Empire Plan Prescription Drug Program

Prescription Reimbursement Claim Form

CVS CAREMARK

Important!

* Always allow up to 30 days for a 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 form.
* Reimbursement is not guaranteed and CVS Caremark will review the claims subject to limitations, exclusions and provisions of the plan.
* Claims must be submitted within 120 days after the end of the calendar year in which the prescription drugs were purchased, or 120 days after another plan processes your claim, whichever is later.

STEP 1 Enrollee Information (see your ID card)

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

Card Holder Information

Identification Number

Group No./Group Name: RX6027

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 Enrollee

Self Spouse/Domestic Partner Child

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 Enrollee Date

(Over)

STEP 2 Submission Requirements:

You MUST include all original "pharmacy" receipts in order for your claim to process. 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: _____

If this is from a foreign country, please fill in below:

Country:_____ **Currency:**_____ **Amount:**_____

Additional Comments

STEP 3 Mailing Instructions:

Please mail your completed claim form and supporting receipt to the address below:

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

IMPORTANT REMINDER

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 Empire Plan at 1-877-7-NYSHIP (1-877-769-7447), select option 4.