

Nonparticipating Provider Reimbursement Request Form

If you saw a doctor or specialist (or other provider) who doesn't participate with HMSA or if you saw a provider while away from home and you paid for services up front, you can submit a [Medical Receipts Form](#) online using My Account. You can also submit your claim as follows:

1. Complete both sides of this form.
2. Make copies of your receipts to send with your claim.
3. Mail the completed form and copies of your receipts to:

HMSA — Claims Administration
P.O. Box 860
Honolulu, HI 96808-0860

About the person receiving care

Name: _____
Date of birth: _____ Contact phone no.: _____
Email address: _____
Mailing address: _____

About your insurance

Your HMSA subscriber number: _____
Any additional health plan you may have: _____

**Please turn the page over and tell us about the services you received.
Here's a sample of a completed form.**

SAMPLE TEMPLATE

Please describe the service	Blood test to check glucose		
Cost of service	\$150		
Country where the service was provided	Australia		
Date(s) of the injury or the start of the illness	10/1/18	Date(s) of services	10/1/18
What you sought treatment for (be specific)	Diabetes		
Where it was performed	<input checked="" type="checkbox"/> Office <input type="checkbox"/> Clinic <input type="checkbox"/> Hospital <input type="checkbox"/> Other: _____		
Name of the provider	Dr. James Smith		
Provider's address	1234 First Street, Sydney New South Wales, Australia		
Provider's phone number	+612345678		
Type of currency used to pay the bill	Australian dollars		
Name of provider who referred you	Dr. Jeffrey Williams		

Please tell us about the services you received.

Please describe the service			
Cost of service			
Country where the service was provided			
Date(s) of the injury or the start of the illness		Date(s) of services	
What you sought treatment for (be specific)			
Where it was performed	<input checked="" type="checkbox"/> Office <input type="checkbox"/> Clinic <input type="checkbox"/> Hospital <input type="checkbox"/> Other: _____		
Name of the provider	Dr Sarah Strong, ND		
Provider's address	23 Chong St, Hilo, HI 96720		
Provider's phone number	808-933-4325		
Type of currency used to pay the bill			
Name of provider who referred you			

Please describe the service			
Cost of service			
Country where the service was provided			
Date(s) of the injury or the start of the illness		Date(s) of services	
What you sought treatment for (be specific)			
Where it was performed	<input type="checkbox"/> Office <input type="checkbox"/> Clinic <input type="checkbox"/> Hospital <input type="checkbox"/> Other: _____		
Name of the provider			
Provider's address			
Provider's phone number			
Type of currency used to pay the bill			
Name of provider who referred you			

STEP 2**Submission Requirements:**

You **MUST** include all original “pharmacy” receipts in order for your claim to process. “Cash register” receipts will be accepted **only** for diabetic supplies. The minimum information that must be included on your pharmacy receipts is listed below:

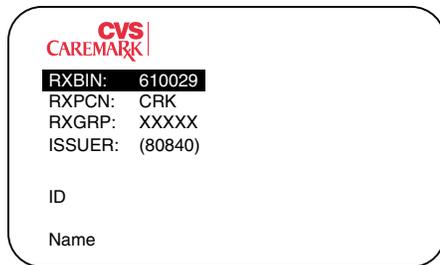
- Patient Name
- Prescription Number
- Medicine NDC number
- Date of Fill
- Metric Quantity
- Total Charge
- Days Supply for your prescription (you may need to ask your pharmacist for this “Days Supply” information)
- Pharmacy Name and Address or Pharmacy NABP Number

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:

Country: _____ Currency: _____ 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.