Mail Service Order Form

The enclosed Mail Service Order Form may be used to order new prescriptions or to refill an existing prescription. For the fastest service on refills, go to www.caremark.com to order or call the number on your prescription benefit identification card.

Form Instructions:

- Please PRINT in CAPITAL letters using **BLACK** or **BLUE** ink only.
- Fill in the applicable ovals completely (●)
- Fill in each box with the appropriate information including last name, first name, nickname, date of birth, and credit card information.
    - **Please note:** *Some boxes that must be filled-in may already have letters inside them that are watermarks. For example:*

Please write in your personal information in each box directly on top of these letters; the watermark will not obstruct your written information.

- **Prescription Information:** Medicare D Members are only allowed to submit the Mail Service Order Form for themselves. Medicare D Member should only fill in the section titled "1ST PERSON ORDERING A PRESCRIPTION" located on the back of the Mail Service Order Form. ***(Please disregard the second section on the back page of the form titled "2ND PERSON ORDERING A PRESCRIPTION". It is not applicable to Medicare D Members.)***
- **Payment Information:** Mail this completed form, the doctor's signed prescription(s), and your payment to CVS Caremark in the envelope provided or to the address located on the top of this form. If you are using the Credit Card payment option, please include you 16 digit credit card number and the expiration date in the boxes provided on the form. Make sure to fill in the oval applicable to the payment method you prefer.
    - **Please note:** If selecting the credit/debit card option, some boxes that must be filled in may already have letters inside them that are watermarks. Write your credit card information/expiration date in each designated box directly on top of these letters; the watermark will not obstruct your information.

For information or questions, visit our Web site at www.RxMedicarePlans.com or call Customer Care toll-free at 1-888-543-4917, 24 hours a day, 7 days a week. TTY users should call 1-866-236-1069.

MAIL SERVICE ORDER FORM

Please fold here

Mail order form to:

CVS CAREMARK
PO BOX 94467
PALATINE IL 60094-4467

Enter ID# if not shown or different from above

Prescription Plan Sponsor or Company Name

DIRECTIONS: Print in **BLUE** or **BLACK** ink, using CAPITAL letters. Fill in ovals completely (●). Complete both sides of form.

To order new prescriptions: Mail your prescription(s) with this form. **# of new prescriptions:**

To order refills: Order by Web, phone, or write in Rx number(s) below. **# of refill prescriptions:**
FOR FASTEST SERVICE, order refills at www.caremark.com or call the number on your prescription benefit identification card.

SHIPPING ADDRESS IF NOT SHOWN OR DIFFERENT FROM ABOVE:

Last Name | First Name | MI | Suffix (JR, SR)

Street Address | Apt./Suite#

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

City | State | ZIP Code

Daytime Phone #: - - Evening Phone #: - -

REFILL INFORMATION:

To order mail service refills, enter your prescription number(s) here:

1)_____ 2)_____ 3)_____ 4)_____

5)_____ 6)_____ 7)_____ 8)_____

Prescriptions sent in one envelope may be shipped together unless you request otherwise.

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FILL IN FOR UP TO TWO PEOPLE WHO WILL RECEIVE PRESCRIPTIONS WITH THIS ORDER

1st PERSON ORDERING A PRESCRIPTION

○ Easy open caps ○ Print in Spanish

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 # _____

ALLERGY/HEALTH INFORMATION: COMPLETE ONLY IF CHANGED OR NOT PREVIOUSLY REPORTED

Allergies: ○ None ○ Aspirin ○ Cephalosporin ○ Codeine ○ Erythromycin ○ Peanuts ○ Penicillin ○ Sulfa ○ Other: _____

Conditions: ○ Arthritis ○ Asthma ○ Diabetes ○ Acid Reflux ○ Glaucoma ○ Heart Problem ○ High Blood Pressure ○ High Cholesterol ○ Migraine ○ Osteoporosis ○ Prostate Issues ○ Thyroid ○ Other: _____

2nd PERSON ORDERING A PRESCRIPTION

○ Easy open caps ○ Print in Spanish

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 # _____

ALLERGY/HEALTH INFORMATION: COMPLETE ONLY IF CHANGED OR NOT PREVIOUSLY REPORTED

Allergies: ○ None ○ Aspirin ○ Cephalosporin ○ Codeine ○ Erythromycin ○ Peanuts ○ Penicillin ○ Sulfa ○ Other: _____

Conditions: ○ Arthritis ○ Asthma ○ Diabetes ○ Acid Reflux ○ Glaucoma ○ Heart Problem ○ High Blood Pressure ○ High Cholesterol ○ Migraine ○ Osteoporosis ○ Prostate Issues ○ Thyroid ○ Other: _____

Special Instructions: _____

PAYMENT INFORMATION: Select one payment method below.

○ Electronic Check Processing (Please pre-register at Caremark.com or call Customer Care)

○ Bill Me Later® (Subject to credit approval. Please pre-register at Caremark.com or call Customer Care)

○ Credit/Debit Card (VISA, MasterCard, Discover or American Express)

- ○ **Charge most recently used credit card**
- ○ **Charge new/updated credit/debit card (provide info below)**

CREDIT CARD# _____ Exp. Date MMYY _____

○ Check/Money Order: Amount $ ____ . ___

Make check or money order payable to CVS Caremark and write your ID# on the check/money order. Returned checks will be subject to a fee of up to $40, depending on state law.

The selected payment method (unless paying by check) will be charged for future orders, unless a different form of payment is provided. It will also be charged for any outstanding balance due.

○ Fill in oval if you DO NOT want the selected payment method to be automatically charged for future orders.

REGULAR DELIVERY IS FREE
(Allow up to 10 days for delivery)

Fill in oval for faster delivery:

○ 2nd Business Day $17 per order

○ Next Business Day $23 per order
(Charges subject to change)

Faster delivery options only affect shipping time, not processing time and can only be sent to a street address, not a P.O. box.

MOF MTP 1208

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