CAREMARK
It all starts with care®

Prescription Drug Claim Form

FOREIGN CLAIM

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 / MIDDLE / LAST)

Patient Street Address: _____

City: _____ State: ☐☐ Zip: ☐☐☐☐☐

Province Country/Code

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: _____

PLAN PARTICIPANT INFORMATION

Plan Participant Name: LAST ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ FIRST ☐☐☐☐☐☐☐☐☐☐

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

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

Check if Full-Time College Student _____

FOREIGN COUNTRY INFORMATION REQUIRED:

Currency Type: _____

Foreign Country Where Drugs Purchased: _____

PHARMACIST'S SIGNATURE: _____

PRESCRIPTION CLAIM INFORMATION REQUIRED:

1 ℞#: _____ New or Refill (circle one) Date Filled MONTH ☐☐ DAY ☐☐ YEAR ☐☐☐☐ 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 ℞#: _____ New or Refill (circle one) Date Filled MONTH ☐☐ DAY ☐☐ YEAR ☐☐☐☐ 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 ℞#: _____ New or Refill (circle one) Date Filled MONTH ☐☐ DAY ☐☐ YEAR ☐☐☐☐ 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.