Health Plans

Pharmacy Benefits Management

Prescription Reimbursement Request

Use a separate claim for each prescription reimbursement request. Each reimbursement request must be completed in full and can be submitted up to 60 days after the prescription is filled.

Mail completed form to:

CVS/Caremark- Rx Claim
P.O Box 52136
Phoenix, AZ 85072-2136

Reimbursement Request Form

Part 1: Employee Information

Please type or print clearly

Employee Name _____ Employer _____

Address _____ Phone Number _____

City _____ State _____ ZIP _____

Part 2: Prescription Information

Enclose copy of prescription receipt. Receipt information must include the following items:

- Patient name
- Date of purchase
- Metric quantity and days' supply
- Prescription number
- NDC number
- Total charge
- Drug name and strength
- Pharmacy name, address, phone number

Part 3: Patient Information (Please type or print clearly)

Patient Name _____ Date of Birth _____

ID # _____ Group # _____

Address _____ Phone Number _____

City _____ State _____ ZIP _____

Copy of insurance card must be enclosed

Part 4: Claim Request Details (Please explain urgent or emergency condition that required the use of a non-IU Health pharmacy. Attach all additional documentation, if available, to help with review.)

CVS Customer Care
Phone: 844.432.0704

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