Mail the Prescription Drug Claim Form to:

CAREMARK INC.
P.O. BOX 686005
SAN ANTONIO, TEXAS 78268-6005

This form is not for submitting Mail Order Prescription requests.

CARD HOLDER INFORMATION

Social Security Number of Participant

Company Employee Number **(If appropriate)**

Employer's Name
State of Florida

Last Name

First Name Middle Initial

Mailing Address – Street Apt.

City State Zip Code

PARTICIPANT INFORMATION

(Use a separate claim form for each covered member of the family)

Participant's Last Name

Participant's First Name Middle Initial

Participant's Birthdate Sex: ☐ Male ☐ Female

Month Day Year

Number of Receipts submitted: ____

Participant's Relationship to Card Holder:
☐ Self ☐ Spouse ☐ Daughter ☐ Son
☐ Widowed ☐ Full-time Student ☐ Sponsored Dependent
☐ Significant Other

Send your ORIGINAL Prescription Receipts along with this form.

Please do not use this form for Mail Service Prescriptions

Prescription Drug Claim Form

CAREMARK
A Better Way to Health

Each Receipt Must Show:
- Participant Name
- Prescription Number
- Pharmacy Name and Address or NABP Number
- Drug Name/Strength or NDC Number
- Metric Quantity/Days Supply
- Dispense as written (DAW), if applicable
- Doctors Name or DEA Number
- Purchase Date
- Total Charge

The submission of this claim form, for you or any of your dependents, authorizes the release of all information to applicable health care providers and all others involved in filling the prescriptions or processing the claims submitted.

CERTIFICATION

I certify that the information on this claim form is correct. I also certify that the participant for whom this claim is made is eligible for benefits. I understand that the drugs listed are not for treatment of an occupational injury or disease for which the Employer has accepted liability.

THIS FORM MUST BE SIGNED Signature _____ Date _____

May 7, 2002