CVS caremark®

# 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.
- For faster review, you can request reimbursement through your Caremark.com account.
- Do not use a highlighter.
- All sections must be filled out.

## Mail completed forms with receipts to:

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

PacificSource Medicare

## STEP 1 Patient Information

### Patient Information

Medicare Part D Identification Number (refer to your ID card)

Last Name | First Name | MI

Address | Address 2 (if applicable)

City | State | Zip

Date of Birth | Phone Number

### Tell us about your prescriptions

For **Compound Prescriptions**: please click here to open the form in a new tab.
For **Vaccines**: please click here to open the form in a new tab.
For **purported representatives**: please click here to open the form in a new tab.

| WERE ANY PRESCRIPTIONS: | | |
|---|---|---|
| Paid for with a discount card? | ☐ YES | ☐ NO |
| Covered under another plan (e.g., through an employer)? | ☐ YES | ☐ NO |
| If yes, include the Explanation of Benefits (EOB) with your submission and let us know: | | |
| Name of Insurance Company: | | |
| ID Number: | | |

| WERE ANY PRESCRIPTIONS: | | |
|---|---|---|
| Approved for a drug tier cost change? | ☐ YES | ☐ NO |
| A compound prescription? (Include the Compound Claim Form) | ☐ YES | ☐ NO |
| From an outpatient hospital observation stay? | ☐ YES | ☐ NO |
| From a long-term care pharmacy? | ☐ YES | ☐ NO |
| Filled as a result of: | | |
| • Traveling outside of the service area? | ☐ YES | ☐ NO |
| • No network pharmacy within reasonable driving distance? | ☐ YES | ☐ NO |
| • Medication not in stock at my network pharmacy? | ☐ YES | ☐ NO |
| • Vaccine received at my doctor's office? | ☐ YES | ☐ NO |
| • Federal emergency/natural disaster? | ☐ YES | ☐ NO |
| Other reasons can be provided in Step 3, page 2. | | |

### Important! A signature is REQUIRED

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.

X

**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 • Quantity 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:** _____

### Number of prescriptions you are submitting for reimbursement:

| | | | |
|---|---|---|---|
| Prescription 1 | Prescription (Rx) Number | Drug Name | |
| | National Drug Code (NDC) Number | Date Filled (MM/DD/YY) | Total Paid ($ Amount) |
| | Prescriber's National Provider ID (NPI) Number | Quantity of Drug | Days Supply |
| Prescription 2 | Rx Number | Drug Name | |
| | NDC Number | Date Filled (MM/DD/YY) | Total Paid ($ Amount) |
| | Prescriber's NPI Number | Quantity of Drug | Days Supply |
| Prescription 3 | Rx Number | Drug Name | |
| | NDC Number | Date Filled (MM/DD/YY) | Total Paid ($ Amount) |
| | Prescriber's NPI Number | Quantity of Drug | Days Supply |

**Please utilize an additional prescription information page if necessary (more than 3 prescriptions).**

## STEP 3 Provide any additional comments or information Here:

**Please remember that completing this form is not a guarantee that you'll be reimbursed.**

**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.



Clear Form