

Mail this form to:



CVS CAREMARK
PO BOX 94467
PALATINE, IL 60094-4467

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

[15 boxes for ID number]

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 ID Card.

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

Last Name

[18 boxes for last name]

First Name

[12 boxes for first name]

MI

[]

Suffix (JR, SR)

[] []

Street Name

[25 boxes for street name]

Apt./Suite #

[] [] []

**Use this address
for this order only.**

City

[20 boxes for 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) _____

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



Please fold here →

Please fold here →

Please fold here →

Please fold here →

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: Easy open caps Spanish forms and labels

LAST NAME FIRST NAME M 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: Easy open caps Spanish forms and labels

LAST NAME FIRST NAME M 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.

CARD NUMBER Exp. Date MMYY

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.

Credit Card Holder Signature/Date

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.

