

# **Medicare Part D Prescription Claim Form**

0	This prescription was covered by a manufacturer patient assistance program
	manufacturer patient assistance program

**Important!** \* Always allow up to 30 days from the time you receive the response to allow for mail time plus claims processing.



- \* Keep a copy of all documents submitted for your records.
- \* Do not staple or tape receipts or attachments to this from.

STEP 1 Card Holder/Patient Information	This section must be fully completed to ensure proper reimbursement of your claim.
ard Holder Information	
entification Number (refer to your prescription card)	Group No./Group Name
me (Last Name)	(First Name) (MI)
dress	
	State Zip
atient Information-Use a separate claim form f	for each patient.
me (Last Name)  te of Birth Male Female  lationship to Primary member	(First Name) (MI) Phone Number
mber Spouse Child Other	
ther Insurance Information	
COB (Coordination of Benefi Are any of these medicines being taken for an on-the-job i Is the medicine covered under any other group insurance? If yes, is other coverage: O Primary O Secondary If other coverage is Primary, include the explanation of ber Name of Insurance Company	injury?
mportant! A signature is REQUIRED	
	NOTICE
any materially false, deceptive, incomplete or misleading inform	r deceive any insurance company, submits a claim or application containing nation pertaining to such claim may be committing a fraudulent insurance civil penalties, including fines, denial of benefits, and/or imprisonment.
I certify that I (or my eligible dependent) have received the med and that all the information entered on this form is true and corr	dicine described herein. I certify that I have read and understood this form, rect.
X Signature of Plan Participant	Date

#### STEP 2

## **Submission Requirements:**

You MUST include all original "pharmacy" receipts in order for your claim to process. "Cash register" receipts will <u>only</u> be accepted for diabetic supplies. The minimum information that must be included on your pharmacy receipts is listed below:

- Patient Name
- Prescription Number
- Medicine NDC number

- Date of Fill
- Metric Quantity
- Total Charge
- Days Supply for your prescription (you need to ask your pharmacist for this "Day Supply" information)
- Pharmacy Name and Address or Pharmacy NABP Number

A valid Prescribing Physician's NPI (National Provider Identification) number is required, please provide:

Additio	onal	Comm	ents

### STEP 3

# **Mailing Instructions:**

Mail to : CVS Caremark P.O. Box 52066 Phoenix, AZ 85072-2066

#### **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.