



Mail Service Order Form

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[illegible]

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.

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:

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)							
<input type="text"/>										<input type="text"/>										<input type="text"/>		<input type="text"/>							
Street Address															Apt./Suite #					<input type="radio"/> Use shipping address for this order only.									
<input type="text"/>															<input type="text"/>														
City															State			ZIP Code											
<input type="text"/>															<input type="text"/>			<input type="text"/>											
Daytime Phone #:															Evening Phone #:														
<input type="text"/>															<input type="text"/>														

**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.

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WEB

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*** WEB ***

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Spanish forms and labels

<hr/>	<hr/>	<hr/>
Doctor's last name	Doctor's first name	Doctor's phone #

Medical conditions: ☐ Arthritis ☐ Asthma ☐ Diabetes ☐ Acid reflux ☐ Glaucoma ☐ Heart problem
☐ High blood pressure ☐ High cholesterol ☐ Migraine ☐ Osteoporosis ☐ Prostate issues ☐ Thyroid
☐ Other:

Spanish forms and labels

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