Medicare Part D Prescription Drug Reimbursement Form

This form can be sent via mail, email or fax:

Mail: PO Box 52077
Phoenix, Arizona 85072-2077

Email: RxPaperClaim_AnthemMEDD@CVSHealth.com **Fax:** (401)-652-1911

Cardholder Information

Cardholder ID #_____

Cardholder Name (*Last, First MI.*)_____

Date of Birth_____ Street Address_____
_____ City_____ State_____ Zip_____

Other Prescription Drug Coverage

1. Is the patient eligible for primary prescription drug coverage from another insurance company? □ Yes □ No

2. If yes, did the patient submit the claim to this other insurance company? *(If yes, include the Explanation of Benefits from the other insurance company.)* □ Yes □ No

3. Did the other insurance company pay as the primary insurer? □ Yes □ No

Pharmacy Information

Pharmacy Name_____ Pharmacy NPI_____

Address_____ Phone _____
City_____ State_____ Zip_____

Physician Information

Name_____ Physician NPI _____

Physician Address_____

Phone _____ City_____ State_____ Zip _____

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Prescription Detail

Date of Service _____ Rx #_____NDC _____
Drug Name_____ Qty_____ Day Supply ____
Drug Cost _____

1. Is this a compound Rx? □ Yes □ No
2. Was this prescription filled in a foreign country? □ Yes □ No

Compound Prescriptions Only *(if covered)*

11-digit NDC Number	Ingredient Name	Quantity	Ingredient Cost
		Total Paid by Cardholder	

Medicare Part D Vaccine Claim Only *(If covered)*	Admin Fee_____ Total Paid by Cardholder _____

Requestor's Signature

Signature_____ Date _____

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