**PRESCRIPTION CLAIM FORM**

## Part 1 Cardholder/ Plan Participant Information

**Part 1 must be fully completed to ensure proper reimbursement of your medicine claim.**

ID #

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

Name of Insurance Company

* Yes ❍ No
* Yes ❍ No

Are any of these medicines being taken for an on-the-job injury?

If yes, is other coverage: ❍Primary ❍Secondary

***COB (Coordination of Benefits)***

**Please type or print clearly.**

Cardholder ID No. Group No./Group Name

Cardholder Name Address

City State ZIP Phone

#### Plan Participant Information — Use a separate claim form for each family member

Plan Participant Name Date of Birth

Plan Participant: ❍ Male ❍ Female Relationship: ❍ Plan Participant ❍ Spouse ❍ Child ❍ Other

**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.

#### x

**Signature of Plan Participant Date**

**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 or covered under another benefit 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.

#### x

**Signature of Plan Participant Date**

**Part 2**

**Important!**

**Please remember to include all original pharmacy receipts.**

## Part 3 Pharmacy Information

**Pharmacist to complete this section ONLY if original pharmacy receipts are not included.**

**Rx 1**

**If you are including all original receipts with the following information, STOP HERE** and submit the claim. It is not necessary to complete Part 3. **NOTE:** Do not staple or tape receipts or attachments to this form.

* Plan Participant Name • Pharmacy Name and Address or NABP Number • Prescription Number
* Date Purchased • Total Charge • Medicine Strength/or NDC Number • Medicine Name
* Metric Quantity, Days’ Supply
* To ensure that the plan participant receives accurate and timely reimbursement for medicine purchases, please assist in completing the information below.
* If compound prescription, please enter COMPOUND RX in the space for the NDC # and complete the Compound Prescriptions section on the reverse side.

Pharmacy Name Pharmacy NABP No.

|  |  |  |  |
| --- | --- | --- | --- |
| Pharmacy Address |  | City |  |
| State | ZIP | Phone ( | ) |

I hereby certify that all the information listed below is correct and represents the actual charge(s) for prescription(s) dispensed. I further understand that all benefit payments as related to the charges listed below will be paid directly to the cardholder.

#### x

**Signature of Pharmacist or Representative Date**

(Required only if original pharmacy receipts are not included)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Rx # | Date Filled (mm/dd/yy) | Prescriber’s DEA No. | * New ❍ Refill ❍ DAW ❍ Compound | | | For office use only  Prior Approval Code |
| NDC **#** | | Medicine Name and Strength | | Metric Quantity | Days Supply | Total Charges |