CVS caremark® Medicare Part D: Prescription Claim Form

Important! **Your complete claim will be processed within 14 days of receipt of your request. Please allow additional mail time. Keep a copy of all documents submitted for your records. Do not staple or tape receipts or attachments to this form.**

Mail to: **CVS Caremark Medicare Part D Claims Processing P.O. Box 52066• Phoenix, Arizona 85072-2066**

STEP 1 Patient Information

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

Patient Information

Identification Number (refer to your ID card)

Group Number/Group Name

Last Name

First Name

MI

Address

Address 2

City

State

Zip

Date of Birth

Male

Female

Phone Number

Tell us about your prescriptions

WERE ANY PRESCRIPTIONS:		
Covered by a manufacturer patient assistance program?	YES	NO
Covered under another plan (e.g., through an employer)?	YES	NO
If yes, is this other plan Primary?	YES	NO

If Primary, include the explanation of benefits (EOB) with your submission and let us know:

Name of Insurance Company:

_____

ID Number:

_____

WERE ANY PRESCRIPTIONS:		
Approved for a drug tier cost change?	YES	NO
A compound prescription?	YES	NO
From an outpatient hospital observation stay?	YES	NO
From a long-term care pharmacy?	YES	NO

Filled as a result of:

• Illness after travelling outside of the service area?		NO
• No network pharmacy within reasonable driving distance?	YES	
• Medication not in stock at my network pharmacy?	YES	NO
	YES	NO
• Vaccine received at my doctor's office?	YES	NO
• Federal emergency/natural disaster?	YES	NO

Other reasons can be provided in Step 3, page 2.

For **Compound Prescriptions,** please click here or use the attached form, for **Vaccines:** please click here or use the attached form.

Important! A signature is REQUIRED

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**

Please note: If completing this form on behalf of a Medicare Part D member, please submit a completed CMS 1696 form (Appointment of Representative form).

Per CMS regulations, a purported representative may submit a completed a CMS 1696 form or a form that includes the same information as a 1696 form.*(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 • Drug's 11 Digit NDC Number • Date of Fill • Quantity of Drug • Total Paid
- Days Supply for your prescription (you need to ask your pharmacist for this "Day Supply" information)

Pharmacy name and address or pharmacy NABP number:

_____ **Prescribing physician's name:**

_____

Prescribing physician's address:

_____

Prescribing physician's phone number:

_____

Number of prescriptions you are submitting for reimbursement:

_____

Prescription1	Prescription (Rx) Number	Drug Name	
	National Drug Code (NDC) Number	Date Filled (MM/DD/YY)	Total Paid ($ Amount)
	Prescriber's NPI Number	Quantity of Drug	Days Supply
Prescription2	Prescription (Rx) Number	Drug Name	
	National Drug Code (NDC) Number	Date Filled (MM/DD/YY)	Total Paid ($ Amount)
	Prescriber's NPI Number	Quantity of Drug	Days Supply
Prescription3	Prescription (Rx) Number	Drug Name	
	National Drug Code (NDC) Number	Date Filled (MM/DD/YY)	Total Paid ($ Amount)
	Prescriber's NPI Number	Quantity of Drug	Days Supply

Please utilize Additional Prescription Information page if necessary (more than 3 prescriptions).

STEP 3 Provide any Additional Comments or Information Here:

Please remember that completing this form is not a guarantee that you'll be reimbursed.

IMPORTANT REMINDER–To avoid having to submit a paper claim form:

- Always have your prescription 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.

Your privacy is important to us. Our employees are trained regarding the appropriate way to handle your private health information. 5246-1108394A1 062620 H6847_H9485_0569_C