CAREMARK®
It all starts with care®

Prescription Drug Claim Form

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

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#

3 Reason for claim submission or special notes:

4 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. I have indicated in the COB box above if there is primary prescription drug coverage under another medical 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**

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

CAREMARK INC.
ATTN: CLAIMS DEPARTMENT
P.O. BOX 52196
PHOENIX, AZ 85072-2196

WEB CLAIM-CCF01-1106

Clear Form Print