



Mail Service Order Form

Please fold here →

| | . | . |

CVS Caremark
PO BOX 94467
PALATINE, IL 60094-4467

Member ID # (if not shown or if different from above)

[illegible]

Prescription Plan Sponsor or Company Name

Please use **blue or black ink** and **print in capital letters**. Fill in **both sides** of this form.

Number of **New** prescriptions:Number of **Refill** prescriptions:

TO RECEIVE YOUR ORDER SOONER request refills or new prescriptions online at www.caremark.com or call the toll-free number on your member ID card.

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

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

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

1) _____ 2) _____ 3) _____ 4) _____
5) _____ 6) _____ 7) _____ 8) _____

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.

©2016 CVS Caremark. All rights reserved. P13-N



Please fold here →

please fold here →

*** WEB ***

C

Spanish forms and labels

Last Name										First Name										MI	Suffix (JR,SR)									
NICKNAME										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										Date of birth: MM-DD-YYYY															
Gender: ☐ M ☐ F																									
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

E

☐ **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.

[illegible]

☐ **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)

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

☐ **Next business day (\$23)**

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)

