

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	
	include the following items: NDC number • Drug name and strength Total charge • 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