CAREMARK®
It all starts with care®

MAIL SERVICE ORDER FORM

Please fold here

Enter ID # below if not shown or if different from above

Mail order form to:

CAREMARK
PO BOX 659541
SAN ANTONIO, TX 78265-9541

Please fold here

Use this form to order NEW and/or REFILL mail service prescriptions. Please print in **BLUE** or **BLACK** INK using CAPITAL letters only. FOR FASTEST SERVICE: Order refills and verify benefit information at www.caremark.com or call toll-free 1-800-256-0388

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 for this order only.**

City | State | Zip Code

Daytime Phone#: ___ - ___ - ____

Prescription Plan Sponsor or Company Name

Evening Phone#: ___ - ___ - ____

Please fold here

Rx Information - To order NEW prescriptions, mail the doctor's prescription(s) with this form.

If space is needed for more refill labels, you may: 1) attach labels to a blank piece of paper and send with this order form, or 2) print a Refill Order Continuation Form at Caremark.com, or 3) call Caremark Customer Care.

Apply Caremark Refill Label here
or
write prescription number above

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or
write prescription number above

Please fold here

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or
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* WEB *

IMPORTANT NOTICE: Caremark wants to provide you with high quality medicines at the best possible price. In order to do this, we will substitute generic medicines for brand name medicines whenever possible. Also, we may contact your doctor for approval to change your prescription to a preferred medicine or a generic alternative. If you do not want us to substitute generics or contact your doctor for permission to switch to a preferred medicine, please provide specific instructions, including drug names, in the "Comments/Special Instructions" section of this form.

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Unless otherwise directed, all prescriptions received on a single order form or in a single envelope may be shipped together in one package.
Please turn over to provide additional information.

Fill in for up to two individuals who will receive prescriptions with this order.

#1: ○ Enrolled in Medicare Part B ○ Easy open caps ○ Print materials in Spanish

Last Name | First Name | MI | Suffix (JR, SR)

Alternate Name (Nickname) | Gender: ○ M ○ F | Date of Birth: MM - DD - YYYY

E-mail address: _____ Date new prescription(s) received from doctor: _____

Doctor / Prescriber's Last Name | Doctor / Prescriber's First Name | Doctor / Prescriber's Telephone # ___ - ___ - ____

COMPLETE ALLERGY/HEALTH INFORMATION ONLY IF CHANGED OR NOT PREVIOUSLY REPORTED

○ Aspirin ○ Cephalosporin ○ Codeine ○ Erythromycin ○ Peanuts ○ Penicillin ○ Sulfonamides/Sulfa
○ None ○ Other: _____

Health Conditions: ○ Arthritis ○ Asthma ○ Diabetes ○ GERD (Acid Reflux) ○ Glaucoma ○ Heart Condition
○ High Blood Pressure ○ High Cholesterol ○ Migraine ○ Osteoporosis ○ Prostate Disorders ○ Thyroid
○ Other: _____

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#2: ○ Enrolled in Medicare Part B ○ Easy open caps ○ Print materials in Spanish

Last Name | First Name | MI | Suffix (JR, SR)

Alternate Name (Nickname) | Gender: ○ M ○ F | Date of Birth: MM - DD - YYYY

E-mail address: _____ Date new prescription(s) received from doctor: _____

Doctor / 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/Sulfa
○ None ○ Other: _____

Health Conditions: ○ Arthritis ○ Asthma ○ Diabetes ○ GERD (Acid Reflux) ○ Glaucoma ○ Heart Condition
○ High Blood Pressure ○ High Cholesterol ○ Migraine ○ Osteoporosis ○ Prostate Disorders ○ Thyroid
○ 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:** $ ___ . __

(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 | Expiration Date MM - YY

Credit Card Holder Signature | Date

Your credit card will be billed for prescription costs and expedited shipping (if requested).

Your order will be shipped standard delivery at no charge. Allow 10 to 14 days for standard delivery. If you require faster delivery, mark the appropriate oval below. Expedited delivery only affects shipping time, not processing time of your order. Expedited shipments can only be sent to a street address, not a P.O. Box.

Fill in oval for expedited delivery:

○ 2nd Business Day = $13 (per order) ○ Next Business Day = $18 (per order)

(Charges subject to change.)

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 primary prescription coverage under any other plan.

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