Worksheet to assist with submitting correct and complete information for Reimbursement.

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

Make sure the following information is included with your claim: Check off the information required to make sure you have it all.

	YES	NO
Patient Name		
Prescription Number		
Date Prescription Filled		
Quantity dispensed		
Days supply		
Total drug cost		
Total member Paid (COB)		
Physician Name or ID		
Pharmacy Name		
Pharmacy Address		

Frequently Asked Questions

MISSING/INVALID INFORMATION	WHAT TO DO?
Days' Supply	Days' supply is the number of days medication is to be taken. This is not the quantity of medication dispensed. See below for quantity. Contact your pharmacy to obtain a new receipt or itemized printout that includes the days' supply in addition to the quantity and directions for use. Once you have the receipt or itemized printout, please resubmit the original claim form and receipt or itemized printout for processing. As an alternative, you may contact your pharmacy for this information and write it on the claim form by hand.
National Drug Code (NDC) Number	The NDC number is a unique 11-digit number assigned to each medication by the U.S. Food and Drug Administration (FDA). Contact your pharmacy to obtain a new receipt or itemized printout that shows the NDC number. Once you have the receipt or itemized printout, please resubmit the original claim form and receipt or itemized printout for processing. As an alternative, you may contact your pharmacy for this information and write it on the claim form by hand.
Original Receipts	Contact your pharmacy to obtain a new receipt or itemized printout. Please make sure the receipt or itemized printout includes the patient's name, prescription number, date filled, dispensing pharmacy name and address, drug name, strength/form, quantity, ingredient cost, gross amount due, days' supply and price. Once you have the receipt or itemized printout, please resubmit the original claim form and receipt or itemized printout for processing. An original cash register receipt is acceptable for diabetic supplies.
NPI, NCPDP or NABP Number	The National Provider Identifier (NPI), National Council for Prescription Drug Programs (NCPDP) or National Boards of Pharmacy (NABP) number is the unique number assigned to each pharmacy. Contact your pharmacy to obtain a new receipt or itemized printout with their valid pharmacy number. Once you have the receipt or itemized printout, please resubmit the original claim form and receipt or itemized printout for processing. You also may contact your pharmacy for this information and write it on the claim form by hand.
Member ID Number	Your member ID number is found on your benefit ID card. Your member ID can't be located or matched in our system. Please provide the member ID number that was valid on the date the pharmacy filled the prescription. Always ensure the member ID is correct on the claim form you submitted. If you have additional questions, call the toll-free number on your benefit ID card.
Prescription Number	Every prescription is assigned a unique prescription number (Rx#) by the pharmacy. Contact your pharmacy to obtain a new receipt or itemized printout that includes the prescription number. Once you have the receipt or itemized printout, please resubmit the original claim form and receipt or itemized printout for processing. As an alternative, you may contact your pharmacy for this information and write it on the claim form by hand.
Date of Fill	Date of fill is the date the pharmacy filled the prescription. Contact your pharmacy to obtain a new receipt or itemized printout that includes the date the prescription was filled. Once you have the receipt or itemized printout, please resubmit the original claim form and receipt or itemized printout for processing.
Quantity	Quantity is the total number of tablets, milliliters or grams of medication that was dispensed. Contact your pharmacy to obtain a new receipt or itemized printout that includes the quantity of your prescription. Once you have the receipt or itemized printout, please resubmit the original claim form and receipt or itemized printout for processing. You also may contact your pharmacy for this information and write it on the claim form by hand.

To avoid or reduce the likelihood of having to submit a paper claim in the future:

- Have your card available at the time you pick up your prescription
- Use a pharmacy that is within the network chosen by your plan sponsor
- Consider medication from your Preferred Drug List
- Refer to the claim form for required information

Please note: Submission of the requested information does not guarantee payment of your claim.

CVS/caremark™ Prescription Reimbursement Claim Form

Important!

- Always allow up to 30 days from 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 other contractor will review the claims subject to limitations, exclusions and provisions of the plan.

STEP 1 Card Holder/Patient Information

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

Card Holder Information

Identification Number (refer to your prescription card)

Group No./Group Name

Name *(Last Name)* *(First Name)* *(MI)*

Address

Address 2

City State Zip

Country

Patient Information–Use a separate claim form for each patient.

Name *(Last Name)* *(First Name)* *(MI)*

Date of Birth Male Female Phone Number

Relationship to Primary member

Member Spouse Child Other_____

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.

Name of Insurance Company_____ ID#_____

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.

x

Signature of Plan Participant **Date**

(Over)

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 need to ask your pharmacist for this "Day Supply" information)
- Pharmacy Name and Address or Pharmacy NABP Number

A valid Prescribing Physician's NPI (National Provider Identification) number is required, please provide: _____

Prescribing physician's information (all fields required):

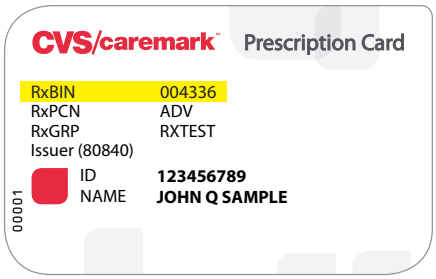
Name: _____

Address: _____

City, state, zip code: _____ **Phone number:** _____

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 or if you are unable to locate your bin # mail to:

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 , 601475 mail to:

CVS/caremark
P.O. Box 53992
Phoenix, Arizona 85072-3992

IMPORTANT REMINDER—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.