Prescription Drug Claim Form

CAREMARK®
It all starts with care®

Each Pharmacy Receipt Must Show:

- Participant Name
- Prescription Number
- Pharmacy Name and Address or NABP Number
- Drug Name/Strength or NDC Number
- Metric Quantity/Days Supply
- Dispense as written (DAW), if applicable
- Doctor's Name or DEA Number
- Purchase Date
- Total Charge

The submission of this claim form, for you or any of your dependents, authorizes the release of all information to applicable health care providers and all others involved in filling the prescriptions or processing the claims submitted.

PLEASE COMPLETE SECTIONS 1 THROUGH 4. INCLUDE RECEIPTS BEFORE MAILING.

1 SUBSCRIBER INFORMATION

Primary Participant ID# **(required)**

Company Employee Number **(if appropriate)**

Plan Sponsor

Last Name

First Name | Middle Initial

Mailing Address – Street | Apt.

City | State | Zip Code

2 PARTICIPANT INFORMATION

(Use a separate claim form for each covered member of the family)

Participant's Last Name

Participant's First Name | Middle Initial

Participant's Birthdate (Month Day Year) | Gender: ☐ Male ☐ Female

Number of Receipts submitted: _____

Participant's Relationship to Card Holder:
Self ☐ Spouse ☐ Daughter ☐ Son
Widowed ☐ Full-time Student ☐ Sponsored Dependent/Other

Was this prescription obtained while traveling/residing outside the United States? Check one: ☐ Yes ☐ No

For Coordination of Benefit Claims:
Does this Participant have other pharmacy benefits? ☐ Yes ☐ No
If yes and Caremark is the participant's secondary insurer, please provide an Explanation of Benefits or Statement of Cost from the primary insurer.

Please include all ORIGINAL PRESCRIPTION RECEIPTS with this form

3 Reason for claim submission or special notes: _____

_____

_____

THIS SECTION MUST BE COMPLETED

4 CERTIFICATION

I certify that the information on this claim form is correct. I also certify that the participant for whom this claim is made is eligible for benefits. I understand that the drugs listed are not for treatment of an occupational injury or disease for which the Employer has accepted liability.

THIS FORM MUST BE SIGNED Signature _____ Date _____

PLEASE MAIL THIS FORM AND ALL **ORIGINAL PRESCRIPTION RECEIPTS** TO:

CAREMARK INC.
ATTN: CLAIMS DEPARTMENT
P.O. BOX 686005
SAN ANTONIO, TX 78268-6005