CVS CAREMARK

Prescription Reimbursement Claim Form

Important!

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

STEP 1 Card Holder/Patient Information

This section must be fully completed to ensure proper reimbursement of your claim.

Card Holder Information

Identification Number (refer to your prescription card)

Group No./Group Name

Name *(Last Name)*

(First Name)

(MI)

Address

Address 2

City

State

Zip

Country

Patient Information-Use a separate claim form for each patient.

Name *(Last Name)*

(First Name)

(MI)

Date of Birth

Male

Female

Phone Number

Relationship to Primary member

Member ☐ Spouse ☐ Child ☐ Other_____

Other Insurance Information

COB (Coordination of Benefits)

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 Insurance Company_____ ID#_____

Important! A signature is REQUIRED

NOTICE

Any person who knowingly and with intent to defraud, injure, or deceive any insurance company, submits a claim or application containing any materially false, deceptive, incomplete or misleading information pertaining to such claim may be committing a fraudulent insurance act which is a crime and may subject such person to criminal or civil penalties, including fines, denial of benefits, and/or imprisonment.

I certify that I (or my eligible dependent) have received the medicine described herein. I certify that I have read and understood this form, and that all the information entered on this form is true and correct.

x _____

Signature of Plan Participant **Date**

(Over)

STEP 2 Submission Requirements:

You MUST include all original "pharmacy" receipts in order for your claim to process. "Cash register" receipts will only be accepted for diabetic supplies. The minimum information that must be included on your pharmacy receipts is listed below:

- Patient Name
- Prescription Number
- Medicine NDC number
- Date of Fill
- Metric Quantity
- Total Charge
- Days Supply for your prescription (you need to ask your pharmacist for this "Day Supply" information)
- Pharmacy Name and Address or Pharmacy NABP Number

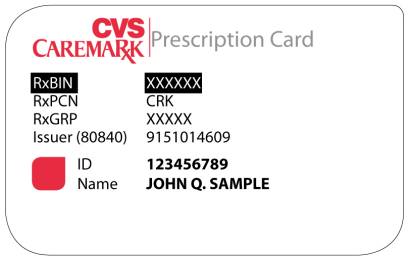
If the Prescribing Physician's NPI (National Provider Identification) number is available, please provide: _____

Each foreign claim submitted must have an exact American equivalent in order to be covered by the plan. If this is from a foreign country, please fill in below:

Country:_____ Currency:_____ Amount:_____

Additional Comments

STEP 3 Mailing Instructions:



The RXBIN # is located on front of your CVS Caremark Prescription ID card. Please see highlighted area to the left for reference. Match your RXBIN # to the addresses below.

RXBIN # 004336 mail to:

CVS Caremark
P.O. Box 52136
Phoenix, Arizona 85072-2136

IMPORTANT REMINDER

By signing this form, I certify that the information submitted with this claim form is accurate. I authorize release of any information relating to this claim to IBM, its contract administrators, or their representatives, as necessary to determine the validity or amount payable on account of this claim. I agree that IBM's contract administrators may release to IBM, or any contract administrator designated by IBM, upon IBM's request, any records and information in its possession in connection with this claim. Information may also be used for other reporting and analysis purposes without identification of the undersigned and the undersigned's family. A photo static copy of this authorization shall be as effective as the original.

I understand that if I file or authorize another to file a claim knowing that:

1. A provider has waived part or all of a fee or other charge listed in the claim; or
2. The claim contains false, deceptive, or misleading information or a deceptive or misleading omission, then I may be subject to dismissal, loss of eligibility under the plans, and/or criminal prosecution.

Reimbursement for Overpayment: I hereby agree to notify IBM promptly if I become aware of any overpayment of this claim; and to reimburse IBM for any amount by which a claim payment is finally determined to have exceeded the applicable benefit.

- Claims will only be paid for dependents who are enrolled in an eligible IBM Plan at the time the expense is incurred. Enrollment questions should be directed to 855-465-0030 (TTY: 800-863-5488).
- Questions regarding the processing of claims should be directed to 855-465-0030.
- Keep a copy of this claim form and supporting bills for your records. This will help you reconcile them to the Explanation of Benefits you will receive. Copies will not be provided.
- Be sure this form is completed in full, signed, and dated. Incomplete or improperly completed claim submissions will be returned for correction and resubmission.

To avoid having to submit a paper claim form:

- Always have your 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 card.

Confidential when completed