# CVS CAREMARK Mail Service Order Form

**Mail this form to:**

CVS CAREMARK
PO BOX 94467
PALATINE, IL 60094-4467

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

Prescription Plan Sponsor or Company Name

Please fold here

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 ID 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)

Street Name | Apt./Suite #

○ **Use this address for this order only.**

City | State | ZIP Code

Daytime Phone #: - - Evening Phone #: - -

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

1)_____ 2)_____ 3)_____ 4)_____

5)_____ 6)_____ 7)_____ 8)_____

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 _____ 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 # _____

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 _____ 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 # _____

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: _____

Please fold here →

Please fold here →

**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.

CARD NUMBER _____ Exp. Date MMYY

Credit Card Holder Signature/Date

○ **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.

**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)**

○ **Next Business Day ($23)**

**Business days are only 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.