Allergenic Extract Claim Form

CVS CAREMARK

MEMBER—PLEASE COMPLETE THIS SECTION

Member/Subscriber Information *See your prescription drug ID card.*

Group No. RXCVSD

Member ID

Member Name (First, Last)

Street Address

City State Zip

Important: All sections of this form must be completed, including the *number of vials*, or the claim will be rejected and returned to the member.

Patient Information

Patient Name (First, Last)

Patient Date of Birth (Month/Day/Year)

Gender
O Female
O Male

Relationship to Plan Member
O 1 Self
O 2 Spouse
O 3 Eligible Dependent

Important: I certify that the information entered on this form is correct; that the claimant is eligible for the benefit and has received the medication described. I agree the benefit payable for prescription drugs is not assignable and that any assignment or attempted assignment shall be void. I further authorize the release of all information on this form to CVS Caremark and the health plan. I have discussed this claim with my doctor, and it covers the allergenic extract only and excludes any administration or office charges.

X
Signature of Member

Date

PHARMACIST/PHYSICIAN—PLEASE COMPLETE THIS SECTION

Pharmacist/Physician Information

Name of Pharmacist/Physician

Street Address

City

State Zip

Telephone (include area code)

Date of Purchase / /

No. of Vials:

No. of Treatments: ____
☐ Single Dose
☐ Multidose

Days' Supply

Vial Contains
☐ Single Antigen
☐ Multiantigen

Directions

Administered by
☐ Physician
☐ Nurse
☐ Self

Ingredients

Charge per treatment for professional immunotherapy in your office.
$____

Charge for preparation of allergenic extract in location other than your office.
$____

Total charge for allergenic extract only.
$____

I CERTIFY THE CHARGES ARE FOR THE ALLERGENIC EXTRACT ONLY, AND THE INFORMATION ON THE FORM IS CORRECT.

X
Pharmacist/Physician Signature

Date

NABP Number

INSTRUCTIONS FOR COMPLETION OF ALLERGENIC EXTRACT CLAIM FORM

1. All of the information requested must be legibly entered on the claim form. This information is required to determine whether the medication is covered under your plan.
2. This claim form is for allergenic extract reimbursement only. Physicians' professional fees are not covered under your prescription plan.
3. Provide date of purchase.
4. Attach the itemized bill from your physician or pharmacist to the form.
5. Submit the completed form to:

CVS Caremark
P.O. Box 52136
Phoenix, AZ 85072-2136