Reset Save to Disk Save As...

SilverScript®

Medicare Part D
Prescription Claim Form

○ This prescription was covered by a manufacturer patient assistance program

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.

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

City State Zip

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)

Save to Disk Save As...

Save to Disk Save As...

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

A valid Prescribing Physician's NPI (National Provider Identification) number is required, please provide:_____

Additional Comments

STEP 3 Mailing Instructions:

Mail to :
CVS Caremark
P.O. Box 52066
Phoenix, AZ 85072-2066

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 number on the back of your card.

Save to Disk Save As...