



# Medicare Part D: Prescription Claim Form

Mail completed forms with receipts to:  
CVS Caremark Medicare Part D Claims Processing  
P.O. Box 52066  
Phoenix, Arizona 85072-2066

## Important!



- Your complete claim will be processed within 14 days of receipt of your request. Please allow additional mail time.
- Keep a copy of all documents submitted for your records.
- Do not staple or tape receipts or attachments to this form.

### STEP 1 Patient Information

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

#### Patient Information

Identification Number (refer to your prescription card)

Group No./Group Name

Name (Last Name)

(First Name)

(MI)

Address

Address 2

City

State

Zip

Date of Birth

Male

Female

Phone Number

#### Tell us about your prescriptions

##### WERE ANY PRESCRIPTIONS:

Covered by a manufacturer patient assistance program? YES  NO

Covered under another plan (e.g., through an employer)? YES  NO

If yes, is this other plan Primary? YES  NO

If Primary, include the explanation of benefits (EOB) with your submission and let us know:

Name of Insurance Company:

ID Number:

##### WERE ANY PRESCRIPTIONS:

Approved for a drug tier cost change? YES  NO

A compound prescription? YES  NO

From an outpatient hospital observation stay? YES  NO

From a long-term care pharmacy? YES  NO

Filled as a result of:

• Illness after travelling outside of the service area? YES  NO

• No network pharmacy within reasonable driving distance? YES  NO

• Medication not in stock at my network pharmacy? YES  NO

• Vaccine received at my doctor's office? YES  NO

• Federal emergency/natural disaster? YES  NO

Other reasons can be provided in Step 3, page 2.

For **Compound Prescriptions**, please [click here](#) or use the attached form, for **Vaccines**: please [click here](#) or use the attached form.

#### Important! A signature is REQUIRED

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

Please note: If completing this form on behalf of a Medicare Part D member, please submit a completed CMS 1696 form (Appointment of Representative form). Per CMS regulations, a purported representative may submit a completed a CMS 1696 form or a form that includes the same information as a 1696 form. (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
- Drug’s 11 Digit NDC Number
- Date of Fill
- Quantity of Drug
- Total Paid
- Days Supply for your prescription (you need to ask your pharmacist for this “Day Supply” information)

Pharmacy name and address or pharmacy NABP number: \_\_\_\_\_

Prescribing physician’s name: \_\_\_\_\_

Prescribing physician’s address: \_\_\_\_\_

Prescribing physician’s phone number: \_\_\_\_\_

Number of prescriptions you are submitting for reimbursement: \_\_\_\_\_

Prescription 1	Prescription (Rx) Number □ □ □ □ □ □ □ □ □ □ □ □	Drug Name	
	National Drug Code (NDC Number) □ □ □ □ □ □ □ □ □ □ □ □	Date Filled (MM/DD/YY) □ □ □ □ □ □ □ □ □ □	Total Paid (\$ Amount) □ □ □ □ □ □ □ □ □ □
	Prescriber’s National Provider Identifier 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 National Provider Identifier Number □ □ □ □ □ □ □ □ □ □ □ □	Quantity of Drug □ □ □ □	Days Supply □ □ □ □
Prescription 3	Prescription (Rx) Number □ □ □ □ □ □ □ □ □ □ □ □	Drug Name	
	National Drug Code (NDC Number) □ □ □ □ □ □ □ □ □ □ □ □	Date Filled (MM/DD/YY) □ □ □ □ □ □ □ □ □ □	Total Paid (\$ Amount) □ □ □ □ □ □ □ □ □ □
	Prescriber’s National Provider Identifier Number □ □ □ □ □ □ □ □ □ □ □ □	Quantity of Drug □ □ □ □	Days Supply □ □ □ □

Please utilize Additional Prescription Information page if necessary (more than 3 prescriptions).

## STEP 3 Provide any Additional Comments or Information Here:

Please remember that completing this form is not a guarantee that you’ll be reimbursed.

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

- Always have your prescription 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.

Your privacy is important to us. Our employees are trained regarding the appropriate way to handle your private health information.

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