CVS CAREMARK | Mail Service Order Form

Mail this form to:

CAREMARK DOCRX
P.O. BOX 2110
PITTSBURGH PA 15230-2110

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

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 toll-free 1-800-565-7091.

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 #

○ **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)_____

Visit www.caremark.com for the fastest refills. Log in to check order status and access personalized information about your prescription benefits.

IMPORTANT NOTICE: When getting a new prescription, be sure to ask your doctor to write your prescription for the maximum amount allowed by your benefit plan, usually a 90-day supply. Make sure your doctor SIGNS and DATES all new prescriptions.

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

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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 | 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: ○ Easy open caps ○ 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 MMYY

Credit Card Holder Signature/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.

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