PASSPORT HEALTH PLAN

Member Prescription Claim Form

Please print using blue or black ink. You must fill out all of this form.

Section A. Member Information		
Name (First, Last)	Member ID Number:	Date of Birth (MM/DD/YYYY):
Address:		Phone Number: ( ) -
City:	State:	Zip:

Section B. Please check the reason you wish to be refunded

- ☐ I have not received my ID card
- ☐ The pharmacy is not in network
- ☐ The pharmacy cannot file claims electronically
- ☐ I have an emergency (please describe the emergency on a separate sheet)
- ☐ Other (please describe on a separate sheet)

Section C. Prescription Information *(you may ask your pharmacist to fill out this section)*		
Pharmacy Name:		
Pharmacy Address:		
City:	State:	Zip:
Pharmacy Phone Number: ( ) -		
Date Written (MM/DD/YYYY):	Date Filled (MM/DD/YYYY):	

(Continued)

Section C. Prescription Information *(Continued)*		
Drug Name:		
NDC Number:	RX Number:	
Prescriber Name:	Number of Pills:	Days' Supply:
Amount Charged:	Amount Paid:	

Section D. Release of Information

I allow the release of all information needed by my health care providers. This includes others who are involved with filing my prescriptions and paying my claims. I declare that all of the information on this form is correct. I declare that I have received the medicine listed on this form.

Member's Signature _____ Date (MM/DD/YYYY): _____

Mail this form, with pharmacy receipt(s) to:

CVS Caremark
Attn: Paper Claims Processing Department
P.O. Box 52136
Phoenix, AZ 85072-2136

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