Print Reset

Caterpillar Prescription Drug Reimbursement Form

Instructions for completing Prescription Drug Claim Form:

- Complete all applicable sections of the claim form below and contact Customer Service at 877-228-7909 with any questions.
- **For compound reimbursement requests**: In addition to this form, also submit a Universal Compound Form completed by the dispensing pharmacy.
- Provide a copy of the pharmacy receipt attached to the bag at time of purchase, and cash register receipt or proof of payment with submitted claim form.
- The pharmacy receipt must show the following prescription information for each expense:
  - Pharmacy Name and Address
  - Patient Name
  - Amount Paid Out-of-Pocket
  - Prescription Number and Fill Date
  - Prescriber Name
  - Drug Cost
  - Drug Name, Strength, and NDC
  - Quantity and Days-Supply
- Mail or fax the completed form and accompanying receipts to:

  Prime Therapeutics
  Attn: CP – 4102
  P.O. Box 64811
  St. Paul, MN 55164-0811

  Fax: 1-800-424-7644

Important address information: Reimbursement will be mailed to the address on file with your health plan. If an address change is required, please update your address in Caterpillar's Workday system (**active employee**) or with Caterpillar Health Enrollment Center (**Retiree**) before submitting this form. Prime Therapeutics is unable to complete address changes and address updates cannot be applied to your reimbursement request after submission.

Note: This claim will not be processed until this form and accompanying receipts are submitted.

1. Policyholder or Insured Name (First, Middle, Last): _____
2. Policyholder or insured ID No. (as shown on ID Card): _____
3. Why was the insurance or drug card not used for this purchase?

   _____
4. Patient's Name (First, Middle, Last): _____
5. Patient's Birth Date: _____
6. Patient's Relationship to Policyholder:

   ☐ Self ☐ Spouse ☐ Dependent ☐ Other
7. Is the patient eligible for any other Prescription Drug Coverage?

   ☐ No ☐ Yes

   If **yes**, please provide a copy of the front and back of the insurance card which includes:
   - Other Insurance Company Name
   - Bank Identification Number (BIN) or Insurer Identification Number (IIN)
   - Processor Control Number (PCN)
   - Cardholder ID and Group Number

I certify that the information on this claim form is correct to the best of my knowledge. I understand that Prime Therapeutics may use and disclose my health information as necessary to process and administer this prescription drug claim.

Signature: _____ **Date:** _____

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