



# MAIL SERVICE ORDER FORM




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Mail order form to:

  
 CVS CAREMARK  
 P.O. BOX 659541  
 SAN ANTONIO, TX 78265-9541

Enter ID# if not shown or different from above

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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](http://www.caremark.com) or call toll-free 1-866-329-3051.

### 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 CVS Caremark 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.



**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 \$ \_\_\_\_\_

Credit Card Holder Signature/Date

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.



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