

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

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I hereby certify that all the information listed below is correct and represents the actual charge(s) for prescription(s) dispensed. I further understand that all benefit payments as related to the charges listed below will be paid directly to the cardholder.

X

Signature of Pharmacist or Representative

Date

4 Mail This Completed Form To:

Please refer to your prescription card to ensure this form is mailed to the proper address.

IF 610415 IS THE RXBIN # ON YOUR CARD MAIL THE COMPLETED FORM TO:

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

IF 004336 IS THE RXBIN # ON YOUR CARD MAIL THE COMPLETED FORM TO:

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