CVS/caremark™ State Employees' Prescription Drug Plan Claim Form

Important!

- Always allow up to 30 days from the date we receive your request for claims processing plus mail time for reimbursement.
- 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 CVS/caremark 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

Identification Number (refer to your prescription card)

Group No./Group Name: State Employees' Prescription Drug Plan

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

Address

Address 2

City State Zip

Country

Patient Information–Use a separate claim form for each patient.

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

Date of Birth Male Female Phone Number

Relationship to Primary member

Member Spouse Child Other_____

Other Insurance Information

Medicare COB (Coordination of Benefits)

Is the medicine covered by Medicare Part A, B or D? ○ Yes ○ No

If yes, is Medicare coverage: ○ Primary ○ Secondary

If Medicare coverage is Primary, include the explanation of benefits (EOB) with this form.

Name on Medicare card: _____ Medicare 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 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**

(Over)

STEP 2 Submission Requirements:

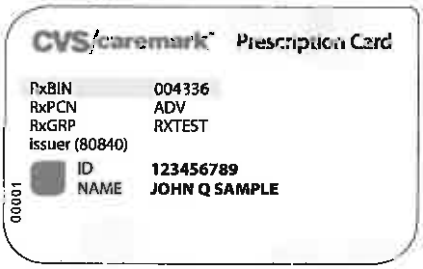
You MUST include all original "pharmacy" receipts for this claim to process. "Cash register" receipts will only be accepted for diabetic supplies. The minimum information that must be included on your pharmacy receipts is listed below:

- Patient Name
- Prescription Number
- 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

If the Prescribing Physician's NPI (National Provider Identification) number is available, please provide: _____

Additional Comments

STEP 3 Mailing Instructions:



CVS/caremark
Paper Claims, MC003
P.O. Box 52010
Phoenix, Arizona 85072-2010

IMPORTANT REMINDER–To Avoid Having To Submit A Paper Claim Form:

- **Always have your ID card available at time of purchase.**
- **Always use pharmacies that are participating in the network.**
- **Use medication from the preferred drug list.**
- **If problems are encountered at the pharmacy, call the number on the back of your ID card.**