

Peralta Pharmacy Benefit for Flu Vaccination



Union #1021 PPO Lite Plan

Pharmacy	Generic	Brand
Benefit	Copay	Copay
Flu Vaccination	\$10	\$15*

Union #1021 PPO Traditional Plan

Pharmacy	Generic	Brand
Benefit	Copay	Copay
Flu Vaccination	\$10	\$15*

Union #39 PPO Lite Plan

Pharmacy	Generic	Brand
Benefit	Copay	Copay
Flu Vaccination	\$10	\$20*

Union #39 PPO Traditional Plan

Pharmacy	Generic	Brand
Benefit	Copay	Copay
Flu Vaccination	\$10	\$20*

Pre 7/2004 Retiree Benefit Plan

Pharmacy	Generic	Brand
Benefit	Copay	Copay
Flu Vaccination	\$1	\$1

^{*}If no generic equivalent, the generic copay will apply.



Prescription Reimbursement Claim Form

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





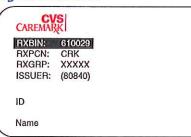
Signature of Member

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	
Address 2	
City	State Zip
Country	
Datient Information - Use a congrate claim fo	rm for each nations
Patient Information—Use a separate claim fo	(First Name) (MI)
Date of Birth Male Female	Phone Number
Relationship to Primary member	
Member Spouse Child Other	
Other Insurance Information	
COB (Coordination of Ben	refits)
Are any of these medicines being taken for an o	n-the-job injury? O Yes O No
Is the medicine covered under any other group in	surance? O Yes O No
If yes, is other coverage: O Primary O Secondary	r.
If other coverage is Primary, include the explanation	
Name of Insurance Company	ID #
Important! A signature is REQUIRED	
Important: A signature is REQUIRED	NOTICE
any materially false, deceptive, incomplete or misleading info	re, or deceive any insurance company, submits a claim or application containing ormation pertaining to such claim may be committing a fraudulent insurance act civil penalties, including fines, denial of benefits, and/or imprisonment.
I certify that I (or my eligible dependent) have received the m that all the information entered on this form is true and corr	nedicine described herein. I certify that I have read and understood this form, and ect.
×	

Date

STEP 2 **Submission Requirements:** You MUST include all original "pharmacy" receipts in order for your claim to process. "Cash register" receipts will only be accepted 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: __ 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.