



## INSTRUCTIONS

To avoid delays in handling your claim, be sure all information is complete and correct.

A separate claim form must be completed for:

- Each plan participant
- Each pharmacy from which you purchase prescription medicines

Obtain additional claim forms from your company or association and mail directly to the Caremark claims department.

## CLAIM SUBMISSION

When submitting a foreign claim, the following information must be included:

- Prescription Number
- Date of Purchase
- Medicine Name (foreign and U.S. equivalent)
- Metric Quantity/Days Supply
- Medicine Strength/or NDC Number
- Total Charge (foreign currency and U.S. dollar equivalent)
- Original Pharmacy Receipts
- Pharmacist's Signature (only if original pharmacy receipts are not included)

DO NOT include charges for durable medical equipment that required a prescription to obtain. No benefits will be provided under this plan for such items.

DO NOT submit canceled checks, cash register slips or personal itemization. These are not acceptable as substitutes for original receipts.

DO NOT submit statements with "balance" amounts only.

## HOW TO COMPLETE THIS FORM

Cardholder /  
Plan  
Participant  
Information

Complete all cardholder and plan participant information in Parts 1 and 2 on reverse side.

- The cardholder ID number can be found on your ID card.
- The group is the name of your company or association through which you have coverage.
- Sign and date in the spaces provided. Your signature certifies that the information is correct and complete.
- Please make a copy of all documents and receipts before you send them to Caremark. No documents will be returned.

## PRESCRIPTION INFORMATION

Cardholder  
to complete  
Part 3 of  
the form

- Include Prescription number(s), including NDC number(s).
- Indicate whether the prescription is new or a refill.
- Include date filled, medicine strength, quantity and form.
- Indicate the "days supply" (the number of days the medicine will last).
- Indicate both the foreign medicine name and the U.S. equivalent name.
- Indicate the amount paid in both foreign currency and U.S. dollars.

## MAIL THIS FORM TO:

Please refer to your prescription card to ensure this form is mailed to the proper address.

If 610415 is the RXBIN # on your card mail the completed form to:

Caremark  
P.O. Box 52116  
Phoenix, Arizona 85072-2116

If 004336 is the RXBIN # on your card mail the completed form to:

Caremark  
P.O. Box 52136  
Phoenix, Arizona 85072-2136

If you have questions, please contact: Caremark toll-free at 1-800-929-2524

Monday–Friday, 7 a.m.–10 p.m. CST / Saturday, 8 a.m.–8 p.m. CST / Sunday, 8 a.m.–4:30 p.m. CST

Closed on national holidays