

Section 1 Cardholder ID No. Group No./Group Name

Plan Participant Information Cardholder Name Address

City State ZIP Phone

Section 1 must be fully completed to ensure proper reimbursement of your drug claim. Please print clearly.

Plan Participant Information—Use a separate claim form for each family member

Plan Participant Name Address

City State ZIP Date of Birth

Important! *Remember to include all original pharmacy receipts.*

Plan Participant: Male Female Relationship: Self Spouse Child Other

Are any of these medications being taken for an on-the-job injury? Yes No

Is the medication covered under any other group insurance? Yes No *If yes, complete the following:*

Name of Insurer: Policy # ID # Phone

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

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.

A Signature of Plan Participant Date

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.

B Signature of Plan Participant Date

Section 2 Pharmacy Information

Have your pharmacist complete the information regarding your prescriptions.

- To ensure that your patient receives accurate and timely reimbursement for medication purchases, please assist in completing the information below.
- If compound prescriptions, please enter 'COMPOUND RX' in the space designated for the NDC# and complete the compound section on the reverse side.

Pharmacy Name Pharmacy NABP No.

Pharmacy Address Phone

City State ZIP

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.

Signature of Pharmacist or Representative Date

Please list the prescriptions below in order of date incurred.

Rx 1	<u>Rx #</u>	<u>Date Filled (m/d/y)</u>	<u>Prescriber's DEA No.</u>	<input type="radio"/> New <input type="radio"/> Refill <input type="radio"/> DAW <input type="radio"/> Compound	For office use only
	<u>NDC #</u>	<u>Drug Name and Strength</u>	<u>Metric Quantity</u>	<u>Days Supply</u>	Prior Approval Code
					<u>Total Charges</u>

Rx 2	<u>Rx #</u>	<u>Date Filled (m/d/y)</u>	<u>Prescriber's DEA No.</u>	<input type="radio"/> New <input type="radio"/> Refill <input type="radio"/> DAW <input type="radio"/> Compound	For office use only
	<u>NDC #</u>	<u>Drug Name and Strength</u>	<u>Metric Quantity</u>	<u>Days Supply</u>	Prior Approval Code
					<u>Total Charges</u>

I N S T R U C T I O N S

To avoid delays in handling your claim, be sure all information is complete and correct.

A separate claim form must be completed for:

- Each plan participant
- Each pharmacy from which you purchase prescription drugs

C L A I M S U B M I S S I O N

When submitting a claim, the following information must be included:

- Date of purchase
- Drug name
- Drug charge
- Pharmacy signature
- Prescription number
- Strength
- Quantity
- Pharmacy name
- *Original pharmacy receipts*

DO NOT include charges for durable medical equipment which required a prescription to obtain. No benefits will be provided under your contract for such items.

DO NOT submit cancelled checks, cash register slips, or personal itemization. These are not acceptable as substitutes for original receipts.

DO NOT submit statements with 'balance' amounts only.

H O W T O C O M P L E T E T H I S F O R M

Cardholder / Plan Participant Information

Complete all cardholder and plan participant information in Section 1 on reverse side.

- The cardholder ID number can be found on your ID card.
- The group is the name of your company or association through which you have coverage.
- Sign and date in the spaces provided. Your signature certifies that the information is correct and complete.
- Complete a separate form for each family member and for each pharmacy.
- Obtain claim forms from your company or association and mail directly to Caremark.
- Please copy all documents and receipts before you send to Caremark as no documents will be returned.

P H A R M A C Y I N F O R M A T I O N

Pharmacy to complete Section 2 of the form

- Include Rx number(s), drug name(s), strength(s), and date filled.
- Include NDC number(s) for the drug(s) dispensed.
- Indicate NABP number, pharmacy address and phone number.
- If compound prescription, enter the NDC number of the most expensive ingredient of the legend drug used.
- Indicate the drug ingredient(s) and quantity.
- Indicate the 'metric quantity' expressed in number of tablets, etc., or grams, or mls for liquids, creams, ointments, and injectables.
- Indicate the 'days supply' (the number of days the medication will last).
- Indicate the dollar amount paid by the patient.
- Sign the form.
- Questions? Call Caremark at 800-929-2524.

C O M P O U N D P R E S C R I P T I O N S			
For pharmacy use only			
NDC	Drug Ingredient	Quantity	Charge

F R A U D P R E V E N T I O N R E G U L A T I O N S / S T A T E - S P E C I F I C

- Arizona** For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.
- California** For your protection, California law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.
- Colorado** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.
- Florida** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.
- New Jersey** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

M A I L T H I S F O R M T O :



Caremark Claims Department / P.O. Box 52136 / Phoenix, Arizona 85072-2136 / www.caremark.com

If you have questions, please contact: Caremark Customer Care: 1-800-929-2524

Monday–Friday 7:00 a.m.–10:00 p.m. CST / Saturday 8:00 a.m.–8:00 p.m. CST / Sunday 8:00 a.m.–4:30 p.m. CST

Closed on national holidays