CVS CAREMARK | Mail Service Order Form

RESET FORM PRINT FORM

Mail this form to:

CVS CAREMARK
PO BOX 94467
PALATINE, IL 60094-4467

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 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 #

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 *

H8452_OHMMC-210

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

©2012 Caremark. All rights reserved. P13-N

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?** (If your copay is $0, you do not need to provide payment information.)

◯ **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 up to 10 days from the day you send this form.

If you want faster delivery, choose:

◯ **2nd Business Day ($17)**

◯ **Next Business Day ($23)**

Business days are only 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.

MOF WEB 0412 MTP

Please fold here →

Please fold here →

Please fold here →

Please fold here →

* WEB *

* WEB *