

Please check if applicable:

This prescription was covered by a manufacturer patient assistance program.

Medicare Part D: Prescription Claim Form

Important!





- Your complete claim will be processed within 14 days of receipt of your request. Please allow additional mail time.
- Keep a copy of all documents submitted for your records.
- Do not staple or tape receipts or attachments to this form.

STEP 1	Patient Information			his section must be fully completed to ensure proper reimbursement of your claim.			
Patient In	formation						
Identification Number (refer to your prescription card)				Group No./Group Name			
Name (Last Name))			(First Name) (MI)			
Address							
Address 2							
City				State Zip			
Date of Birth		Male	Female Phone Num	ber			
Other Insurance Information							
PLEASE CHO	OSE FROM BE	LOW:		TYPE OF REQUEST:			
Is the medicine covered under any other 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:				Is this a request for a drug tier change? ☐ YES ☐ NO			
				Were any of these medicines received from a compounding facility? \square YES \square NO			
				Were any of these medicines received from a hospital? ☐ YES ☐ NO			
				Were any of these medicines received from a long term care facility? ☐ YES ☐ NO			
ID#:				Were any of these medicines received while on vacation? ☐ YES ☐ NO			
		· DEALH	DED -				
Importan	t! A signati	re is RFOUL	KFD				

NOTICE

Any person who knowingly and with intent to defraud, injure, or deceive any insurance company, submits a claim or application containing any materially false, deceptive, incomplete or misleading information pertaining to such claim may be committing a fraudulent insurance act which is a crime and may subject such person to criminal or civil penalties, including fines, denial of benefits, and/or imprisonment.

I certify that I (or my eligible dependent) have received the medicine described herein. I certify that I have read and understood this form, and that all the information entered on this form is true and correct.

Signature of Plan Participant

Date

Please note: If completing this form on behalf of a Medicare Part D member, please submit a completed CMS 1696 form (Appointment of Representative form). Per CMS regulations, a purported representative may submit a completed a CMS 1696 form or a form that includes the same information as a 1696 form.

(Over)

STEP 2 **Submission Requirements:** You MUST include all original "pharmacy" receipts in order for your claim to process. "Cash register" receipts will only be accepted for diabetic supplies. The minimum information that must be included on your pharmacy receipts is listed below: • Patient Name Prescription Number • Drug's 11 Digit NDC Number Date of Fill Ouantity of Drug Total Paid • Days Supply for your prescription (you need to ask your pharmacist for this "Day Supply" information) Pharmacy name and address or pharmacy NABP number: Prescribing physician's name: Prescribing physician's address: Prescribing physician's phone number: **Additional comments:** Number of prescriptions you are submitting for reimbursement: **Drug Name** Prescription (Rx) Number Prescription National Drug Code (NDC Number) Date Filled (MM/DD/YY) Total Paid (\$ Amount) Prescriber's National Provider Identifier Number **Quantity of Drug Days Supply** Prescription (Rx) Number **Drug Name** Prescription 2 National Drug Code (NDC Number) Date Filled (MM/DD/YY) Total Paid (\$ Amount) Prescriber's National Provider Identifier Number **Quantity of Drug Days Supply Drug Name** Prescription (Rx) Number Prescription 3 National Drug Code (NDC Number) Date Filled (MM/DD/YY) Total Paid (\$ Amount) Prescriber's National Provider Identifier Number **Quantity of Drug Days Supply** Please utilize Additional Prescription Information page if necessary (more than 3 prescriptions).

STEP 3

Mail completed forms with receipts to:

CVS Caremark Medicare Part D Claims Processing P.O. Box 52066 Phoenix, Arizona 85072-2066

IMPORTANT REMINDER—To avoid having to submit a paper claim form:

- Always have your prescription card available at time of purchase. Always use pharmacies within your network.
- Use medication from your formulary list.

• If problems are encountered at the pharmacy, call the number on the back of your card.

Additional Prescription Information

4 د	Prescription (Rx) Number	Drug Name	
Prescription	National Drug Code (NDC Number)	Date Filled (MM/DD/YY)	Total Paid (\$ Amount)
Pre	Prescriber's National Provider Identifier Number	Quantity of Drug	Days Supply
n 5	Prescription (Rx) Number	Drug Name	
Prescription	National Drug Code (NDC Number)	Date Filled (MM/DD/YY)	Total Paid (\$ Amount)
Pre	Prescriber's National Provider Identifier Number	Quantity of Drug	Days Supply
9 U	Prescription (Rx) Number	Drug Name	
Prescription	National Drug Code (NDC Number)	Date Filled (MM/DD/YY)	Total Paid (\$ Amount)
	Prescriber's National Provider Identifier Number	Quantity of Drug	Days Supply
n 7	Prescription (Rx) Number	Drug Name	
Prescription 7	National Drug Code (NDC Number)	Date Filled (MM/DD/YY)	Total Paid (\$ Amount)
	Prescriber's National Provider Identifier Number		
		Quantity of Drug	Days Supply
8 u	Prescription (Rx) Number	Quantity of Drug Drug Name	Days Supply
scription 8			Total Paid (\$ Amount)
Prescription 8	Prescription (Rx) Number	Drug Name	
	Prescription (Rx) Number National Drug Code (NDC Number)	Drug Name Date Filled (MM/DD/YY)	Total Paid (\$ Amount)
Prescription 9 Prescription 8	Prescription (Rx) Number National Drug Code (NDC Number) Prescriber's National Provider Identifier Number	Drug Name Date Filled (MM/DD/YY) Quantity of Drug	Total Paid (\$ Amount)