SilverScript®

Medicare Part D: Prescription Claim Form

Please check if applicable:

☐ This prescription was covered by a manufacturer patient assistance program.

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.

STEP 1 Patient Information

This section must be fully completed to ensure proper reimbursement of your claim.

Patient Information

Identification Number (refer to your prescription card)

Group No./Group Name

Name *(Last Name)* *(First Name)* *(MI)*

Address

Address 2

City State Zip

Date of Birth Male Female Phone Number

Other Insurance Information

PLEASE CHOOSE FROM BELOW:

Is the medicine covered under any other 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#: _____

TYPE OF REQUEST:

Is this a request for a drug tier change? ☐ YES ☐ NO

Were any of these medicines received from a compounding facility?
☐ YES ☐ NO

Were any of these medicines received from a hospital?
☐ YES ☐ NO

Were any of these medicines received from a long term care facility?
☐ YES ☐ NO

Were any of these medicines received while on vacation?
☐ YES ☐ NO

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 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: _____

Additional comments: _____

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 Identifier Number ☐☐☐☐☐☐☐☐☐☐	**Quantity of Drug** ☐☐☐☐	**Days Supply** ☐☐☐☐
Prescription 2	**Prescription (Rx) Number**	**Drug Name**	
	National Drug Code (NDC Number) ☐☐☐☐☐-☐☐☐☐-☐☐	**Date Filled (MM/DD/YY)** ☐☐/☐☐/☐☐	**Total Paid ($ Amount)** ☐☐☐☐☐.☐☐
	Prescriber's National Provider Identifier Number ☐☐☐☐☐☐☐☐☐☐	**Quantity of Drug** ☐☐☐☐	**Days Supply** ☐☐☐☐
Prescription 3	**Prescription (Rx) Number**	**Drug Name**	
	National Drug Code (NDC Number) ☐☐☐☐☐-☐☐☐☐-☐☐	**Date Filled (MM/DD/YY)** ☐☐/☐☐/☐☐	**Total Paid ($ Amount)** ☐☐☐☐☐.☐☐
	Prescriber's National Provider Identifier Number ☐☐☐☐☐☐☐☐☐☐	**Quantity of Drug** ☐☐☐☐	**Days Supply** ☐☐☐☐

Please utilize Additional Prescription Information page if necessary (more than 3 prescriptions).

STEP 3 Mail completed forms with receipts to:

CVS Caremark Medicare Part D Claims Processing
P.O. Box 52066
Phoenix, Arizona 85072-2066

IMPORTANT REMINDER–To avoid having to submit a paper claim form:

- Always have your prescription card available at time of purchase.
- Use medication from your formulary list.
- Always use pharmacies within your network.
- If problems are encountered at the pharmacy, call the number on the back of your card.

Your privacy is important to us. Our employees are trained regarding the appropriate way to handle your private health information.

Additional Prescription Information

Prescription 4

Prescription (Rx) Number	Drug Name	
National Drug Code (NDC Number) - -	Date Filled (MM/DD/YY) / /	Total Paid ($ Amount) .
Prescriber's National Provider Identifier Number	Quantity of Drug	Days Supply

Prescription 5

Prescription (Rx) Number	Drug Name	
National Drug Code (NDC Number) - -	Date Filled (MM/DD/YY) / /	Total Paid ($ Amount) .
Prescriber's National Provider Identifier Number	Quantity of Drug	Days Supply

Prescription 6

Prescription (Rx) Number	Drug Name	
National Drug Code (NDC Number) - -	Date Filled (MM/DD/YY) / /	Total Paid ($ Amount) .
Prescriber's National Provider Identifier Number	Quantity of Drug	Days Supply

Prescription 7

Prescription (Rx) Number	Drug Name	
National Drug Code (NDC Number) - -	Date Filled (MM/DD/YY) / /	Total Paid ($ Amount) .
Prescriber's National Provider Identifier Number	Quantity of Drug	Days Supply

Prescription 8

Prescription (Rx) Number	Drug Name	
National Drug Code (NDC Number) - -	Date Filled (MM/DD/YY) / /	Total Paid ($ Amount) .
Prescriber's National Provider Identifier Number	Quantity of Drug	Days Supply

Prescription 9

Prescription (Rx) Number	Drug Name	
National Drug Code (NDC Number) - -	Date Filled (MM/DD/YY) / /	Total Paid ($ Amount) .
Prescriber's National Provider Identifier Number	Quantity of Drug	Days Supply