CAREMARK
It all starts with care®

Prescription Drug Claim Form

STANDARD CLAIM

INSTRUCTIONS:

- **In order to process your claim(s) in a timely manner, you must provide all information requested below.**
- We will send any reimbursement and/or communications to the address provided below, except if a confidential address is on file.
- **Please allow up to 21 days from the time you send this form until the time you receive the response to allow for mail time plus claims processing.**
- Please use a separate claim form **for each plan participant.**
- Sign 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.
- **Do not staple or tape receipts or attachments to this form.**

INSURED INFORMATION REQUIRED:

Cardholder's Name: _____ (FIRST MIDDLE LAST)

Street Address: _____

City: _____ State: ____ Zip: _____

RXGRP#: _____

ID #: _____ Plan Participant ID Code: ____

Employer/ Company Name: _____

I certify that the information I have provided 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: _____

PLAN PARTICIPANT INFORMATION

Plan Participant Name: LAST _____ FIRST _____

Date of Birth: ____ ____ ____ Male: ☐ Female: ☐

Plan Participant's Relationship to Cardholder: Self ☐ Spouse ☐ Dependent ☐

Check if Full-Time College Student _____

PHARMACY INFORMATION REQUIRED:

Pharmacy Name: _____ NABP #: ____-____ Phone: ___-___-____

Address: _____

City: _____ State: ____ Zip: _____

PHARMACIST'S SIGNATURE: _____

PRESCRIPTION CLAIM INFORMATION

If you are including all original receipts with the following information, it is not necessary to complete this section.
Exception: When submitting compound receipts, this section must be completed.

1 ℞ #: _____ New or Refill (circle one) Date Filled : MONTH ____ DAY ____ YEAR _____ Quantity (ml., #tablets, gm., etc.) _____

Days Supply: ____ Name of Medication: _____ Prescriber DEA# _____

NDC#: _____ Form of Medication (capsules, cream, etc): _____

Drug Manufacturer: _____ Dosage (250 mg., etc.): _____ Is this a compound? Yes ☐ No ☐

Prescription Cost: $ _____ Tax: $ _____ Total Cost: $ _____

2 ℞ #: _____ New or Refill (circle one) Date Filled : MONTH ____ DAY ____ YEAR _____ Quantity (ml., #tablets, gm., etc.) _____

Days Supply: ____ Name of Medication: _____ Prescriber DEA# _____

NDC#: _____ Form of Medication (capsules, cream, etc): _____

Drug Manufacturer: _____ Dosage (250 mg., etc.): _____ Is this a compound? Yes ☐ No ☐

Prescription Cost: $ _____ Tax: $ _____ Total Cost: $ _____

- 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

- Allergen and Compound Definitions:

  Allergen - A prescription for a substance that causes an allergy, prepared in precise dosage to treat that allergy. Please complete an Allergy Claim Form.

  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.