

**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.**
- **Receipts must be included. NOTE: Do not staple or tape receipts or attachments to this form.**
- Do not submit this claim form until you receive your Caremark ID card (from which you will obtain your identification numbers).
- Please use a separate claim form for each family member.

**Part 1 Cardholder Information**

Cardholder ID No. \_\_\_\_\_ Group No./Name \_\_\_\_\_

Cardholder Name \_\_\_\_\_  
First Middle Last

Address \_\_\_\_\_

City State ZIP Phone ( ) \_\_\_\_\_

Province Country/Code \_\_\_\_\_

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 Cardholder or Legal Representative \_\_\_\_\_ Date \_\_\_\_\_

**Part 2 Plan Participant Information**

Plan Participant Name \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  Male  Female  
mm dd yy

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**

<b>Rx 1</b>	Rx # _____	<input type="radio"/> New <input type="radio"/> 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) _____

<b>Rx 2</b>	Rx # _____	<input type="radio"/> New <input type="radio"/> 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) _____

<b>Rx 3</b>	Rx # _____	<input type="radio"/> New <input type="radio"/> 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) _____

**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.

## 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 space 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:

Caremark Claims Department / P.O. Box 52136 / Phoenix, AZ 85072-2136 / [www.caremark.com](http://www.caremark.com)

**If you have questions, please contact:** Caremark 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