REIMBURSEMENT CLAIM FORM
COORDINATION OF PRESCRIPTION BENEFITS

Coordination of Prescription Drug Benefits is only available when both Husband and Wife are enrolled in the University of Utah Employee Health Care Plan and cover each other and any eligible dependent children

Cardholder Information (Secondary Coverage)

Name:			Empl ID#:
Address:	City:	St: ZIP:	Phone: ( )

Coverage Information

Secondary Coverage (Card not used to purchase the prescription)	Primary Coverage (Card used to purchase the prescription)
Cardholder ID No.________________	Cardholder Name ________________
Group No.________ ________	Cardholder ID No.________________
Day Phone (____)________________	Group No.________ ________
	Day Phone (____)________________

Patient Information (Person for whom the prescription was purchased) – Please use a separate claim form for each family member

Patient Name:____________________ Date of Birth:________________

Relationship to Secondary Coverage Cardholder: ☐ Spouse ☐ Child

Certification and Signature

I hereby certify the following:

- I (or my eligible dependent) have received the medication described herein and the patient named is eligible for prescription drug benefits under both University of Utah coverages listed above.
- The medication is not for treatment of an on-the-job injury or covered under another benefit plan.
- I did not use my flexible spending account card to pay for the prescription(s) and have not and will not request reimbursement of this cost through a flexible spending account.
- I certify that my spouse and I have valid dual coverage through the University of Utah.
- I certify that all the information entered on this form is correct.
- I authorize release of all information pertaining to this claim to Caremark, the plan administrator, insurance underwriter, plan sponsor, policyholder and/or employer.

X

Signature of Cardholder or Legal Representative Date

Instructions for Submitting Claims:

Please complete and submit the following with this form:

- Caremark Prescription Drug Standard Claim Form https://www.advancerx.com/ms/content/standard.pdf
- Prescription drug receipt (original or copy)

Submit forms and receipt(s) to:

Caremark
Attention: Chad Madden, Client Advocate
9501 East Shea Boulevard
Mail Code 005
Scottsdale, AZ 85260-6719