Prescription Drug Claim Form

Use this form to file claims for covered prescriptions which you paid 100 percent, for covered prescriptions you received without showing your ID card and for covered prescriptions you received from a non-participating pharmacy.

BC 11803
CMK 13900
Rev. 07/07

PART ONE: Your benefit information

Date Submitted: _____

Number of Prescriptions Attached: _____

MEMBER NUMBER

MEMBER NAME

MAILING ADDRESS

CITY STATE ZIP

( )
DAY TIME TELEPHONE NUMBER

PATIENT'S NAME (FIRST AND LAST)

/ /
PATIENT'S DATE OF BIRTH (MM/DD/YY)

PATIENT IS: ☐ MALE ☐ FEMALE

☐ MEMBER ☐ SPOUSE ☐ CHILD ☐ STUDENT

Please use a separate form for each family

☐ Check if coverage was provided by another insurance company. If checked, attach Explanation of Benefits (EOB) from the other company.

The undersigned certifies that the prescription receipts attached herein were received by the undersigned for the member noted above, who is eligible for drug benefits, and that such prescriptions were not for an on-the-job injury or covered under any other benefit plan. The undersigned authorizes release of any and all information to the plan administrator, underwriter, sponsor, policy holder, employer and their agents for use in connection with the benefit plan program. Information may also be used for other reporting and analysis purposes without identification of the undersigned or the member noted above. The undersigned further authorizes use of such person's member number for identification purposes and further recognizes that reimbursement will be paid directly to the member and assignment of these benefits to a pharmacy or other party is void.

SIGNATURE OF PATIENT, GUARDIAN OR LEGAL REPRESENTATIVE

PART TWO: Your prescription information – Please see reverse for helpful reminders.

Tape prescriptions or attach computer receipt for each prescription for which you are seeking reimbursement. ***NO STAPLES PLEASE.***

- If any of the prescriptions are compounds, ask your pharmacist to list all the ingredients and quantities on your receipt.
- Ask your pharmacist to submit diabetic and/or ostomy supplies just like prescription drugs. You'll be able to enjoy discounts where applicable and all necessary information for processing will be on your receipt(s).

Prescription Item #1 **TAPE OR AFFIX RECEIPT** *NO STAPLES PLEASE*	**Prescription Item #2** **TAPE OR AFFIX RECEIPT** *NO STAPLES PLEASE*
Prescription Item #3 **TAPE OR AFFIX RECEIPT** *NO STAPLES PLEASE*	**Prescription Item #4** **TAPE OR AFFIX RECEIPT** *NO STAPLES PLEASE*

Remember to always ask your doctor if a generic drug is right for your condition. If so, ask your doctor to allow your pharmacy to fill your prescriptions with generic drugs. Generic drugs contain the same ingredients as their brand-name counterparts. When you use generic drugs, you get the same quality as brand-name drugs – at a lower cost. If there is no generic available, ask your doctor if a preferred drug is available to treat your condition.

HELPFUL REMINDERS

- Always use participating network pharmacies to save more money. To find a network pharmacy, visit the Prescription Drug Information page on the Web site listed on your ID card. You can print a network pharmacy directory or use our pharmacy locator for the most up-to-date information. You can also call Caremark, the independent company your health plan has chosen to administer your pharmacy benefits, toll free at 1-888-963-7290.

- Show your ID card to the pharmacist before you receive your prescriptions.

- Completely fill out Part One of the prescription drug claim form and attach your prescription receipts.

    - Use a separate form for each family member. Don't attach more than one family member's receipts to one claim form.

    - Keep a copy for your records.

- Make sure your prescription receipts show the dates your prescriptions were filled; the name and address of your pharmacy; and the name, strength, quantity, and days supply you received. Your receipts should also show the National Drug Code (NDC) numbers for your prescriptions, your prescription numbers and the amounts you paid for them.

- If you need help or have questions, call the Customer Service number printed on your ID card or in your health benefits booklet or policy. You can also visit the Web site indicated on your ID card for assistance.

- Mail your prescription drug claim form to:

Caremark
Prescription Drug Claim Processing Center
P.O. Box 52059
Phoenix, AZ 85072-2059

SAVE MONEY WITH GENERICS! If you want to lower your prescription drug costs, consider using generic drugs. Generic drugs are widely recognized as quality medications. You can expect the same clinical results as brand-name drugs at a lower cost. The color and shape of a generic drug may be different from its brand-name counterpart, but the active ingredients are the same for both. Generic drugs must meet the same U.S. Food and Drug Administration (FDA) quality standards as brand-name drugs. The next time your doctor writes you a prescription, ask if a generic is available to help you save money. When you take your prescription to the pharmacy, tell your pharmacist you would like a generic drug.

Non-Discrimination Statement and Foreign Language Access

We do not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status in our health plans, when we enroll members or provide benefits.

If you or someone you're assisting is disabled and needs interpretation assistance, help is available at the contact number posted on our website or listed in the materials included with this notice.

Free language interpretation support is available for those who cannot read or speak English by calling one of the appropriate numbers listed below.

If you think we have not provided these services or have discriminated in any way, you can file a grievance online at contact@hcrcompliance.com or by calling our Compliance area at 1-800-832-9686 or the U.S. Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019 or 1-800-537-7697 (TDD).

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de este plan de salud, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-396-0183. (Spanish)

如果您，或是您正在協助的對象，有關於本健康計畫方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 [在此插入數字 1-844-396-0188。 (Chinese)

Nếu quý vị, hoặc là người mà quý vị đang giúp đỡ, có những câu hỏi quan tâm về chương trình sức khỏe này, quý vị sẽ được giúp đở với các thông tin bằng ngôn ngữ của quý vị miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-844-389-4838 (Vietnamese)

이 건보험에 관하여 궁금한 사항 혹은 질문이 있으시면 1-844-396-0187 로 연락주십시오. 귀하의 비용 부담없이 한국어로 도와드립니다. PC 명조 (Korean)

Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa planong pangkalusugang ito, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-844-389-4839 . (Tagalog)

Если у Вас или лица, которому вы помогаете, имеются вопросы по поводу Вашего плана медицинского обслуживания, то Вы имеете право на бесплатное получение помощи и информации на русском языке. Для разговора с переводчиком позвоните по телефону 1-844-389-4840. (Russian)

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص خطة الصحة هذه، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة.للتحدث مع مترجم اتصل ب 1-844-396-0189 (Arabic)

Si ou menm oswa yon moun w ap ede gen kesyon konsènan plan sante sa a, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-844-398-6232. (French/Haitian Creole)

Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de ce plan médical, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-844-396-0190 . (French)

Jeśli Ty lub osoba, której pomagasz, macie pytania odnośnie planu ubezpieczenia zdrowotnego, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-844-396-0186. (Polish)

Se você, ou alguém a quem você está ajudando, tem perguntas sobre este plano de saúde, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-844-396-0182. (Portuguese)

Se tu o qualcuno che stai aiutando avete domande su questo piano sanitario, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-844-396-0184. (Italian)

あなた、またはあなたがお世話をされている方が、この健康保険 についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、1-844-396-0185 までお電話ください。 (Japanese)

Falls Sie oder jemand, dem Sie helfen, Fragen zu diesem Krankenversicherungsplan haben bzw. hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-844-396-0191 an. (German)

اگر شما یا فردی که به او کمک می کنید سؤالاتی در باره‌ی این برنامه‌ی بهداشتی داشته باشید، حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت کنید. برای صحبت کردن با مترجم، لطفاً با شماره‌ی 1-844-398-6233 تماس حاصل نمایید. (Persian-Farsi)
