CAREMARK®
It all starts with care®

Prescription Drug Claim Form

STANDARD CLAIM

INSTRUCTIONS:

- **In order to process your claim(s) in a timely manner, you must provide all information requested below.**
- We will send any reimbursement and/or communications to the address provided below, except if a confidential address is on file.
- **Please allow up to 21 days from the time you send this form until the time you receive the response to allow for mail time plus claims processing.**
  Please use a separate claim form **for each plan participant.**
- Sign in the space provided. Your signature certifies that the information is correct and complete.
- Please make a copy of all documents and receipts before you send them to Caremark. No documents will be returned.
- **Do not staple or tape receipts or attachments to this form.**

INSURED INFORMATION REQUIRED:

Cardholder's Name: ______ FIRST ______ MIDDLE ______ LAST

Street Address: ______

City: ______ State: ______ Zip: ______

RXGRP#: ______

ID #: ______ Plan Participant ID Code: ______

Employer/ Company Name: ______

I certify that the information I have provided is correct and that the plan participant indicated below is eligible for benefits. I have received the medicine described hereon and authorize release of all information contained on this claim form to Caremark and the plan administrator. I agree that any benefits payable hereunder for prescription drugs are not assignable and that any assignment thereof shall be void. I further represent that there has been no assignment of benefits hereunder.

CARDHOLDER'S SIGNATURE: ______

PLAN PARTICIPANT INFORMATION

Plan Participant Name: LAST ______ FIRST ______

Date of Birth: ______ Male: ☐ Female: ☐

Plan Participant's Relationship to Cardholder: Self ☐ Spouse ☐ Dependent ☐

Check if Full-Time College Student ______

PHARMACY INFORMATION REQUIRED:

Pharmacy Name: ______ NABP #: ______ Phone: ______

Address: ______

City: ______ State: ______ Zip: ______

PHARMACIST'S SIGNATURE: ______

PRESCRIPTION CLAIM INFORMATION

If you are including all original receipts with the following information, it is not necessary to complete this section.
Exception: When submitting compound receipts, this section must be completed.

1 ℞ #: ______ New or Refill (circle one) Date Filled: MONTH ______ DAY ______ YEAR ______ Quantity (ml., #tablets, gm., etc.) ______

Days Supply: ______ Name of Medication: ______ Prescriber DEA# ______

NDC#: ______ Form of Medication (capsules, cream, etc): ______

Drug Manufacturer: ______ Dosage (250 mg., etc.): ______ Is this a compound? Yes ☐ No ☐

Prescription Cost: $ ______ Tax: $ ______ Total Cost: $ ______

2 ℞ #: ______ New or Refill (circle one) Date Filled: MONTH ______ DAY ______ YEAR ______ Quantity (ml., #tablets, gm., etc.) ______

Days Supply: ______ Name of Medication: ______ Prescriber DEA# ______

NDC#: ______ Form of Medication (capsules, cream, etc): ______

Drug Manufacturer: ______ Dosage (250 mg., etc.): ______ Is this a compound? Yes ☐ No ☐

Prescription Cost: $ ______ Tax: $ ______ Total Cost: $ ______

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4 Mail This Completed Form To:

Please refer to your prescription card to ensure this form is mailed to the proper address.

IF 610415 IS THE RXBIN # ON YOUR CARD MAIL THE COMPLETED FORM TO:

Caremark
P.O. Box 52116
Phoenix, Arizona 85072-2116

IF 004336 IS THE RXBIN # ON YOUR CARD MAIL THE COMPLETED FORM TO:

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