




Work Related Injury Claim #

New York State Insurance Fund

Mail this form to:


 CVS CAREMARK
 PO BOX 2110
 PITTSBURGH, PA 15230-2110

Please fold here →

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Instructions:
 Please use **blue or black ink, capital letters**, and fill in **both sides** of this form.

New Prescriptions - Mail your new prescriptions with this form. Number of **New** prescriptions:

Refills - Order by Web, phone, or write in Rx number(s) below. Number of **Refill** prescriptions:

TO RECEIVE YOUR ORDER SOONER request refills or new prescriptions online at www.caremark.com or call toll-free 1-866-493-1640.

A Shipping Address. To ship to an address different from the one printed above, please make changes here.

Last Name First Name MI Suffix (JR, SR)

Street Address Apt./Suite # **Use shipping address for this order only.**

City State ZIP Code -

Daytime Phone #: -- Evening Phone #: --

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B Refills. To order mail service refills, enter your prescription number(s) here.

1) _____ 2) _____ 3) _____ 4) _____

5) _____ 6) _____ 7) _____ 8) _____

When a brand name drug is prescribed to treat an injury for which a self-insured employer or insurance carrier is liable pursuant to New York State Workers' compensation Law Section 13, a generic drug equivalent, if a generic equivalent is available, shall be provided unless the prescribing physician specifically provides otherwise on the prescription in accordance with New York Education Law Section 6810(6).

We may package all of these prescriptions together unless you tell us not to.
 All claims for prescriptions submitted to CVS Caremark Pharmacy using this form must be for the work related injury claim # indicated above. All claims for payment will be submitted to the workers' compensation carrier.



C Tell us about the person getting prescriptions.

1st person with a refill or new prescription.

Spanish forms and labels

LAST NAME

FIRST NAME

M Suffix (JR,SR)

NICKNAME

Gender: M F

Date of Birth: MM-DD-YYYY

E-Mail Address: _____ Date new prescription written: _____

Doctor's Last Name

Doctor's First Name

Doctor's Phone #

Tell us about new health information if never provided or if changed.

Allergies: None Aspirin Cephalosporin Codeine Erythromycin Peanuts Penicillin Sulfa Other: _____

Medical Conditions: Arthritis Asthma Diabetes Acid Reflux Glaucoma Heart Problem High Blood Pressure High Cholesterol Migraine Osteoporosis Prostate Issues Thyroid Other: _____

For Internal Use Only - DO NOT COMPLETE THIS SECTION

Spanish forms and labels

LAST NAME

FIRST NAME

M Suffix (JR,SR)

NICKNAME

Gender: M F

Date of Birth: MM-DD-YYYY

E-Mail Address: _____ Date new prescription written: _____

Doctor's Last Name

Doctor's First Name

Doctor's Phone #

Tell us about new health information if never provided or if changed.

Allergies: None Aspirin Cephalosporin Codeine Erythromycin Peanuts Penicillin Sulfa Other: _____

Medical Conditions: Arthritis Asthma Diabetes Acid Reflux Glaucoma Heart Problem High Blood Pressure High Cholesterol Migraine Osteoporosis Prostate Issues Thyroid Other: _____

D Special Instructions: _____

E Payment information is required if you want faster delivery or if NYSIF is not 100% liable for your claim(s).

Electronic Check. Pay from your bank account. (You must first register online or call Customer Care.)

Credit or Debit Card. (VISA®, MasterCard®, Discover®, or American Express®)

Fill in this oval to use your card on file.

Fill in this oval to use a new card or to update your card expiration date.

CARD NUMBER Exp. Date MMY Y

Check or Money Order. Amount: \$ _____ . _____

- Make check or money order out to CVS Caremark.
- Write your claimant ID number on your check or money order.
- If your check is returned, we will charge you up to \$40.

Payment for Balance Due and Future Orders: If you chose Electronic Check, or a Credit or Debit Card, we will also use it to pay for any balance that you owe and for future orders.

Fill in this oval if you **DO NOT** want us to use this payment method for future orders.

Credit Card Holder Signature/Date

Regular delivery is free and will take up to 10 days from the day you send this form.

If you want faster delivery, choose:

- 2nd Business Day (\$17)** Business days are only Monday-Friday
- Next Business Day (\$23)** Monday-Friday

- Faster delivery charges may change.
- Faster delivery is for shipping time only, not processing.
- Faster delivery can only be sent to a street address, not a PO Box.



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