER INFORMATION REQUIRED:

Cardholder's Name: ____________________________

First Name: ____________________________

Middle Name: ____________________________

Last Name: ____________________________

RXGRP#: ____________________________

ID #: ____________________________

Plan Participant ID Code: ____________________________

Company Name: ____________________________

I certify that the information is correct and that the plan participant indicated below is eligible for benefits. I have received the medicine described hereon and authorize release of all information contained on this claim form to Caremark, and the plan administrator. I agree that any benefits payable hereunder for prescription drugs are not assignable and that any assignment thereof shall be void. I further represent that there has been no assignment of benefits hereunder.

CARDHOLDER'S SIGNATURE: ____________________________________________________________________________

FOREIGN COUNTRY INFORMATION REQUIRED:

Foreign Country Purchased: ____________________________

Where Drugs Purchased: ____________________________

Plan Participant Information Required:

Currency Type: ____________________________

FOREIGN COUNTRY INFORMATION REQUIRED:

Foreign Country Purchased: ____________________________

Where Drugs Purchased: ____________________________

PRESCRIPTION CLAIM INFORMATION REQUIRED:

1. Rx #: ____________________________

New or Refill (circle one) __________ Date Filled __________ Quantity (ml., #tablets, gm.) __________

Days Supply: __________

Name of Medication ____________________________

NDC#: ____________________________

U.S. Drug Equivalent Name ____________________________

Form of Medication (capsules, cream, etc.) ____________________________

Dosage (250 mg., etc.): ____________________________

Prescription Cost: amount paid in

Foreign currency $ ____________________________

U.S. dollars equivalent ____________________________

Is this a compound? Yes [ ] No [ ]

(See back for definitions)

2. Rx #: ____________________________

New or Refill (circle one) __________ Date Filled __________ Quantity (ml., #tablets, gm.) __________

Days Supply: __________

Name of Medication ____________________________

NDC#: ____________________________

U.S. Drug Equivalent Name ____________________________

Form of Medication (capsules, cream, etc.) ____________________________

Dosage (250 mg., etc.): ____________________________

Prescription Cost: amount paid in

Foreign currency $ ____________________________

U.S. dollars equivalent ____________________________

Is this a compound? Yes [ ] No [ ]

(See back for definitions)

3. Rx #: ____________________________

New or Refill (circle one) __________ Date Filled __________ Quantity (ml., #tablets, gm.) __________

Days Supply: __________

Name of Medication ____________________________

NDC#: ____________________________

U.S. Drug Equivalent Name ____________________________

Form of Medication (capsules, cream, etc.) ____________________________

Dosage (250 mg., etc.): ____________________________

Prescription Cost: amount paid in

Foreign currency $ ____________________________

U.S. dollars equivalent ____________________________

Is this a compound? Yes [ ] No [ ]

(See back for definitions)
Please mail completed claim form to: Caremark
P.O. Box 52116
Phoenix, Arizona 85072-2116

For your protection state law requires the following statement to appear on this form. 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.

Compound - Any medication the pharmacist creates by mixing two or more ingredients, at least one of which is a prescription drug. Please list the ingredients used to create the compound. Contact your pharmacist for this information.