

3 Pharmacy Information

NOTE: The pharmacist is to complete this section **ONLY** if original pharmacy receipts are not included or if there is a compound prescription.

Pharmacy Name

Pharmacy NABP No.

Pharmacy Phone Number

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

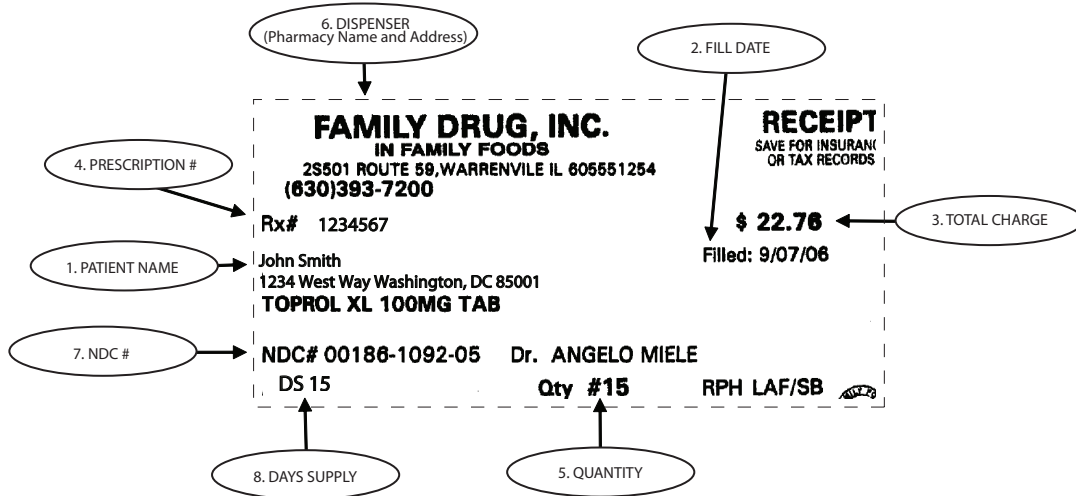
Date

4 Submission Requirements

You **MUST** include all original receipts for your claim to process. You **MUST** include your pharmacy receipt. Cash register receipts will only be accepted for diabetic supplies. The minimum information required is:

- | | | |
|-----------------|--|------------------------|
| 1. Patient Name | 4. Prescription Number | 7. Medicine NDC number |
| 2. Date of Fill | 5. Metric Quantity | 8. Days Supply |
| 3. Total Charge | 6. Pharmacy Name and Address or Pharmacy NABP Number | |

Example Pharmacy Receipt:



5 Mail This Completed Form To:

Please refer to your prescription card to ensure this form is mailed to the proper address.

IF 004336 IS THE RXBIN # ON YOUR CARD MAIL THE COMPLETED FORM TO:

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 number on the back of your card