




Mail Service Order Form

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| | Mail this form to:  CVS CAREMARK X0735 P O BOX 94467 PALATINE IL 60094-4467 |
| Member ID # (if not shown or if different from above) <input style="width: 100%; height: 20px;" type="text"/> | |
| Prescription Plan Sponsor or Company Name <input style="width: 100%; height: 20px;" type="text"/> | |

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Instructions:
 Please use **blue or black ink** and **print in capital letters**. 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 toll-free 1-866-234-6952.

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

| | | | |
|--|--|--|--|
| Last Name <input style="width: 100%; height: 25px;" type="text"/> | First Name <input style="width: 100%; height: 25px;" type="text"/> | MI <input style="width: 20px; height: 25px;" type="text"/> | Suffix (JR, SR) <input style="width: 100%; height: 25px;" type="text"/> |
| Street Address <input style="width: 100%; height: 25px;" type="text"/> | Apt./Suite # <input style="width: 60%; height: 25px;" type="text"/> | <input type="radio"/> Use shipping address for this order only. | |
| City <input style="width: 100%; height: 25px;" type="text"/> | State <input style="width: 30px; height: 25px;" type="text"/> | ZIP Code <input style="width: 60%; height: 25px;" type="text"/> - <input style="width: 30px; height: 25px;" type="text"/> | |
| Daytime Phone #: <input style="width: 20px; height: 25px;" type="text"/> <input style="width: 20px; height: 25px;" type="text"/> - <input style="width: 20px; height: 25px;" type="text"/> <input style="width: 20px; height: 25px;" type="text"/> <input style="width: 20px; height: 25px;" type="text"/> | Evening Phone #: <input style="width: 20px; height: 25px;" type="text"/> <input style="width: 20px; height: 25px;" type="text"/> - <input style="width: 20px; height: 25px;" type="text"/> <input style="width: 20px; height: 25px;" type="text"/> <input style="width: 20px; height: 25px;" type="text"/> | | |

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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) _____ |

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CVS Caremark wants to provide you with high quality medicines at the best possible price. In order to do this, we will substitute equivalent generic medicines for brand name medicines whenever possible. If you do not want us to substitute generics, please provide specific instructions, including drug names, in the "Special Instructions" section of this form.

We may package all of these prescriptions together unless you tell us not to.
 All claims for prescriptions submitted to CVS Caremark Mail Service Pharmacy using this form will be submitted to your prescription benefit plan for payment. If you do not want them submitted to your plan, do not use this form. You may call Customer Care to make alternate arrangements for submission of your order and payment.



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

First person with a refill or new prescription.

Spanish forms and labels

Last Name

First Name

MI 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 for 1st person 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: _____

Second person with a refill or new prescription.

Spanish forms and labels

Last Name

First Name

MI 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 for 2nd person 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 How would you like to pay for this order? (If your copay is \$0, you do not need to provide payment information.)

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®)

Use your card on file.

Use a new card or update your card's expiration date.

Exp. Date MMY

Check or money order. Amount: \$

- Make check or money order payable 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 choose electronic check or a credit or debit card, we will use it to pay for any balance due and for future orders unless you provide another form of payment.

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 takes up to 5 days after your order is processed.

If you want faster delivery, choose:

2nd business day (\$17)

Next business day (\$23)

Faster delivery can only be sent to a street address, not a PO Box

Expected processing time from receipt of this form:

- Refills: 1-2 days
- New/renewed prescriptions: Within 5 days unless additional information is needed from your doctor (Charges subject to change)



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