CVS CAREMARK

Prescription Reimbursement Claim Form

Important!

* Always allow up to 30 days from the time you send this form until the time you receive the response to allow for mail time plus claims processing.
* **For Aetna Better Health of Pennsylvania members: call Member Services at 866-638-1232 (PA Relay 711) for questions**
* **You can use this form for OTC Covid tests reimbursement**
* **Do not staple or tape receipts or attachments to this form.**

STEP 1 Card Holder/Patient Information

This section must be fully completed to ensure proper reimbursement of your claim.

Card Holder Information

Identification Number *(refer to your prescription card)*

Group No./Group Name

Name *(Last Name)*

(First Name)

(MI)

Address

City

State

Zip

Patient Information–Use a separate claim form for each patient.

Name *(Last Name)*

(First Name)

(MI)

Date of Birth

Male ☐

Female ☐

Phone Number

Relationship to Primary member

Member ☐ Spouse ☐ Child ☐ Other _____

Parent/Guardian name if less than 18 years old (check will be payable to parent/guardian):

_____

Other Insurance Information

COB (Coordination of Benefits)

Are any of these medicines being taken for an on-the-job injury? ○ Yes ○ No

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

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 misleding information pertaining to such claim may be commiting 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.

x _____

Signature of Plan Participant **Date**

(Over)

STEP 2 Submission Requirements:

You MUST include all original receipts in order for your claim to process. Cash register receipts will only be accepted for diabetic supplies and OTC Covid tests. The minimum information required is:

- Patient Name
- Prescription Number
- Medicine NDC number
- Date of Fill
- Metric Quantity
- Days Supply
- Total Charge
- Pharmacy Name and Address or Pharmacy NABP Number

If Foreign Claim: Country:_____ **Currency:**_____ **Amount:**_____

STEP 3 Mail To:

CVS Caremark Pharmacy Management
P.O. Box 52444
Phoenix, Arizona 85072-2444

IMPORTANT REMINDER

To avoid having to submit a paper claim form:

- Always have your 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 .