

Mail this form to:



CVS CAREMARK
 PO BOX 94467
 PALATINE, IL 60094-4467

Enter ID # below if not shown or if different from above

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Prescription Plan Sponsor or Company Name

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:

FOR FASTEST SERVICE, order refills at www.caremark.com or call the number on your prescription benefit identification card.

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 Name

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Apt./Suite #

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Use this address for this order only.

City

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

State

--	--

ZIP Code

--	--	--	--	--	--	--	--	--	--

Daytime Phone #: - -

Evening Phone #: - -

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

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

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

Please fold here →

Please fold here →

Please fold here →

Please fold here →

* WEB *

* WEB *

We may package all of these prescriptions together unless you tell us not to.



C Tell us about the people getting prescriptions. If there are more than two people, please complete another form.

1st person with a refill or new prescription. This person needs:

Spanish forms and labels

Last Name

First Name

MI Suffix (JR,SR)

NICKNAME

Gender: M F Date of Birth: MM-DD-YYYY - -

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

Doctor's Last Name _____ Doctor's First Name _____ Doctor's Phone # _____

Tell us about **new** allergies or health information for this person. Only tell us about **new** information.

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

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

2nd person with a refill or new prescription. This person needs:

Spanish forms and labels

Last Name

First Name

MI Suffix (JR,SR)

NICKNAME

Gender: M F Date of Birth: MM-DD-YYYY - -

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

Doctor's Last Name _____ Doctor's First Name _____ Doctor's Phone # _____

Tell us about **new** allergies or health information for this person. Only tell us about **new** information.

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

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

D Special Instructions: _____

E How would you like to pay for this order? Fill in the oval to choose a payment.

Electronic Check. Pay from your bank account. First time users register online or call Customer Care.

Bill Me Later®. Works like a credit card. First time users 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.

Exp.Date

Check or Money Order. Amount: \$.

- Make check or money order out to CVS Caremark.
- Write your prescription benefit 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, Bill Me Later®, 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 to use this payment method for future orders.

Regular delivery is free and will take 7 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, not processing time.
- Faster delivery can only be sent to a street address, not a PO box.



Please fold here →

Please fold here →

Please fold here →

Please fold here →

* WEB * * WEB *