Prescription Reimbursement Claim Form

CareFirst Community Health Plan Maryland

IMPORTANT!

- **To allow for mailing and processing, we may take up to 30 days from the time you send this form to provide you with a response.**
- **Keep a copy of all documents submitted for your records.**
- **Do not staple or tape receipts or attachments to this form.**
- **If approved, reimbursements will be either the lesser of the cash amount paid or the adjudicated amount through the pharmacy claims processing system minus any applicable copay.**

STEP 1 CARD HOLDER/PATIENT INFORMATION (THIS SECTION MUST BE FULLY COMPLETED TO ENSURE PROPER REIMBURSEMENT OF YOUR CLAIM.)

CARD HOLDER INFORMATION—USE A SEPARATE CLAIM FORM FOR EACH PATIENT.

Identification Number (refer to your prescription card)	Group No./Group Name	
Last Name	First Name	MI
Address		
City	State	ZIP

REQUESTOR INFORMATION

Last Name	First Name	MI
◯ Male ◯ Female	Phone Number	

Relationship to Primary member
◯ Member ◯ Spouse ◯ Child ◯ Other_____

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 #_____

SIGNATURE

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.

Signature of Plan Participant	Date

STEP 2 SUBMISSION REQUIREMENTS:

You MUST include all original receipts in order for your claim to process. Cash register receipts will only be accepted for diabetic supplies. The minimum required information on the pharmacy receipt is:

- Patient Name
- Date of Fill
- Total Charge
- Prescription Number
- Metric Quantity
- Pharmacy Name and Address or Pharmacy NABP Number
- Medicine NDC number
- Days' Supply

Briefly describe the reason(s) for cash payment (below):

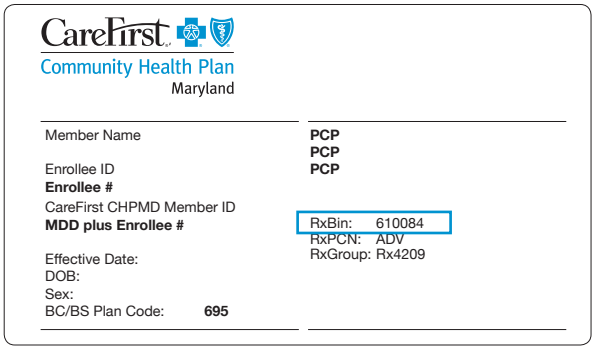
_____

_____

_____

If Foreign Claim: Country:_____Currency:_____Amount:_____

STEP 3 MAILING INSTRUCTIONS:



The RxBin # is located on front of your CareFirst BlueCross BlueShield Community Health Plan Maryland ID card. Please see highlighted area to the left for reference. Match your RxBin # to the addresses below.

RXBIN # 610084 mail to:

CVS Caremark
P.O. Box 52136
Phoenix, Arizona 85072

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