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STANDARD

CVS CAREMARK

# Prescription Reimbursement Claim Form

**Important!**

- Please 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.
- Keep a copy of all documents submitted for your records.
- Do not staple or tape receipts or attachments to this form.
- Reimbursement is not guaranteed and the contractor will review the claims subject to limitations, exclusions and provisions of the plan.

## STEP 1 Card Holder/Patient Information

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

### Card Holder Information

**Oscar ID Number** *(refer to your insurance card)*

**Group No./Group Name**

**Name** *(Last Name)* *(First Name)* *(MI)*

**Address**

**Address 2**

**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**

**Address**

**Address 2**

**City** **State** **Zip**

### Other Insurance Information

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 misleading 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 Member /Guardian** **Date**

(Over)

**STEP 2** ## Submission Requirements:

**You MUST include all original receipts or a patient history printout from your pharmacy in order for your claim to process. Cash register receipts will only be accepted for diabetic supplies. The minimum information required is:**

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

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

**Comment Section**

**STEP 3** ## Mail to:

CVS Caremark
P.O. Box 52136
Phoenix, Arizona 85072-2136

## As a 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 **855-OSCAR-55**