

Allergy Medication Claim Form

ALLERGY CLAIM

INSTRUCTIONS:

- In order to process your claim(s) in the most timely manner, you must provide all of the information requested below.
- Do not submit this claim form until you receive your Caremark® card (from which you will obtain your identification numbers).
- Please use a separate claim form for each plan participant.
- Please include the CPT code (Current Procedural Terminology) for this Allergen and a breakdown of professional service fee and the cost of allergen serum. (This information is available from your physician or allergy clinic).
- If this is for a prescription drug charge, please use the standard claim form.
- Do not staple or tape receipts or attachments to this form.

CARDHOLDER INFORMATION REQUIRED:		
Cardholder's Name: Street	LAST	RXGRP#:
Address:		Plan Participant
		ID #:
City: State:	Zip:	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.		
CARDHOLDER'S SIGNATURE:		
PLAN PARTICIPANT INFORMATION	S/DOT	
Plan Participant Name:	FIRST	Plan Participant's Relationship to Cardholder: Self Spouse Dependent
Date of Birth:	Male: Female:	Check if Full-Time College Student
PHYSICIAN INFORMATION REQUIRED:	Observed	
Please Complete the Following:	Street Address:	
Physician Name:	City:	State: Zip:
DEA#:	DHASICI	AN'S SIGNATURE:
NOTE: Benefits are payable directly to the covered individual. PHYSICIAN'S SIGNATURE: PRESCRIPTION CLAIM INFORMATION REQUIRED:		
1 MONTH DAY YEAR		N 1 001 1111
Date of Treatment:	New or Refill (circle one	
Ingr. Cost of Allergy Serum:	Prof. Service Fee:	CPT code:
Single Dose Vial or Multiple Dose Vial (circle one)		
Ingredients of Allergy Serum:		
NOTE: DAY NEED		
Date of Treatment:	New or Refill (circle one	e) Number of Vials:
Ingr. Cost of Allergy Serum:	Prof. Service Fee:	CPT code:
Single Dose Vial or Multiple Dose Vial (circle one)		
Ingredients of Allergy Serum:		
Date of Treatment:	New or Refill (circle one	e) Number of Vials:
Ingr. Cost of Allergy Serum:	Prof. Service Fee:	CPT code:
Single Dose Vial or Multiple Dose Vial (circle one) Ingredients of Allergy Serum:		

Caremark Card Identification Numbers

■ Please mail completed claim form to: Caremark
P.O. Box 52116
Phoenix, Arizona 85072-2116

■ 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