

Prescription Drug Claim Form

PARTICIPANT INFORMATION

Social Security Number of Participant

Grid for Social Security Number

Company Employee Number (it applicable)

Grid for Company Employee Number

Employer's Name

Grid for Employer's Name

Last Name

Grid for Last Name

First Name

Initial

Grid for First Name and Initial

Street Address

Grid for Street Address

Street Address

Grid for Street Address

City

State

Zip Code

Grid for City, State, and Zip Code

Each Receipt Must Show:

- Patient Name
• Prescription Number
• Doctor's Name or DEA Number
• Pharmacy Name and Address or NABP Number
• Drug Name/Strength or NDC Number
• Metric Quantity/Days Supply
• Dispense as Written (DAW), if applicable
• Purchase Date
• Total Charge

The submission of this claim form, for you or any of your dependents, authorizes the release of all information to the Plan Sponsor, Administrator or Underwriter.

CERTIFICATION

I certify that the information on this claim form is correct. I also certify that the patient for whom this claim is made is eligible for benefits and that, if the patient has primary prescription drug coverage under any other group medical plan, I have indicated this in the C.O.B. box above. I understand that the drugs listed are not for treatment of an occupational injury or disease for which the Employer has accepted liability.

THIS FORM MUST BE SIGNED

Signature

Line for Signature

Date

Line for Date

PATIENT INFORMATION

(Use a separate claim form for each covered member of the family)

Patient's Last Name

Grid for Patient's Last Name

Patient's First Name

Initial

Grid for Patient's First Name and Initial

Patient's Birthdate

Grid for Patient's Birthdate

Sex:

Female Male

Relationship to Participant:

- Self Spouse Daughter
Widowed Full-time Student Son
Sponsored Dependent

C.O.B. (complete ONLY if plan design provides C.O.B.)

If this claim is for a dependent, the following information must be completed or this claim will be returned:

Is any other family member employed? Yes No

Is this patient eligible for benefits from that employer? Yes No

Please provide primary EOB

Please attach your ORIGINAL prescription receipts and mail to:

Caremark Inc.

P.O. Box 686005

San Antonio, Texas 78268-6005