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	Mail this form to:	
Member ID # (if not shown or if different from above)	ЧрШиШрШиШиЦиЦиЦиЦиЦиЦиЦиЦиЦиЦиЦиЦи CVS Caremark PO BOX 2110 PITTSBURGH, PA 15230-2110	
Instructions:	lottors Fill in both sides of this form	
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.empireplanrxprogram.com or call toll-free 1-877-7-NYSHIP and select option 4. 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) Image: Suffix state Image: Suffix state	
Street Address	Apt./Suite # Use shipping address for this order only.	
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this, we will substitute equivalent generic medicine	ality medicines at the best possible price. In order to do es for brand name medicines whenever possible. If you ide speci c instructions, including drug names, in the	
We may package all of these prescriptions together unless you tell All claims for prescriptions submitted to CVS Caremark Mail Servic will be submitted to your prescription bene t plan for payment. If yo to your plan, do not use this form. You may call Customer Care to n for submission of your order and payment. ©2016 CVS Caremark. All rights reserved. P13-N		

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C Tell us about the people ordering prescriptions. If there are more than two people, please complete another form.

First person with a refill or new prescription.	Spanish forms and labels
Last Name First Name	
	(JR,SR)
N I C K N A M E Gender: O M O F Date of bit MM-DD-YY	
E-mail address:	Date new prescription written:
Doctor's last name Doctor's first name	Doctor's phone #
Tell us about new health information for 1st person if never p Allergies: None Aspirin Cephalosporin Codein Sulfa Other: Other: Other:	•
Medical conditions: () Arthritis () Asthma () Diabetes () Ac () High blood pressure () High cholesterol () Migraine () () Other:	
Second person with a refill or new prescription.	◯ Spanish forms and labels
Last Name First Name First Name	
	rth:
Gender: () M () F MM-DD-YY	
E-mail address:	Date new prescription written:
Doctor's last name Doctor's first name	Doctor's phone #
Tell us about new health information for 2nd person if never	provided or if changed.
Other:	
Special instructions:	
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How would you like to pay for this order? (If your copay is \$0	, you do not need to provide payment information.)
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