Illinois AIDS Drug Assistance Program

Incident Form

<table>
<thead>
<tr>
<th>Incident Date:</th>
<th>For IDPH Use Only</th>
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<tbody>
<tr>
<td></td>
<td>Date Received:</td>
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<tr>
<td></td>
<td>Date Resolved:</td>
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</tbody>
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Please complete this form. This form is used for ADAP to correspond with CVS on issues providers may be experiencing with CVS Specialty CareMark. You may fax or mail this document to the ADAP office.

Fax Number: (217) 785-8013   Phone Number: (800) 825-3518 or (217) 524-5983

Address: Illinois Department of Public Health – ADAP
525 West Jefferson Street, First Floor
Springfield, IL. 62761

Agency Name: ________________________________

Agency Contact Name: ________________________

Agency Phone Number: ________________________

Patient Name: ______________________________

Patient Date of Birth: ________________________

Incident Details: (Please include a detailed description of the incident. Include names of person you talked to at CVS Specialty CareMark Pharmacy). Use additional pages if needed