NEW YORK STATE | The Empire Plan

Empire Plan Medicare Rx
Prescription Reimbursement Claim Form

CVS caremark®

Important!

- Always allow up to 30 days for a 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 CVS Caremark® will review the claims subject to limitations, exclusions and provisions of the plan.
- Claims must be submitted within three (3) years after the date of fill in accordance with CMS guidance.

STEP 1 Enrollee Information (see your ID card) This section must be fully completed to ensure proper reimbursement of your claim.

Card Holder Information

Identification Number

Group No./Group Name RXCVSD

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

Address

Address 2

City **State** **Zip**

Country

Patient Information-Use a separate claim form for each patient.

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

Date of Birth **Male** **Female** **Phone Number**

Relationship to Enrollee

Self ☐ Spouse/Domestic Partner ☐ Child ☐

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 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 Enrollee **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

If the Prescribing Physician's NPI (National Provider Identification) number is available, please provide: _____

If this is from a foreign country, please fill in below:

Country:_____ Currency:_____ Amount:_____

Additional Comments

STEP 3 Mailing Instructions:

Please mail your completed claim form and supporting receipt to the address below:

CVS Caremark
P.O. Box 52066
Phoenix, Arizona 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 network.
- Use medication from your formulary list.
- If problems are encountered at the pharmacy, call the Empire Plan at 1-877-7-NYSHIP (1-877-769-7447), select option 4.