CAREMARK CAREMARK

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1	Primary	Primary Member/Patient Information							This section must be fully completed to ensure proper reimbursement of your claim.												im.			
Prin	nary Mem	ber Inf	orma	ntion																				
Identification Number (refer to your prescription card)							Group No./Gı					o./Gr	roup Name											
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Pati	ent Infor	nation	–Use	a se	para	te cla	aim	for	m fo	or ea	ch	pati	ent	•										
	and Patient Co	des will be	found	on your	prescrip	ption ca	ard.																	
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3 Pharmacy Information	NOTE: The pharmacist is to complete this section ONLY if original pharmacy receipts are not included or if there is a compound prescription.									
Pharmacy Name		Pharmacy NABP No.								
Pharmacy Phone Number										
I hereby certify that all the information listed below is correc understand that all benefit payments as related to the charge	t and represents the actua s listed below will be paid	al charge(s) for p directly to the c	rescription ardholder.	n(s) disper	1sed. I furt	ther				
X										

Signature of Pharmacist or Representative

Date

4 Mail This Completed Form To:

Caremark P.O. Box 52010 Phoenix, AZ 85072-2010