

## Prescription Drug Claim Form

## SECONDARY COVERAGE

### INSTRUCTIONS:

- Please allow up to 21 days from the time you send this form until the time you receive the response to allow for mail time plus claims processing.
- This form should be used if you have primary prescription drug coverage with another insurance carrier.
- After you have submitted your claim to the primary carrier:
  - Provide all information requested below.
  - Rx receipt(s), EOB(s), or denial letter from primary insurer must be enclosed.
  - Please use a separate claim form for each plan participant.
- **Did you use another Prescription Drug Card when purchasing this prescription? Yes \_\_\_ No \_\_\_ If no, please attach the explanation of benefits (EOB) or Denial letter from your Primary Insurance Carrier.**
- Sign in the space provided. Your signature certifies that the information is correct and complete.
- We will send any reimbursement and/or communications to the address below, except if a confidential address is on file.

■ Do not staple or tape receipts or attachments to this form.



### CARDHOLDER INFORMATION REQUIRED:

Cardholder's Name: \_\_\_\_\_  
FIRST MIDDLE LAST  
 Street Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

RXGRP#: \_\_\_\_\_  
 ID #: \_\_\_\_\_ Plan Participant ID Code: \_\_\_\_\_  
 Employer/ 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.

PLAN PARTICIPANT SIGNATURE: \_\_\_\_\_ CARDHOLDER SIGNATURE: \_\_\_\_\_

### PLAN PARTICIPANT INFORMATION REQUIRED:

Plan Participant Name: \_\_\_\_\_  
LAST FIRST  
 Date of Birth: \_\_\_\_\_ Male:  Female:   
 Plan Participant's Relationship to Cardholder:  
 Self  Spouse  Dependent   
 Check if Full-Time College Student

### PHARMACY INFORMATION REQUIRED:

Pharmacy Name: \_\_\_\_\_ NABP #: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Pharmacist's Signature: \_\_\_\_\_

### PRESCRIPTION CLAIM INFORMATION REQUIRED:

**1** R #: \_\_\_\_\_ New or Refill (circle one) Date Filled: MONTH DAY YEAR \_\_\_\_\_ Quantity (ml., #tablets, gm., etc.) \_\_\_\_\_  
 Days Supply: \_\_\_\_\_ Name of Medication: \_\_\_\_\_ Prescriber DEA# \_\_\_\_\_  
 NDC#: \_\_\_\_\_ Form of Medication (capsules, cream, etc.): \_\_\_\_\_  
 Drug Manufacturer: \_\_\_\_\_ Dosage (250 mg., etc.): \_\_\_\_\_ Is this a compound? Yes  No   
 Prescription Cost: \$ \_\_\_\_\_ Tax: \$ \_\_\_\_\_ Total Cost: \$ \_\_\_\_\_

**2** R #: \_\_\_\_\_ New or Refill (circle one) Date Filled: MONTH DAY YEAR \_\_\_\_\_ Quantity (ml., #tablets, gm., etc.) \_\_\_\_\_  
 Days Supply: \_\_\_\_\_ Name of Medication: \_\_\_\_\_ Prescriber DEA# \_\_\_\_\_  
 NDC#: \_\_\_\_\_ Form of Medication (capsules, cream, etc.): \_\_\_\_\_  
 Drug Manufacturer: \_\_\_\_\_ Dosage (250 mg., etc.): \_\_\_\_\_ Is this a compound? Yes  No   
 Prescription Cost: \$ \_\_\_\_\_ Tax: \$ \_\_\_\_\_ Total Cost: \$ \_\_\_\_\_

**3** R #: \_\_\_\_\_ New or Refill (circle one) Date Filled: MONTH DAY YEAR \_\_\_\_\_ Quantity (ml., #tablets, gm., etc.) \_\_\_\_\_  
 Days Supply: \_\_\_\_\_ Name of Medication: \_\_\_\_\_ Prescriber DEA# \_\_\_\_\_  
 NDC#: \_\_\_\_\_ Form of Medication (capsules, cream, etc.): \_\_\_\_\_  
 Drug Manufacturer: \_\_\_\_\_ Dosage (250 mg., etc.): \_\_\_\_\_ Is this a compound? Yes  No   
 Prescription Cost: \$ \_\_\_\_\_ Tax: \$ \_\_\_\_\_ Total Cost: \$ \_\_\_\_\_

## Instructions

- Mail claim form, receipt(s), EOB(s), to: Caremark, P.O. Box 52054, Phoenix, AZ 85072-2054
- If another prescription drug card was used to purchase the prescription:
  - Please circle the copay amount on the receipt.
- For Puerto Rico employees:
  - Please use the Puerto Rico location address as your own address on the front of this claim form:  
P.O. Box 100, Carolina, PR 00986-0100
- 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.

## Compound Definitions

**Compound** - Any medication the pharmacist creates by mixing two or more ingredients, at least one of which is a prescription drug.