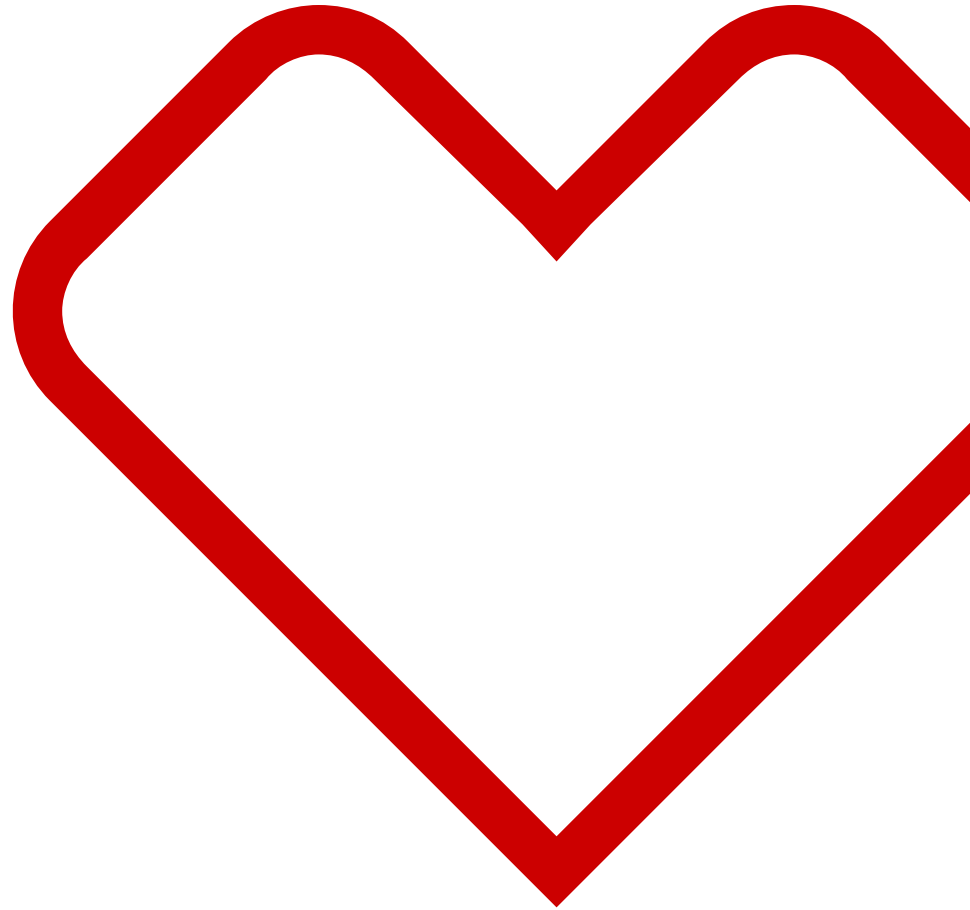




Digital Claim Submission

Paper Claims

March 2019

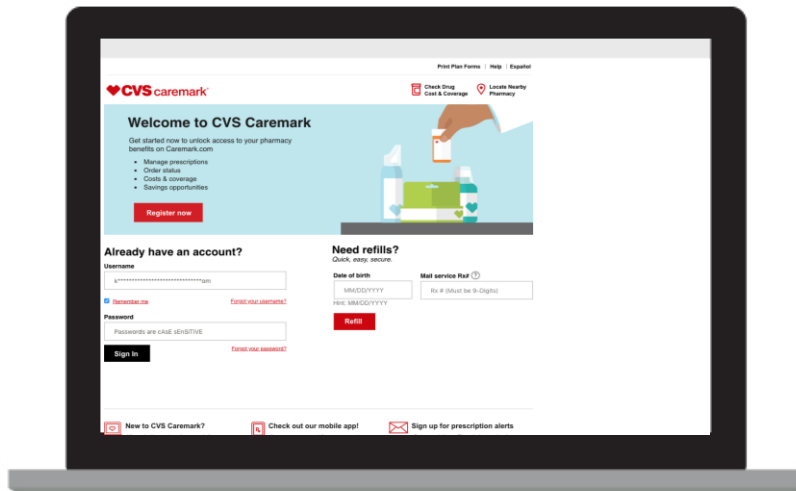


CURRICULUM
DESIGN 



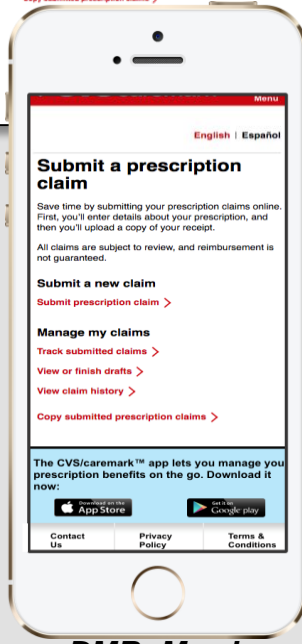
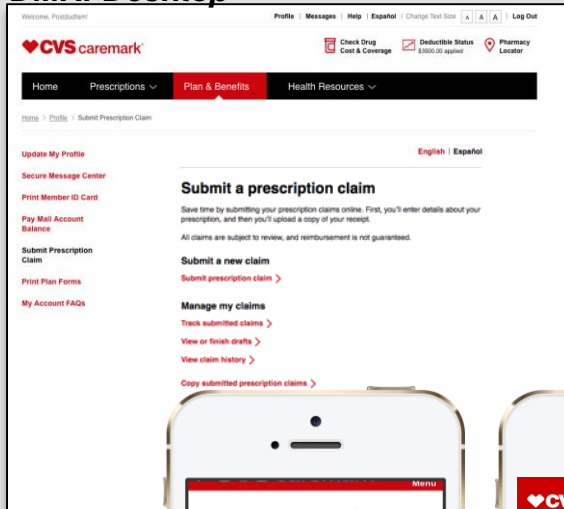
Digital Claim Submission

Reliable, Trackable and Efficient Modes for Caremark Members to submit member-paid prescription reimbursement requests online via Caremark Web Portal (Caremark.com) and Caremark Mobile app (iOS and Android).

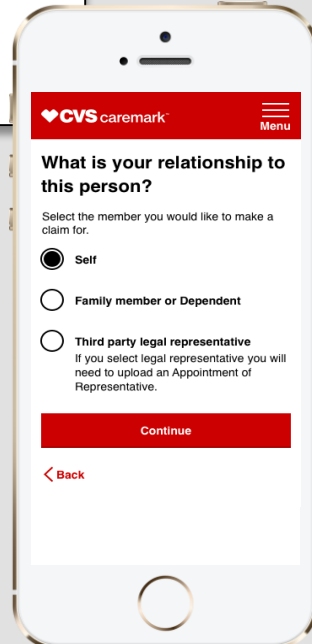


Digital Claim Submission: Benefits

DMR: Desktop



DMR: Mweb



DMR: App

Reasons to Believe



Member

- Facilitates seamless Claims submission modes for Members, their dependents or persons they care for.
- No need to obtain or submit Paper Reimbursement Request Forms.
- Member receives immediate acknowledgement of claim submission.
- Member has access to claim status information



Colleague

- **Reduced claim processing time.**
 - Digital claims direct input to MedForce (DMR Workflow)
 - Eliminate the need for Claims data entry.
 - Examiner will only need to validate Claim information before Adjudication.
- **Reduced Calls to CARE.**
 - Member Dashboard with Claim information will reduce Member calls to CARE.



Client

- **Increase in End Customer Satisfaction:**
 - Quicker Turnaround in deciding claims outcome.
 - Reduction in Manual reject of Claims for missing or incorrect information.
 - Flexible to acceptable client feedback to improve member experience

* Digital claim submission currently available for Commercial Clients only. Rollout for Med D Clients expected Mid 2019.

Claim Submission

Claim Submission Methods

CAREMARK.COM WEBSITE

The screenshot shows the CVS Caremark website home page. At the top, there are links for "Print Plan Forms", "Help", "Español", and "Change Text Size". The main heading is "Welcome to CVS Caremark". Below this, a sub-heading says "Get started now to unlock access to your pharmacy benefits on Caremark.com". A list of features includes: Manage prescriptions, Order status, Costs & coverage, and Savings opportunities. A red "Register now" button is present. Below the welcome message, there are two sections: "Already have an account?" and "Need refills?". The "Already have an account?" section has fields for "Username" and "Password" (with a note "Passwords are cAsE sENSITIVE"), a "Remember my username" checkbox, and a "Sign In" button. The "Need refills?" section has fields for "Date of birth" (format MMDYYYY) and "Mail service Rx#", a "Refill" button, and a link "Where is my mail service Rx#?". At the bottom, there are links for "I forgot my username" and "I forgot my password", and a "Feedback" icon.

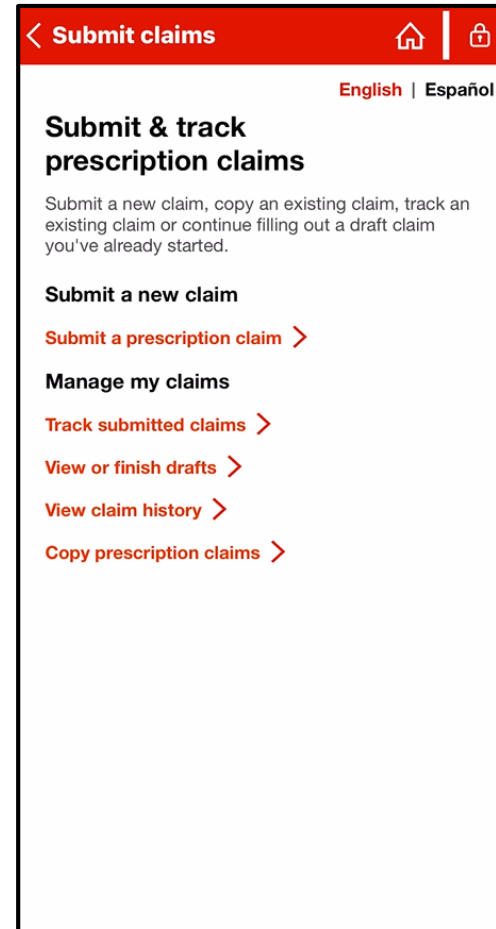
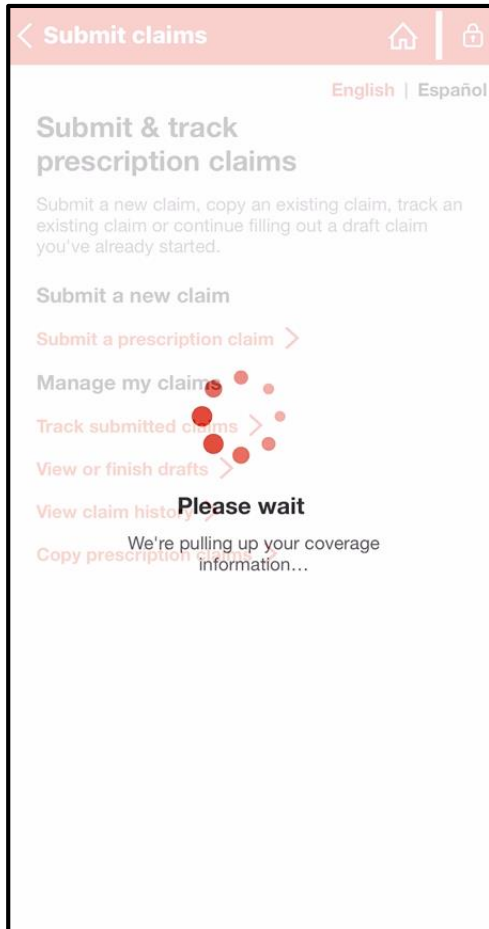
MOBILE APP

The screenshot shows the CVS Caremark mobile app home screen. At the top, the time is 9:41 and the battery level is 50%. The app header is "CVS caremark™" with a lock icon. Below the header, there are four main navigation icons: "Easy Refill", "Start Mail Service", "Submit Claims", and "View I.D. Card". A large blue "2" indicates "2 prescriptions to refill" with a right arrow. Below this, there is a section "Manage prescriptions." with three icons: "Refill Prescriptions", "View Recent Orders", and "Auto Refill". The next section is "Member tools." with six icons: "Check Drug Costs", "Check Drug Interactions", "Identify Pills", "View Financial Summary", "Profile", and "Pharmacy Locator". At the bottom, there is a message "Your opinion helps us help you." and a "Share your feedback" button with a right arrow.





Digital Claim Submission Menu

ELIGIBILITY VERIFICATION



Submitting a Digital Claim

MEMBER SELECTION

< Submit claims  

Who is this claim for?

Select the person you'd like to make a claim for.

Self

Other person for whom I am responsible

Select this if you're acting as a legal representative for someone else in connection with this claim. You'll need to upload an Appointment of Representative form.

[Appointment of Representative - English \(PDF\)](#)



[Appointment of Representative - Spanish \(PDF\)](#)

To view PDFs you may need to download the free Adobe Acrobat Reader.

[Download Adobe Acrobat Reader](#)

[Continue](#)

FAQs | Contact Us

< Submit claims  

Before you start, here's what you'll need.

We'll ask you to provide information about your prescription, your pharmacy, and any secondary insurance you may have. Make sure you have this information ready:

- **Prescription receipt. (This would have been attached to your prescription.) This receipt must include:**
 - Member name
 - Prescription number
 - Drug name and strength (or NDC number)
 - Quantity and days of supply
 - Refill information
 - Dispense as written info, if applicable
 - Prescriber's name
 - Pharmacy name and address
 - Purchase date
 - Total charge
- **Any other insurance information (if applicable)**

All claims are subject to review, and reimbursement is not guaranteed.

You can submit both allergen and compound claims (with up to 50 ingredients) online, or you can submit them by mail. If you'd like to submit by mail, here's what to do:

Compound claims: Download and print this worksheet and form.
[Compound claims worksheet \(PDF\)](#)

[Paper claim form \(PDF\)](#)

Allergen claims: Download and print this form.
[Allergen claim form \(PDF\)](#)

To view PDFs you may need to download the free [Adobe Acrobat Reader](#).

[I'm ready, continue](#)



MEMBER VERIFICATION

< Submit claims Home Lock

Member delivery address: Edit

IRVING, TX, 75038

Address to send the check. To change the address for reimbursement, select 'Edit'. (This is a one-time change only, and will only be applied to this claim.)

Member phone Edit

Primary (Mobile):617

If we have questions, we may use this number to contact you. To change the phone number for this claim, select 'Edit'. (This is a one-time change only, and will only be applied to this claim.)

Continue

Done

1	2 ABC	3 DEF
4 GHI	5 JKL	6 MNO
7 PQRS	8 TUV	9 WXYZ
0		Back

INITIAL QUESTIONS

< Submit claims Home Lock

Now, a few questions about your claim

Your answers help us determine how to best process your claim.
All fields are required unless marked optional

Is this medication covered under any other insurance?

No
 Yes

Was this medication purchased outside of the U.S.?

No
 Yes

Was this medication needed for an emergency?

No
 Yes

Is this medication taken for an on-the-job injury?

This information helps us more efficiently route your claim.

No
 Yes

Continue

< Submit claims Home Lock

What type of medication is this?

All fields are required unless marked optional

A regular prescription



Compound drug

Allergen or allergy serum

Continue



PHARMACY SEARCH

[Submit claims](#)  

What pharmacy provided in your prescription?

For best results, enter either the pharmacy phone number or the pharmacy name and ZIP code.

Pharmacy phone number

Ex: 123-123-1234. This can usually be found on your receipt

OR



Pharmacy name

Ex: CVS, Walgreens, Walmart

Pharmacy ZIP code

[Search](#)

PHARMACY SELECTION

[Submit claims](#)  

Pharmacy Results

1 results for "5088392240"



CVS PHARMACY
100 WORCESTER ST,
GRAFTON, MA 01536
Phone: 5088392240

[Select](#)

[Enter a pharmacy manually >](#)



NDC SEARCH

[Submit claims](#)  

What medication is this claim for?

All fields are required

National Drug Code (NDC)

This is an 11-digit number

Tip

How to find the NDC

The national drug code, or NDC, is an 11-digit number that's printed on a prescription receipt. You may see it noted like this:



NDC: 00000-0000-00

If the NDC you see isn't 11 digits, please contact your pharmacy to get the correct code.

Search

[Enter drug manually >](#)

PRESCRIPTION CLAIM INFO

[Submit claims](#)  

Enter information from your Rx receipt

All fields are required unless marked optional

AZITHROMYCIN INJ 500MG

National Drug Code
63323039812

Rx number

Include numbers only

DAW (dispense as written) (optional)

This will be a 2-digit number from 01 to 09. (i.e., 01, 02, 03)

Refill code (optional)

This will be a number from 0 to 11, and is typically located a few spaces to the right of the prescription number

Date filled

Within the last 1 year<->, and in this format: MMDDYYYY

Quantity / Amount

Number of tablets, amount of liquid, etc.

Days supply



Number of days the prescription is for. Enter numbers only

Amount charged

Continue



PRESCRIBER SEARCH

< Submit claims  

Enter information about your prescriber

Find your prescriber by either entering their first name, last name, and ZIP code; or their National Provider ID.

All fields are required unless marked optional

Prescriber first name

Prescriber last name

ZIP code

OR

National Provider ID

This is a 10-digit number.



Tip

How to find the National Provider ID

The national provider ID is a unique 10-digit number issued to health care providers in the U. S. It may be printed on a prescription receipt or label. If you don't see it, try searching for your prescriber by first name, last name, and ZIP code.

Search

PRESCRIBER SELECTION

< Submit claims  

Select your prescriber for this claim

2 results for "1982643581"



Dr. RICHARD DANIEL
3601 NORTHSTAR RD,
RICHARDSON, TX 75082

Select


[Enter prescriber manually >](#)





CLAIM REVIEW

< Submit claims  

Here's the information we have so far



Pharmacy address  Edit
CVS PHARMACY
100 WORCESTER ST
GRAFTON, MA 01536

Prescription Information  Edit
Prescription:
AZITHROMYCIN INJ 500MG
Rx #:
12345
Date of fill:
10/08/2018
Qty / Amount dispensed:
30
Day Supply:
30
Amount charged (Incl. tax):
\$10.00

Prescriber  Edit
RICHARD DANIEL

Continue

RECEIPT UPLOAD

< Submit claims  

Attach your receipt

Next, you'll need to attach a receipt for the prescription. You can either take a photo of the receipt, or upload an image of it.
Attach prescription receipts only. (We can't accept cash register receipts.) Typically, a prescription receipt is attached to your prescription. Only one receipt per claim, please.

[See a sample of a prescription receipt](#)



The receipt must show:

- Participant name
- Prescription number
- Drug Name and Strength or NDC Number
- Quantity and Days of Supply
- Refill information
- Dispense as written (DAW) if applicable
- Prescriber's name (or DEA Number)
- Pharmacy name and address or NABP
- Purchase Date
- Total Charge

Maximum file size: 3MB.
Accepted formats include JPEG, PNG and PDF.

Add receipt

CLAIM COMMENTS

< Submit claims  

If you have additional comments, you can add them now.

Optional comments

100-character maximum

Continue



CLAIM VERIFICATION

Submit claims

Review your claim
for PREDUDIND AETNA CDH 01/01/1986

Delivery address: **Edit**
750 W. JOHN CARPENTER FRWY, IRVING,
TX 75038
The claim reimbursement will be mailed to this address.

Rx added to this claim

Pharmacy Address: **Edit**
CVS PHARMACY, 100 WORCESTER ST, GRAFTON,
MA 01536

Prescription Information **Edit**
Prescription: AZITHROMYCIN INJ 500MG
Rx: 12345
Date of fill: 10/08/2018
Qty / Amount dispensed: 30
Days supply: 30
Amount charged(incl.tax): \$10.00

Prescriber: **Edit**
RICHARD DANIEL

Receipt 1 **View**

Requested claim amount
\$10.00

NOTE: Reimbursement amounts are subject to change based on the prescriptions submitted and the type of coverage.

[Add another prescription to this claim](#)

[Continue to submit claim](#)

SUBMISSION AND CONFIRMATION

Submit claims

Complete and submit your claim

All medications included in this claim:

AZITHROMYCIN INJ 500MG **Edit** | **Delete**
03/13/2019

Signature required: Any person who knowingly and with intent to defraud, injure, or deceive any insurance company, submits a claim or application containing any materially false, deceptive, incomplete or misleading information pertaining to such claim may be committing a fraudulent insurance act which is a crime and may subject such person to criminal or civil penalties, including fines, denial of benefits, and/or imprisonment.

I certify that I (or my eligible dependent) have received the medicine described herein. I certify that I have read and understood this form, and that all the information entered on this form is true and correct.

Date of signature:
03/13/2019

[Submit claim](#)

Save as draft **Cancel claim**

Submit claims

Your claim for PREDUDIND AETNA CDH has been submitted!

Included in this claim:
AZITHROMYCIN INJ 500MG

- Claim processing time is dependent on applicable laws and your carrier's guidelines.
- Keep a copy of all your receipts.
- Remember, reimbursements are not guaranteed.
- We may contact you with questions.

Confirmation Number
D4001303366

[Submit another claim >](#)

[Go to dashboard >](#)

Thank You

