CAREMARK®
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PRESCRIPTION CLAIM FORM

14588
Rev. 03/05

Part 1 Cardholder/ Plan Participant Information

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

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 _____

Are any of these medicines being taken for an on-the-job injury? ❍ Yes ❍ No

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 Insurer _____ Policy # _____ ID # _____ Phone ( )

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 Cardholder or Legal Representative **Date**

Part 2 Important!

Please remember to include all original pharmacy receipts.

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

Part 3 Pharmacy Information

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

- 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 designated 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 1

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

Rx 2

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

Rx 3

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

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.

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INSTRUCTIONS

To avoid delays in handling your claim, be sure all information is complete and correct.

A separate claim form must be completed for:

- Each plan participant/family member
- Each pharmacy from which you purchase prescription medicines

Obtain additional claim forms from your company or association and mail directly to the Caremark claims department.

CLAIM SUBMISSION

When submitting a claim, the following information must be included:

- Pharmacy Name and Address or NABP Number
- Prescription Number
- Date of Purchase
- Medicine Name
- Medicine Strength/or NDC Number
- Metric Quantity/Days Supply
- Total Charge
- Original Pharmacy Receipts
- Pharmacist's Signature (only if original pharmacy receipts are not included)

DO NOT include charges for durable medical equipment that required a prescription to obtain. No benefits will be provided under this plan for such items.

DO NOT submit canceled checks, cash register slips or personal itemization. These are not acceptable as substitutes for original receipts.

DO NOT submit statements with "balance" amounts only.

HOW TO COMPLETE THIS FORM

Cardholder / Plan Participant Information

Complete all cardholder and plan participant information in Part 1 on reverse side.

- The cardholder ID number can be found on your ID card.
- The group is the name of your company or association through which you have coverage.
- Sign and date in the space provided. Your signature certifies that the information is correct and complete.
- Please make a copy of all documents and receipts before you send them to Caremark. No documents will be returned.

PHARMACY INFORMATION

Pharmacist to complete Part 3 of the form

- Indicate pharmacy name, NABP number, address and phone number.
- Include Prescription number(s), medicine name(s), strength(s) and date filled.
- Indicate prescriber's DEA number and whether the prescription is new, refill, DAW or compound.
- Include NDC number(s) for the medicine(s) dispensed.
- If a compound prescription, enter the NDC number of the most expensive ingredient of the legend medicine used.
- Indicate the medicine ingredient(s) and quantity.
- Indicate the "metric quantity" expressed in number of tablets, grams or mls for liquids, creams, ointments and injectables.
- Indicate the "days supply" (the number of days the medicine will last).
- Indicate the amount paid by the plan participant.
- Sign and date the form.
- Pharmacist questions? Call Caremark toll-free at 1-800-364-6331.

COMPOUND PRESCRIPTIONS
For pharmacy use only

NDC #	Prescription Ingredient	Quantity	Charge

MAIL THIS FORM TO:

Caremark Claims Department/ P.O. Box 52136 / Phoenix, AZ 85072-2136
If you have questions, please contact: Caremark toll-free at 1-800-929-2524 Monday–Friday, 7 a.m.–10 p.m. CST / Saturday, 8 a.m.–8 p.m. CST / Sunday, 8 a.m.–4:30 p.m. CST Closed on national holidays
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