CVS caremark®

Prescription Claim Form

Important!

- It may take up to 30 days for us to complete your claim. **You can submit your claim on Caremark.com for faster review.**
- Keep a copy of all the papers you turn in.
- Do not staple receipts to this form.
- Please note that sending a claim in may not result in payment.
- All sections must be filled out.
- Give us the pharmacy receipt or print out.
- Complete one form for each member.

PacificSource Community Solutions

STEP 1 Card Holder/Member Information

Card Holder Information

Identification Number (refer to your ID card)

Group Number/Group Name

Last Name

First Name MI

Address

Address 2

City

State Zip/Postal Code Country

Member Information

Last Name

First Name MI

Date of Birth Phone Number

Pharmacy Information

Pharmacy Name

Address

City State Zip/Postal Code

REQUIRED: Please check the reason for sending your claim in.

- ☐ Allergy/Allergen Clinic
- ☐ Pharmacy does not accept insurance
- ☐ Compound
- ☐ No insurance coverage at the time
- ☐ Traveling within the U.S.
- ☐ Natural disaster/emergency
- ☐ Insurance card unavailable
- ☐ Appealing Claim
- ☐ Requesting tiering exception
- ☐ Needed approval first
- ☐ Other-provide reason below

_____

- ☐ Medicine purchased outside of the U.S.

PLEASE INDICATE:
Country/Region: _____
Currency used: _____

Other Insurance Information

Coordination of Benefits (COB)

Is this medicine being used because you got hurt at work? ☐ Yes ○ No

Do you have another plan to help pay for this? ☐ Yes ☐ No

If YES, is other plan:

- ○ PRIMARY
- ○ SECONDARY
- ☐ MEDICARE PART D

If other plan is PRIMARY, include the Explanation of Benefits (EOB) with this form.

Name of the Plan: _____

_____

ID#: _____

Pharmacy Information (Cont.)

Phone Number

Is this a nursing home claim? ○ YES ○ NO

NCPDP/NPI

x

Signature of Pharmacist or Representative

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.

(New York Members Only) Any person who knowingly and with intent to defraud, injure, or deceive 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

(California Members Only) For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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 Member (REQUIRED) Date

STEP 2 Prescriber's Information

Name:_____

Address: _____

City, State, Zip/Postal Code:_____

Phone:_____

STEP 3 Mail completed forms with receipts to:

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

To avoid having to submit a claim:

- Have your ID card ready at the time of purchase.
- Use pharmacies covered by your plan.
- If problems occur, call the number your ID card.

Comments:

 106-71097A 040726

Required Claim Information

Prescription 1	Prescription (Rx) Number	Drug Name	
	National Drug Code (NDC) Number	Date Filled (MM/DD/YY)	Total Paid (Cost)
	Prescriber's National Provider ID (NPI) Number	Quantity of Drug	Days Supply
Prescription 2	Rx Number	Drug Name	
	NDC Number	Date Filled (MM/DD/YY)	Total Paid (Cost)
	Prescriber's NPI Number	Quantity of Drug	Days Supply
Prescription 3	Rx Number	Drug Name	
	NDC Number	Date Filled (MM/DD/YY)	Total Paid (Cost)
	Prescriber's NPI Number	Quantity of Drug	Days Supply
Prescription 4	Rx Number	Drug Name	
	NDC Number	Date Filled (MM/DD/YY)	Total Paid (Cost)
	Prescriber's NPI Number	Quantity of Drug	Days Supply
Prescription 5	Rx Number	Drug Name	
	NDC Number	Date Filled (MM/DD/YY)	Total Paid (Cost)
	Prescriber's NPI Number	Quantity of Drug	Days Supply
Prescription 6	Rx Number	Drug Name	
	NDC Number	Date Filled (MM/DD/YY)	Total Paid (Cost)
	Prescriber's NPI Number	Quantity of Drug	Days Supply

Allergy Claim Information

Allergy 1

Date of Purchase (MM/DD/YY)	Number of Vials	Cost of treatment for professional fee.
Number of Treatments ☐Single Dose ○Multidose	Days Supply	Cost to prepare the allergy extract.
Vial Contains ☐Single Antigen ○Multiantigen	Administered By ☐Physician ○Nurse ○Self	Total cost for allergy extract only.
Directions		
Ingredients		

Allergy 2

Date of Purchase (MM/DD/YY)	Number of Vials	Cost of treatment for professional fee.
Number of Treatments ☐Single Dose ○Multidose	Days Supply	Cost to prepare the allergy extract.
Vial Contains ☐Single Antigen ○Multiantigen	Administered By ☐Physician ○Nurse ○Self	Total cost for allergy extract only.
Directions		
Ingredients		

Allergy 3

Date of Purchase (MM/DD/YY)	Number of Vials	Cost of treatment for professional fee.
Number of Treatments ☐Single Dose ○Multidose	Days Supply	Cost to prepare the allergy extract.
Vial Contains ☐Single Antigen ○Multiantigen	Administered By ☐Physician ○Nurse ○Self	Total cost for allergy extract only.
Directions		
Ingredients		

Usted puede recibir este documento en otro idioma, impreso en una letra más grande o de otra manera que sea mejor para usted. También puede solicitar un intérprete. Esta ayuda es sin costo. Llame al 800-431-4135 o por TTY al 711. Aceptamos llamadas del servicio de retransmisión.

You can get this document in another language, large print, or another way that’s best for you. You can also request an interpreter. This help is free. Call 800-431-4135 or TTY: 711. We accept all relay calls.