

Prescription Drug Program Direct Member Reimbursement Form

Please complete this form in its entirety in order to receive reimbursement. We will only accept a FULL PRINTOUT from the pharmacist (including name of medication(s), quantity, day supply, strength, NDC number, date, and pharmacy information), or the ORIGINAL ATTACHED RECEIPT that was on your medication bag at time of purchase. The cash register receipt is NOT

sat	isfactory evidence of purchase.	,		- 5
	is form and FULL PHARMACY PRINTC st be mailed to: CVS Caremark, P.O. Box 5213			CHED RECEIPT(S)
Participant Name:			Member ID:	
Pa	rticipant		Rx Group #:	
Address:			(located on your ID card)	
Pre	escription(s) for: 🗖 Member 🗖 Spouse 🛚	Dependent Child		
	When submitting multiple pre	scriptions, please group	together by family memb	er.
1.			\$	
	Member	Date of Birth	Total Prescriptions	# of Rx's
2.			\$	
	Member	Date of Birth	Total Prescriptions	# of Rx's
3.			\$	
Ο.	Member	Date of Birth	Total Prescriptions	# of Rx's
4.			\$	
→.	Member	Date of Birth	Total Prescriptions	
5.			•	
J.	Manuface		\$	
_	Member	Date of Birth	Total Prescriptions	# OI KX S
6.			<u> </u>	
	Member	Date of Birth	Total Prescriptions	# of Rx's
	Reimbursement wil	be 80% of the Network	Discounted Price	
.	\$50 accumulation of prescriptions per covered individual (not per family) is required. Prescription drug claims for less than \$50.00 will be rejected and returned to the participant.			
÷	Only prescriptions for Federal Legend Drugs (drugs that cannot be dispensed without a prescription) are eligible for benefits.			
•	Some prescriptions require a letter of medical necessity.			
÷	If you used your Prescription Identification Card to purchase your prescriptions, you do not need to complete this form.			
÷	This form may be used for multiple eligible family members. Each patient must be identified.			
	Claims must be submitted within three (3) years of	the dispense date in order	to he eligible for reimbursem	ent

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PRIVACY NOTICE: We will use the address provided above to send your reimbursement, even if contrary to any confidential communications instructions you may have on file with CVS Caremark. If you desire this reimbursement to be sent to a confidential address that has previously been communicated to CVS Caremark, please indicate that address on this form. In any case, the address that you provide here will be used only for mailings related to this Direct Member Reimbursement.

Any person who knowingly and with intent to defraud, injure, or deceive any insurance company, submits a claims 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.