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Please	Use this form to order NEW and/or REFILL mail service prescriptions. Please print in <b>BLUE</b> or <b>BLACK</b> INK using CAPITAL letters only. FOR FASTEST SERVICE: Order refills and verify benefit information at www.caremark.com or call the number on your prescription benefit identification card. Address Change/Shipping Information (Complete ONLY IF DIFFERENT or not shown above)
	Last Name       First Name       MI       Suffix (JR, SR)         Street Address       Apt./Suite#       Use this address         City       State       Zip Code         Daytime Phone#:       -       -
← Please fold here	Prescription Plan Sponsor or Company Name       Evening Phone#:
* WEB *	Apply Caremark Refill Label here       Apply Caremark Refill Label here         Image: Construction of the preserve of the p

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Last Name       First Name       MI       Suffix (JR, SR)         Alternate Name (Nickname)       Gender:       M       F       Date of Birth:       Date of Birth:         Completer AlLERGY/HEALTH INFORMATION ONLY IF CHANGED OR NOT PREVIOUSLY REPORTED       Allernate Name       Doctor / Prescriber's Telephone #         Completer AlLERGY/HEALTH INFORMATION ONLY IF CHANGED OR NOT PREVIOUSLY REPORTED       Allernate Name       Octor / Prescriber's Telephone #         Health Conditions:       Arthritis       Asthma       Diabetes       GERD (Acid Reflux)       Glaucoma       Heart Condition         High Blood Pressure       High Cholesterol       Migraine       Osteoporosis       Prostate Disorders       Thyroid         Other:	Fill in for up to two individuals who will receive prescriptions v	
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Gender:       M       P       MM-DD-YMYY         E-mail Address:	Last Name	
Dactor / Prescriber's Last Name       Doctor / Prescriber's First Name       Doctor / Prescriber's Telephone #         COMPLETE ALLERGY/HEALTH INFORMATION ONLY IF CHANGED OR NOT PREVIOUSLY REPORTED         Allergies:       Aspirin       Cephalosporin       Codeine       Erythromycin       Peanuts       Penicillin       Sulfonamides/Sulf         None       Other:	(-ondor' ())// () F	
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○ High Blood Pressure ○ High Cholesterol ○ Migraine ○ Osteoporosis ○ Prostate Disorders ○ Thyroid         ○ Other:         #2:       ○ Easy open caps ○ Print materials in Spanish         First Name       Mil Suffix (JR, SR)         △ Alternate Name (Nickname)       Gender: ○ M ○ F       Date of Birth:         △ Date of Birth:       ○       Date of Birth:         △ Herritorics       Date of Birth:       ○         △ Herritorics       Doctor / Prescriber's First Name       Doctor / Prescriber's First Name         ○ Conv/Prescriber's Last Name       Doctor / Prescriber's First Name       Doctor / Prescriber's First Name         ○ Conv/Prescriber's Last Name       Doctor / Prescriber's First Name       Doctor / Prescriber's First Name       Doctor / Prescriber's First Name         ○ Conv/Prescriber's Last Name       Octor / Prescriber's First Name       Doctor / Prescriber's First Name       Doctor / Prescriber's First Name         ○ Conv/Prescriber's Last Name       Octor / Prescriber's First Name       Doctor / Prescriber's First Name       Doctor / Prescriber's First Name         ○ None ○ Other:	Health Conditions: () Arthritis () Asthma () Diabetes () GER	D (Acid Reflux) () Glaucoma () Heart Condition
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Alternate Name (Nickname)       Gender:       M       F       Date of Birth:       Date of Birth:         E-mail Address:       Doctor / Prescriber's Last Name       Doctor / Prescriber's Telephone #         Doctor / Prescriber's Last Name       Doctor / Prescriber's Telephone #         COMPLETE ALLERGY/HEALTH INFORMATION ONLY IF CHANGED OR NOT PREVIOUSLY REPORTED         Allergies:       Aspin ()       Cephalosporin ()       Codeine ()       Erythromycin ()       Peanuts ()       Penicillin ()       Sulfonamides/Sulf ()         None ()       Other:		· · ·
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Comments/Special Instructions:         Method of Payment/Shipping Information         Please make check or money order payable to Caremark. Include ID# on check/money order.         Check       Money Order/Cashier's Check       Voucher/Coupon       Amt. of check/money order: \$         Check main of the subject to a processing fee of up to \$40, depending on state law.)         OR pay by credit or debit card (preferred). We accept VISA®, MasterCard®, Discover®, and American Express®.         Fill in oval to charge most recently used credit card for this order and future orders for all individuals included in the family.         Fill in oval to charge most recently used credit card for this order only.         To add, change or update your credit card information, write in below:         Credit/Debit Card Number       Expiration Date         Credit Card Holder Signature       Date         Your credit card will be billed for prescription costs and expedited shipping (if requested).       Next Business Day = \$13 (per order)         By submitting this form you acknowledge that eligibility under the prescription benefit is subject to plan verification and that you/your dependents do not have       Image: State Sta	Allergies: O Aspirin O Cephalosporin O Codeine O Erythrom	
Method of Payment/Shipping Information         Please make check or money order payable to Caremark. Include ID# on check/money order.            (Check ) Money Order/Cashier's Check ) Voucher/Coupon (Checks returned for insufficient funds will be subject to a processing fee of up to \$40, depending on state law.)            OR pay by credit or debit card (preferred). We accept VISA®, MasterCard®, Discover®, and American Express®.             Fill in oval to charge most recently used credit card for this order and future orders for all individuals included in the family.             Fill in oval to charge most recently used credit card for this order only.         To add, change or update your credit card information, write in         below:             Credit/Debit Card Number             Credit Card Holder Signature         Your credit card will be billed for prescription costs and expedited         shipping (if requested).          By submitting this form you acknowledge that eligibility under the prescription         benefit is subject to plan verification and that you/your dependents do not have           Next Business         Date         (Charges subject to change.)	Allergies:       Aspirin       Cephalosporin       Codeine       Erythrom         None       Other:	D (Acid Reflux) O Glaucoma O Heart Condition
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Credit Card Holder Signature       Date         Your credit card will be billed for prescription costs and expedited shipping (if requested).       O 2nd Business Day = \$13 (per order)         By submitting this form you acknowledge that eligibility under the prescription benefit is subject to plan verification and that you/your dependents do not have       O 2nd Business Day = \$13 (per order)	Allergies:       Aspirin       Cephalosporin       Codeine       Erythrom         None       Other:	ycin () Peanuts () Penicillin () Sulfonamides/Sulf D (Acid Reflux) () Glaucoma () Heart Condition eoporosis () Prostate Disorders () Thyroid # on check/money order. on Amt. of check/money order: \$
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