CVS CAREMARK | CAREMARK

Medicare Part D
Prescription Drug Claim Form

❍ This prescription was covered by a manufacturer patient assistance program

PLAN PARTICIPANT INFORMATION

Cardholder ID#

Last Name | First Name | Middle Initial

Mailing Address - Street | Apt. | City | State | Zip Code

PATIENT INFORMATION

(Use a separate claim form for each cardholder.)

Patient's Last Name | Patient's First Name | Middle Initial

Patient's Birth Date (Month Day Year) | Sex: ☐ Male ☐ Female | Number of Receipts submitted: _____

COB (Coordination of Benefits)

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 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 x _____
Signature of Plan Participant | Date

RELEASE OF INFORMATION: I certify that the information on this claim form is correct. I also certify that the patient for whom this claim is made is eligible for benefits and that, if the patient has primary prescription drug coverage under any other group medical plan, I have indicated this in the C.O.B. Box above. I understand that the drugs listed are not for treatment of an occupational injury or diesase for which the Employer has accepted liability.t

B x _____
Signature of Plan Participant | Date

MAIL THIS FORM TO:

MEDICARE PART D PAPER CLAIMS • P.O. Box 52193 • Phoenix, AZ 85072-2193

Each Receipt Must Show:

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

The submission of this claim form authorizes the release of all information to applicable healthcare providers and all others involved in filling the prescriptions or processing the claims submitted.

Please do not use this form for Mail Service Prescriptions