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FOREIGN CLAIM FORM

Do not staple or tape receipts or attachments to this form.

This form is to provide direct reimbursement for prescriptions that were purchased outside the United States.

- In order to process your claim(s) in the most timely manner, **you must provide all information requested below in English.**
- **Legible prescription (Rx) receipts must be included. Please print drug name on receipt copy.**
- Please use a separate claim form for each plan participant.
- Do not submit this claim form until you receive your Caremark ID card (from which you will obtain your identification numbers).
- Always allow up to 21 days from the time you send this form until the time you receive the response.

Part 1 Cardholder Information

Cardholder ID No. | | | | | | | | | | | | | | |

Group No./Name _____

Cardholder Name

First Middle Last

Address

City State ZIP Phone ( )

Province Country/Code

Important! A signature is REQUIRED in both A and B.

A

Fraud Prevention Regulation: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

x _____

Signature of Plan Participant **Date**

B

Release of Information: I certify that I (or my eligible dependent) have received the medicine described herein and that the plan participant named is eligible for prescription benefits. I also certify that the medicine received is not for treatment of an on-the-job injury or covered under another benefit plan. I authorize release of all information pertaining to this claim to Caremark, the prescription benefit manager; insurance underwriter; sponsor; policyholder; and/or employer. I certify that all the information entered on this form is correct.

x _____

Signature of Plan Participant **Date**

Part 2 Plan Participant Information

Plan Participant Name

Date of Birth: ____ (mm) / ____ (dd) / ____ (yy) ❍ Male ❍ Female

Plan Participant's Relationship to Cardholder:

❍ Self ❍ Spouse ❍ Child ❍ Other _____

Full-Time Student: ❍ Yes ❍ No

Foreign Country Information

Foreign Country Where Medicines Purchased

Foreign Currency Type

Pharmacist's Signature

(Required only if original pharmacy receipts are not included)

Part 3 Prescription Information

Rx 1

Rx #	❍ New ❍ Refill	Date Filled (mm/dd/yy)	Foreign Medicine Name	U.S. Medicine Equivalent Name	For office use only Prior Approval Code

NDC #	Form of Medicine (capsules, cream, etc.)	Quantity (ml., # tablets, gm.)	Dosage (250 mg., etc.)	Days Supply	Total Charges (Foreign Currency)	Total Charges (U.S. Dollar Equivalent)

Rx 2

Rx #	❍ New ❍ Refill	Date Filled (mm/dd/yy)	Foreign Medicine Name	U.S. Medicine Equivalent Name	For office use only Prior Approval Code

NDC #	Form of Medicine (capsules, cream, etc.)	Quantity (ml., # tablets, gm.)	Dosage (250 mg., etc.)	Days Supply	Total Charges (Foreign Currency)	Total Charges (U.S. Dollar Equivalent)

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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