



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.

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)								
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 →

WEB

Please fold here →

please fold here →

*** WEB ***

C

☐ Spanish forms and labels

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

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:

D

E

