Each Pharmacy Receipt Must Show:

Participant Name

It all starts with care

- Prescription Number
- Pharmacy Name and Address or NABP Number
- Drug Name/Strength or NDC Number Doctor's Name or DEA Number
- Metric Quantity/Days Supply • Dispense as written (DAW), if

applicable

• Purchase Date

Date

• Total Charge

The submission of this claim form, for you or any of your dependents, authorizes the release of all information to applicable health care providers and all others involved in filling the prescriptions or processing the claims submitted.

PLEASE COMPLETE SECTIONS 1 THROUGH 4. INCLUDE RECEIPTS BEFORE MAILING.

1SUBSCRIBER INFORMATION	2 PARTICIPANT INFORMATION
Primary Participant ID# (required) Company Employee Number (if appropriate)	(Use a separate claim form for each covered member of the family) Participant's Last Name Participant's First Name Middle Initial
Plan Sponsor	Participant's Birthdate Gender: 🗌 Male 🔲 Female
First Name Middle Initial	Participant's Relationship to Card Holder: Self Spouse Daughter Son Widowed Full-time Student Sponsored Dependent/Other Was this prescription obtained while traveling/residing outside the United States? Check one: Yes No COB (Coordination of Benefits) 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#
Mailing Address – Street Apt.	
City State Zip Code	

² Reason for claim submission or special notes:

IMPORTANT! A SIGNATURE IS REQUIRED IN BOTH A AND B

FRAUD PREVENTION REGULATION: 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.

Α.

Signature of Plan Participant

RELEASE OF INFORMATION: I certify that I (or my eligible dependent) have received the medicine described herein and that the plan participant named is eligible for prescription benefits. I also certify that the medicine received is not for treatment of an on-the-job injury. I have indicated in the COB box above if there is primary prescription drug coverage under another medical plan. I authorize release of all information pertaining to this claim to Caremark, the prescription benefit manager; insurance underwriter; sponsor; policyholder; and/or employer. I certify that all the information entered on this form is correct.

Β.

Signature of Plan Participant		Date
	PLEASE MAIL THIS FORM AND ALL ORI	GINAL PRESCRIPTION RECEIPTS TO:
	CAREMARK I	NC.
	ATTN: CLAIMS	S DEPARTMENT
	P.O. BOX 686	005
	SAN ANTONIO	O, TX 78268-6005 WEB CLAIM-C