


	<p>Mail this form to:</p> <p style="text-align: center;">  CVS CAREMARK PO BOX 94467 PALATINE, IL 60094-4467 </p>																																	
<p>Enter ID # below if not shown or if different from above</p> <table border="1" style="width:100%; height: 20px;"> <tr> <td style="width:25px; height: 20px;"></td><td style="width:25px; height: 20px;"></td><td style="width:25px; height: 20px;"></td><td style="width:25px; height: 20px;"></td><td style="width:25px; height: 20px;"></td><td style="width:25px; height: 20px;"></td><td style="width:25px; height: 20px;"></td><td style="width:25px; height: 20px;"></td><td style="width:25px; height: 20px;"></td><td style="width:25px; height: 20px;"></td><td style="width:25px; height: 20px;"></td><td style="width:25px; height: 20px;"></td><td style="width:25px; height: 20px;"></td><td style="width:25px; height: 20px;"></td><td style="width:25px; height: 20px;"></td><td style="width:25px; height: 20px;"></td><td style="width:25px; height: 20px;"></td><td style="width:25px; height: 20px;"></td><td style="width:25px; height: 20px;"></td><td style="width:25px; height: 20px;"></td><td style="width:25px; height: 20px;"></td><td style="width:25px; height: 20px;"></td><td style="width:25px; height: 20px;"></td><td style="width:25px; height: 20px;"></td><td style="width:25px; height: 20px;"></td><td style="width:25px; height: 20px;"></td><td style="width:25px; height: 20px;"></td><td style="width:25px; height: 20px;"></td><td style="width:25px; height: 20px;"></td><td style="width:25px; height: 20px;"></td><td style="width:25px; height: 20px;"></td><td style="width:25px; height: 20px;"></td><td style="width:25px; height: 20px;"></td> </tr> </table>																																		
<p>Prescription Plan Sponsor or Company Name</p>																																		

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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)
<input style="width:100%; height:25px;" type="text"/>	<input style="width:100%; height:25px;" type="text"/>	<input style="width:20px; height:25px;" type="text"/>	<input style="width:40px; height:25px;" type="text"/>
Street Name	Apt./Suite #	<input type="radio"/> Use this address for this order only.	
<input style="width:100%; height:25px;" type="text"/>	<input style="width:40px; height:25px;" type="text"/>		
City	State	ZIP Code	
<input style="width:100%; height:25px;" type="text"/>	<input style="width:20px; height:25px;" type="text"/>	<input style="width:60px; height:25px;" type="text"/> - <input style="width:20px; height:25px;" type="text"/>	
Daytime Phone #: <input style="width:20px; height:25px;" type="text"/> <input style="width:20px; height:25px;" type="text"/> - <input style="width:20px; height:25px;" type="text"/> <input style="width:20px; height:25px;" type="text"/>	Evening Phone #: <input style="width:20px; height:25px;" type="text"/> <input style="width:20px; height:25px;" type="text"/> - <input style="width:20px; height:25px;" type="text"/> <input style="width:20px; height:25px;" type="text"/>		

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B Refills. To order mail service refills, enter your prescription number(s) here.

1) _____	2) _____	3) _____	4) _____
5) _____	6) _____	7) _____	8) _____

* WEB *

* WEB *

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



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? 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

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.

Credit Card Holder Signature/Date _____

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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