



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

Medicare Part D: Prescription Claim Form

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.
- For faster review, you can request reimbursement through your Caremark.com account.
- Do not use a highlighter.
- All sections must be filled out.

STEP 1 Patient Information

Patient Information

Medicare Part D Identification Number (refer to your ID card)

Last Name

First Name

MI

Address

Address 2 (if applicable)

City

State

Zip

Date of Birth

Phone Number

Tell us about your prescriptions

For **Compound Prescriptions**: please [click here](#) to open the form in a new tab.

For **Vaccines**: please [click here](#) to open the form in a new tab.

For **purported representatives**: please [click here](#) to open the form in a new tab.

WERE ANY PRESCRIPTIONS:

Paid for with a discount card? ☐ YES ☐ NO

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

If yes, 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?
(Include the Compound Claim Form) ☐ YES ☐ NO

From an outpatient hospital observation stay? ☐ YES ☐ NO

From a long-term care pharmacy? ☐ YES ☐ NO

Filled as a result of:

• Traveling 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.

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 ID (NPI) Number 	Quantity of Drug 	Days Supply
Prescription 2	Rx Number 	Drug Name 	
	NDC Number 	Date Filled (MM/DD/YY) 	Total Paid (\$ Amount)
	Prescriber’s NPI Number 	Quantity of Drug 	Days Supply
Prescription 3	Rx Number 	Drug Name 	
	NDC Number 	Date Filled (MM/DD/YY) 	Total Paid (\$ Amount)
	Prescriber’s NPI Number 	Quantity of Drug 	Days Supply

Please utilize an 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.