CAREMARK®
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14423-0206

Prescription Reimbursement Standard Claim Form

Important!

* **Always 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.**
* **Make a copy of all documents submitted and do not staple or tape receipts or attachments to this form. No documents will be returned.**

1 Primary Member/Patient Information

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

Primary Member 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.

ID No. and Patient Codes will be found on your prescription card.

Name *(Last Name)*

(First Name)

(MI)

Date of Birth

Male

Female

Relationship to Primary member

Member ☐ Spouse ☐ Child ☐ Other _____

Full-Time College Student

Yes ☐ No ☐

Important! A signature is REQUIRED in both A and B.

A

Fraud Prevention Regulation: 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.

x _____

Signature of Plan Participant **Date**

B

Release of Information: 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 authorize release of all information pertaining to this claim to Caremark, the prescription benefit manager; insurance underwriter; sponsor; policyholder; and/or employer. I certify that all the information entered on this form is correct.

x _____

Signature of Plan Participant **Date**

2 Prescription Claim Information

NOTE: If you are including all original receipts with the following information, it is not necessary to complete this section. **Exception: If submitting compound receipts, this section must be completed.**
ONLY INCLUDE charges for prescription medications, original receipts and full itemized statements.

Rx

Rx #	Date Filled (m/d/y)	Prescriber's DEA No.	❍ New ❍ Refill ❍ DAW ❍ Compound	For office use only Prior Approval Code
N D C #		Drug Name and Strength	Metric Quantity	Days Supply	Total Charges

(Over)

3 Pharmacy Information

NOTE: The pharmacist is to complete this section **ONLY** if original pharmacy receipts are not included or if there is a compound prescription.

Pharmacy Name

Pharmacy NABP No.

Pharmacy Phone Number

( ) -

I hereby certify that all the information listed below is correct and represents the actual charge(s) for prescription(s) dispensed. I further understand that all benefit payments as related to the charges listed below will be paid directly to the cardholder.

X

Signature of Pharmacist or Representative **Date**

4 Mail This Completed Form To:

Please refer to your prescription card to ensure this form is mailed to the proper address.

IF 610415 IS THE RXBIN # ON YOUR CARD MAIL THE COMPLETED FORM TO:

Caremark
P.O. Box 52116
Phoenix, Arizona 85072-2116

IF 004336 IS THE RXBIN # ON YOUR CARD MAIL THE COMPLETED FORM TO:

Caremark
P.O. Box 52136
Phoenix, Arizona 85072-2136