### 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.
- Reimbursement is not guaranteed and the contractor will review the claims subject to limitations, exclusions and provisions of the plan.

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

#### Card Holder Information

<table>
<thead>
<tr>
<th>Identification Number (refer to your prescription card)</th>
<th>Group No./Group Name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name (Last Name)</th>
<th>(First Name)</th>
<th>(MI)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address</th>
<th>Address 2</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
<th>Country</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Name (Last Name)</th>
<th>(First Name)</th>
<th>(MI)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date of Birth</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Relationship to Primary member</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member</td>
</tr>
<tr>
<td>--------</td>
</tr>
<tr>
<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>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Important! A signature is REQUIRED

**NOTICE**

Any person who knowingly and with intent to defraud, injure, or deceive any insurance company, submits a claim or application containing any materially false, deceptive, incomplete or misleading information pertaining to such claim may be committing a fraudulent insurance act which is a crime and may subject such person to criminal or civil penalties, including fines, denial of benefits, and/or imprisonment.

I certify that I (or my eligible dependent) have received the medicine described herein. I certify that I have read and understood this form, and that all the information entered on this form is true and correct.

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X  
Signature of Member  
Date
STEP 2 Submission Requirements:

You MUST include all original “pharmacy” receipts in order for your claim to process. “Cash register” receipts will only be accepted for diabetic supplies. The minimum information that must be included on your pharmacy receipts is listed below:

- Patient Name
- Prescription Number
- Medicine NDC number
- Date of Fill
- Metric Quantity
- Total Charge
- Days Supply for your prescription (you may need to ask your pharmacist for this “Days Supply” information)
- Pharmacy Name and Address or Pharmacy NABP Number

If the Prescribing Physician’s NPI (National Provider Identification) number is available, please provide: ______________________

If this claim is from a foreign country, please fill in below:

Country: ______________________  Currency: ______________________  Amount: ______________________

Additional Comments

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, 012114 mail to: USC Network Participants use address directly below:
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

RXBIN # 610473, 610475 mail to:
CVS Caremark
P.O. Box 53992
Phoenix, Arizona 85072-3992

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.

IMPORTANT REMINDER