# Nonparticipating Provider Reimbursement Request Form

If you saw a doctor or specialist (or other provider) who doesn't participate with HMSA or if you saw a provider while away from home and you paid for services up front, you can submit a Medical Receipts Form online using My Account. You can also submit your claim as follows:

1. Complete both sides of this form.
2. Make copies of your receipts to send with your claim.
3. Mail the completed form and copies of your receipts to:

   HMSA — Claims Administration
   P.O. Box 860
   Honolulu, HI 96808-0860

**About the person receiving care**

Name: _____

Date of birth: _____ Contact phone no.: _____

Email address: _____

Mailing address: _____

**About your insurance**

Your HMSA subscriber number: _____

Any additional health plan you may have: _____

## Please turn the page over and tell us about the services you received. Here's a sample of a completed form.

**SAMPLE TEMPLATE**

| | | | |
|---|---|---|---|
| **Please describe the service** | Blood test to check glucose | | |
| **Cost of service** | $150 | | |
| **Country where the service was provided** | Australia | | |
| **Date(s) of the injury or the start of the illness** | 10/1/18 | **Date(s) of services** | 10/1/18 |
| **What you sought treatment for (be specific)** | Diabetes | | |
| **Where it was performed** | ■ Office ☐ Clinic ☐ Hospital ☐ Other: _____ | | |
| **Name of the provider** | Dr. James Smith | | |
| **Provider's address** | 1234 First Street, Sydney New South Wales, Australia | | |
| **Provider's phone number** | +612345678 | | |
| **Type of currency used to pay the bill** | Australian dollars | | |
| **Name of provider who referred you** | Dr. Jeffrey Williams | | |

6000-1053702 8:24 BY

## Please tell us about the services you received.

| | | | |
|---|---|---|---|
| Please describe the service | | | |
| Cost of service | | | |
| Country where the service was provided | | | |
| Date(s) of the injury or the start of the illness | | Date(s) of services | |
| What you sought treatment for (be specific) | | | |
| Where it was performed | ☒ Office ☐ Clinic ☐ Hospital ☐ Other: _____ | | |
| Name of the provider | | | |
| Provider's address | | | |
| Provider's phone number | | | |
| Type of currency used to pay the bill | | | |
| Name of provider who referred you | | | |

| | | | |
|---|---|---|---|
| Please describe the service | | | |
| Cost of service | | | |
| Country where the service was provided | | | |
| Date(s) of the injury or the start of the illness | | Date(s) of services | |
| What you sought treatment for (be specific) | | | |
| Where it was performed | ☒ Office ☐ Clinic ☐ Hospital ☐ Other: _____ | | |
| Name of the provider | | | |
| Provider's address | | | |
| Provider's phone number | | | |
| Type of currency used to pay the bill | | | |
| Name of provider who referred you | | | |

CVS CAREMARK

14423-1010
STANDARD

# Prescription Reimbursement Claim Form

## Important!

- Always allow up to 30 days from the time you send this form until the time you receive the response to allow for mail time plus claims processing.
- Keep a copy of all documents submitted for your records.
- Do not staple or tape receipts or attachments to this form.
- Reimbursement is not guaranteed and the contractor will review the claims subject to limitations, exclusions and provisions of the plan.

## STEP 1 Card Holder/Patient Information

This section must be fully completed to ensure proper reimbursement of your claim.

### Card Holder Information

Identification Number *(refer to your prescription card)*

Group No./Group Name

Name *(Last Name)*

*(First Name)*

*(MI)*

Address

Address 2

City

State

Zip

Country

### Patient Information—Use a separate claim form for each patient.

Name *(Last Name)*

*(First Name)*

*(MI)*

Date of Birth

Male

Female

Phone Number

Relationship to Primary member

Member ☐ Spouse ☐ Child ☐ Other _____

### Other Insurance Information

#### COB (Coordination of Benefits)

Are any of these medicines being taken for an on-the-job injury? ❍ Yes ❍ No

Is the medicine covered under any other group insurance? ❍ Yes ❍ No

If yes, is other coverage: ❍ Primary ❍ Secondary

If other coverage is Primary, include the explanation of benefits (EOB) with this form.

Name of Insurance Company_____ ID #_____

### Important! A signature is REQUIRED

**NOTICE**

Any person who knowingly and with intent to defraud, injure, or deceive any insurance company, submits a claim or application containing any materially false, deceptive, incomplete or misleading information pertaining to such claim may be committing a fraudulent insurance act which is a crime and may subject such person to criminal or civil penalties, including fines, denial of benefits, and/or imprisonment.

I certify that I (or my eligible dependent) have received the medicine described herein. I certify that I have read and understood this form, and that all the information entered on this form is true and correct.

x _____

**Signature of Member** **Date**

(Over)

## STEP 2 Submission Requirements:

**You MUST include all original "pharmacy" receipts in order for your claim to process. "Cash register" receipts will be accepted only for diabetic supplies. The minimum information that must be included on your pharmacy receipts is listed below:**

- Patient Name
- Prescription Number
- Medicine NDC number
- Date of Fill
- Metric Quantity
- Total Charge
- Days Supply for your prescription (you may need to ask your pharmacist for this "Days Supply" information)
- Pharmacy Name and Address or Pharmacy NABP Number

**If the Prescribing Physician's NPI (National Provider Identification) number is available, please provide:**

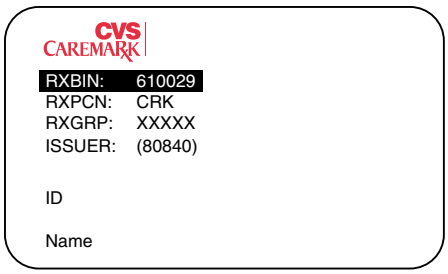
_____

**If this claim is from a foreign country, please fill in below:**

**Country:** _____ **Currency:** _____ **Amount:** _____

**Additional Comments**

## STEP 3 Mailing Instructions:




**The RXBIN # is located on front of your CVS Caremark Prescription ID card. Please see highlighted area to the left for reference. Match your RXBIN # to the addresses below.**

### RXBIN # 610415 mail to:

CVS Caremark
P.O. Box 52116
Phoenix, Arizona 85072-2116

### RXBIN # 004336 , 012114 mail to:

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

### RXBIN # 610029 mail to:

CVS Caremark
P.O. Box 52196
Phoenix, Arizona 85072-2196

### RXBIN # 610474 , 610468 , 004245 or 610449 mail to:

CVS Caremark
P.O. Box 52010
Phoenix, Arizona 85072-2010

### RXBIN # 610473 , 610475 mail to:

CVS Caremark
P.O. Box 53992
Phoenix, Arizona 85072-3992

## IMPORTANT REMINDER

**To avoid having to submit a paper claim form:**

- Always have your card available at time of purchase.
- Always use pharmacies within your network.
- Use medication from your formulary list.
- If problems are encountered at the pharmacy, call the number on the back of your card.