CAREMARK
It all starts with care®

Prescription Drug Claim Form

SECONDARY COVERAGE

INSTRUCTIONS:

- Please allow up to 21 days from the time you send this form until the time you receive the response to allow for mail time plus claims processing.
- This form should be used if you have primary prescription drug coverage with another insurance carrier.
- After you have submitted your claim to the primary carrier:
  - Provide all information requested below.
  - Rx receipt(s), EOB(s), or denial letter from primary insurer must be enclosed.
  - Please use a separate claim form for each plan participant.
- **Did you use another Prescription Drug Card when purchasing this prescription? Yes____ No____ If no, please attach the explanation of benefits (EOB) or Denial letter from your Primary Insurance Carrier.**
- Sign in the space provided. Your signature certifies that the information is correct and complete.
- We will send any reimbursement and/or communications to the address below, except if a confidential address is on file.
- **Do not staple or tape receipts or attachments to this form.**

CARDHOLDER INFORMATION REQUIRED:

Cardholder's Name: _____ (FIRST MIDDLE LAST)

Street Address: _____

City: _____ State: ____ Zip: _____

RXGRP#: _____

ID #: _____ Plan Participant ID Code: ____

Employer/ Company Name: _____

I certify that the information I have provided is correct and that the plan participant indicated below is eligible for benefits. I have received the medicine described hereon and authorize release of all information contained on this claim form to Caremark, and the plan administrator. I agree that any benefits payable hereunder for prescription drugs are not assignable and that any assignment thereof shall be void. I further represent that there has been no assignment of benefits hereunder.

PLAN PARTICIPANT SIGNATURE: _____ CARDHOLDER SIGNATURE: _____

PLAN PARTICIPANT INFORMATION REQUIRED:

Plan Participant Name: LAST _____ FIRST _____

Date of Birth: ____ ____ ____ Male: ☐ Female: ☐

Plan Participant's Relationship to Cardholder: Self ☐ Spouse ☐ Dependent ☐

Check if Full-Time College Student _____

PHARMACY INFORMATION REQUIRED:

Pharmacy Name: _____ NABP #: ____-____ Phone: ___-___-____

Address: _____

City: _____ State: ____ Zip: _____

PHARMACIST'S SIGNATURE: _____

PRESCRIPTION CLAIM INFORMATION REQUIRED:

1 ℞ #: _____ New or Refill (circle one) Date Filled : MONTH ____ DAY ____ YEAR _____ Quantity (ml., #tablets, gm., etc.) _____

Days Supply: ____ Name of Medication: _____ Prescriber DEA# _____

NDC#: _____ Form of Medication (capsules, cream, etc): _____

Drug Manufacturer: _____ Dosage (250 mg., etc.): _____ Is this a compound? Yes ☐ No ☐

Prescription Cost: $ _____ Tax: $ _____ Total Cost: $ _____

2 ℞ #: _____ New or Refill (circle one) Date Filled : MONTH ____ DAY ____ YEAR _____ Quantity (ml., #tablets, gm., etc.) _____

Days Supply: ____ Name of Medication: _____ Prescriber DEA# _____

NDC#: _____ Form of Medication (capsules, cream, etc): _____

Drug Manufacturer: _____ Dosage (250 mg., etc.): _____ Is this a compound? Yes ☐ No ☐

Prescription Cost: $ _____ Tax: $ _____ Total Cost: $ _____

3 ℞ #: _____ New or Refill (circle one) Date Filled : MONTH ____ DAY ____ YEAR _____ Quantity (ml., #tablets, gm., etc.) _____

Days Supply: ____ Name of Medication: _____ Prescriber DEA# _____

NDC#: _____ Form of Medication (capsules, cream, etc): _____

Drug Manufacturer: _____ Dosage (250 mg., etc.): _____ Is this a compound? Yes ☐ No ☐

Prescription Cost: $ _____ Tax: $ _____ Total Cost: $ _____

Instructions

- Mail claim form, receipt(s), EOB(s), to: Caremark, P.O. Box 52054, Phoenix, AZ 85072-2054

- If another prescription drug card was used to purchase the prescription:
  - Please circle the copay amount on the receipt.

- For Puerto Rico employees:
  - Please use the Puerto Rico location address as your own address on the front of this claim form: P.O. Box 100, Carolina, PR 00986-0100

- For your protection state law requires the following statement to appear on this form. 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.

Compound Definitions

Compound - Any medication the pharmacist creates by mixing two or more ingredients, at least one of which is a prescription drug.