CVS CAREMARK Part D Services

Medicare Part D
Prescription Claim Form

MVP HEALTH CARE

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 form.**
* **Reimbursement is not guaranteed and other contractor will review the claims subject to limitations, exclusions and provisions of the plan.**

○ This prescription was covered by a manufacturer patient assistance program

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

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 imprisionment.

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)

STEP 2 Submission Requirements:

You MUST include all original "pharmacy" receipts in order for your claim to process. 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:

_____

Prescribing Physician's information (all fields required):
Name: _____
Address: _____
City, state, zip code: _____ **Phone number:** _____

Additional Comments

Please check the appropriate box for the vaccine you have received. If the vaccine you received does not appear below, please fill in the vaccine name, NDC number, quantity, vaccine charge, and administration fee in the blank space provided below.

X	Brand Name	Valid 11-digit NDC#	Quantity	Days' Supply	Date Filled	Vaccine Charge	Vaccine Admin. Fee
☐	ZOSTAVAX	00006496341	1 Vial	1			
☐	ZOSTAVAX	00006496300	1 Vial	1			
☐	ADACEL	49281040010	0.5 mL	1			
☐	ADACEL	49281040015	0.5 mL	1			
☐	BOOSTRIX	58160084252	0.5 mL	1			
☐	BOOSTRIX	58160084211	0.5 mL	1			
☐	TETANUS-DIPHTHERIA TOXOIDS	17478013101	0.5 mL	1			
☐	TETANUS-DIPHTHERIA TOXOIDS	00006413341	0.5 mL	1			
☐	TENIVAC	49281021515	0.5 mL	1			
☐	TENIVAC	49281021510	0.5 mL	1			
☐	ENGERIX-B	58160082152	1 mL	1			
☐	ENGERIX-B	58160082111	1 mL	1			
☐	HAVRIX	58160082652	1 mL	1			
☐	HAVRIX	58160082611	1 mL	1			
☐							

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 own network.
- Use medication from your formulary list.
- If problems are encountered at the pharmacy, call the number on the back of your card.