

Prescription Reimbursement Claim Form

Important!

- Always allow up to 30 days from the time you receive the response to allow for claims processing and delivery.
- Keep a copy of all documents submitted for your records.
- Do not staple receipts or attachments to this form.
- Reimbursement is not guaranteed and other contractor will review the claims subject to limitations, exclusions and provisions of the plan.

SIEP	cara moraci/ racio	ent Information ompleted to ensure proper reimbursement of your claim.	REQUIKED: Please check appropriate box for submitting a paper claim. Claim will
Card Hol	der Information		be returned if incomplete. (Tape receipts and/or itemized bills on another sheet of paper)
Identification	Number (refer to your ID card)		Reason I am filing this form is:
Group Numbe	r/Group Name		Allergy/Allergen Clinic
			Pharmacy does not accept insurance
Last Name			□ Compound
			No insurance coverage at the time
First Name		MI	Other-provide reason below
Address			
Address 2			☐ Medication purchased outside of the
			United States (Tape receipts and/or itemized
City			bills on another sheet of paper)
			PLEASE INDICATE: Country:
State	ZIP Code	Country	,
			Currency used:
Patient	Information—Use a s	eparate claim form for each patient	Other Insurance Information
Last Name		parate damin control care parate	
			Coordination of Benefits (COB) Are any of these medicines being taken
First Name		MI	for an on-the-job injury? YES NO
Date of Birth		Wale Female Phone Number	Is the medicine covered under any other
			group insurance?
	o Primary Member ouse Child Other		☐ PRIMARY ☐ SECONDARY
Member Sp	ouse Child Other		☐ MEDICARE PART D
			If other coverage is PRIMARY, include
Pharma	cy Information		the Explanation of Benefits (EOB) with this form.
Pharmacy Nan	ne		Name of Insurance Company:
Address			
City		State ZIP Code	ID#:

Pharmacy Informa	tion (Cont.)						
Phone Number		Is this an on-site nur	sing home pharmacy	? YES N	0	NCPDP/NPI Required	
X							
Signature of Pharmacist of	r Representative						
Important! A signa	iture is REQU	IRED					
	or misleading inf	ormation pertaining t	o such claim may b	e committin	g a fraudulen	n or application containing any n t insurance act which is a crime	
l certify that I (or my eligibl information entered on this			e described herein.	I certify that	I have read a	nd understood this form, and th	at all the
X							
Signature of Patient (REQ	UIRED)					Date	
STEP 2 Submis	sion Require	ments					
	nal "pharmacy" r	eceipts in order for y				ots will ONLY be accepted for o	diabetes
Patient Name		ription Number	. ,	• Medicine N			
Date of Fill		ic Quantity		• Total Charg			
 Days Supply for your presc Pharmacy Name and Addi 	ription (you need	to ask your pharmacis		_			
Number of prescriptions ye	ou are submitting	for reimbursement:					
Prescribing physician's nat	ional provider ide	ntification (NPI) num	ber (required):				
Prescribing physician's inf Name:	ormation (all fiel	ds required):					
Address:							
City, State, ZIP Code:							
Phone:							
Additional comments:							
STEP 3 Mail co	mpleted forr	ns with receipts	s to:				
CVS Carer P.O. Box 5 Phoenix.		136					

IMPORTANT REMINDER—To avoid having to submit a paper claim form:

- Always have your ID 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 the number on the back of your ID card.

Prescription Claim Information

n 1	Prescription (Rx) Number	Drug Name		
Prescription	National Drug Code (NDC) Number	Date Filled (MM/DD/YY)	Total Paid (\$ Amount)	
Pres	Prescriber's NPI Number	Quantity of Drug	Days Supply	
Prescription 2	Prescription (Rx) Number	Drug Name		
	National Drug Code (NDC) Number	Date Filled (MM/DD/YY)	Total Paid (\$ Amount)	
	Prescriber's NPI Number	Quantity of Drug	Days Supply	
n 3	Prescription (Rx) Number	Drug Name		
Prescription 3	National Drug Code (NDC) Number	Date Filled (MM/DD/YY)	Total Paid (\$ Amount)	
	Prescriber's NPI Number	Quantity of Drug	Days Supply	
n 4	Prescription (Rx) Number	Drug Name		
scription 4	Prescription (Rx) Number National Drug Code (NDC) Number	Drug Name Date Filled (MM/DD/YY)	Total Paid (\$ Amount)	
Prescription 4		-	Total Paid (\$ Amount) Days Supply	
2	National Drug Code (NDC) Number	Date Filled (MM/DD/YY)		
2	National Drug Code (NDC) Number Prescriber's NPI Number	Date Filled (MM/DD/YY) Quantity of Drug		
	National Drug Code (NDC) Number Prescriber's NPI Number Prescription (Rx) Number	Date Filled (MM/DD/YY) Quantity of Drug Drug Name	Days Supply	
Prescription 5	National Drug Code (NDC) Number Prescriber's NPI Number Prescription (Rx) Number National Drug Code (NDC) Number	Date Filled (MM/DD/YY) Quantity of Drug Drug Name Date Filled (MM/DD/YY)	Days Supply Total Paid (\$ Amount)	
2	National Drug Code (NDC) Number Prescriber's NPI Number Prescription (Rx) Number National Drug Code (NDC) Number Prescriber's NPI Number	Date Filled (MM/DD/YY) Quantity of Drug Drug Name Date Filled (MM/DD/YY) Quantity of Drug	Days Supply Total Paid (\$ Amount)	

Allergy Claim Information

Allergy 1	Date of Purchase (MM/DD/YY)	Number of Vials Days Supply Administered By Physician Nurse Self	Charge per treatment for professional immunotherapy in your office. (\$ Amount) Charge for preparation of allergenic extract in location other than your office. (\$ Amount) Total charge for allergenic extract only. (\$ Amount)		
	Ingredients				
Allergy 2	Date of Purchase (MM/DD/YY) Number of Treatments Single Dose Multidose Vial Contains Single Antigen Multiantigen Directions Ingredients	Number of Vials Days Supply Administered By Physician Nurse Self	Charge per treatment for professional immunotherapy in your office. (\$ Amount) Charge for preparation of allergenic extract in location other than your office. (\$ Amount) Total charge for allergenic extract only. (\$ Amount)		
Allergy 3	Date of Purchase (MM/DD/YY)	Number of Vials Days Supply Administered By Physician Nurse Self	Charge per treatment for professional immunotherapy in your office. (\$ Amount) Charge for preparation of allergenic extract in location other than your office. (\$ Amount) Total charge for allergenic extract only. (\$ Amount)		