Drug Interchange – Health Care Reimbursement Claim Form

Directions

CVS Caremark reimburses plan participants for copays incurred within 90 days of a drug interchange for health care services ordered by a doctor as a direct result of a drug interchange and for the purpose of assessing continuum of therapy. Claims may be reviewed by an independent third party. Approved claims up to $200 are paid within 30 days of receipt to CVS Caremark of an appropriate claim form certified by the plan participant and the prescriber or doctor. Claims of more than $200 may be reviewed by an independent third party, and if approved, are paid within 60 days of receipt to CVS Caremark.

Step 1: Complete all plan participant, prescription, and claim reimbursement information.

Step 2: Attach your insurance explanation of benefits (EOB), copay receipt or itemized statement from the healthcare provider. The statement must show the health care provider name and address, cardholder name, date and description of services and itemized charges. The statement must clearly display the reimbursable amount paid by the plan participant.

Step 3: Sign and date the form. Be sure to read the certification statement before signing.

Step 4: Have the prescriber or doctor sign the certification statement.

Step 5: Submit the completed claim form with copies of supporting documentation by fax or mail:

Fax Number: 1-866-799-6047

Mailing Address: Health Care Reimbursement Department, NBT-2, 2215 Sanders Road, Northbrook, IL 60062. *If you have any questions, you may call toll-free* 1-866-643-5154.

Plan Participant Information Date:

Plan Participant Name:	**DOB:**	
Mailing Address:		
City:	**State:**	**ZIP:**
Plan Participant ID:	**Plan Participant's Employer:**	
Daytime Phone: ( ) -	**Evening Phone: ( ) -**	
E-mail Address (Optional):		

Prescription Drug Information

Name of Drug Prescribed by Doctor:	**Fill Date of Prescription:**
Name of Drug Received:	**Prescription #:**
Plan Participant Copay Amount:	
Pharmacy Name:	

Claim Reimbursement Information

Date of Medical Treatment:	**Patient Name:**
Patient's Relationship to Cardholder: ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other:**	
Name of Health Care Insurance Provider:	
Name of Doctor or Authorized Agent:	
Description of Services:	
Total Copay Reimbursement Amount Requested: $	

I certify that the information provided on this form is true and correct. These expenses were incurred for drug interchange related health care costs. These expenses have not been reimbursed previously and are not reimbursable from any other source. I agree it is my responsibility to return any duplicate reimbursement from any other source.

(Plan Participant Signature) _____ ***(Date)*** _____

I certify that the patient named in this claim has incurred the described services and costs and they are directly related to the drug interchange listed above.

(Doctor or Authorized Agent Signature) _____ ***(Date)*** _____