

Mail Service Order Form

Mail this form to:



CVS Caremark
PO BOX 659541
SAN ANTONIO, TX 78265-9541

Member ID # (if not shown or if different from above)

Prescription plan sponsor name

Choose one of three ways to order:

Online: Visit Caremark.com

By phone: Call us at the number on your member ID card.

of **New** prescriptions:

By mail: Complete both sides of this form and mail it with your check or credit card information. For new prescriptions, be sure to include your original paper prescription. Please use **black or blue ink** and print in CAPITAL letters. **Medicare** members should complete one form per person.

of **Refill** prescriptions:

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)

Street Address

Apt./Suite #

Use shipping address for this order only.

City

State

ZIP Code

Daytime Phone #: - -

Evening Phone #: - -

B Refills. To order mail service refills, enter the Rx number(s) found on your prescription label.

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

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

To provide you with high quality medications at the lowest possible price, CVS Caremark will substitute equivalent generic medications for brand name medications whenever possible. If you do not want us to substitute generics, please provide specific instructions, including medication names, in the "Special Instructions" section of this form.



C Tell us about the member who the prescriptions are for:

Fill in oval to receive mail service forms and prescription drug labels in Spanish:

LAST NAME

FIRST NAME

M

Suffix (JR,SR)

NICKNAME

Gender: M F

Date of birth: MM-DD-YYYY

E-mail address:

Doctor's last name

Doctor's first name

Doctor's phone #

Tell us about new health information if never provided or if changed.

Allergies: None Aspirin Cephalosporin Codeine Erythromycin Peanuts Penicillin Sulfa Other:

Medical conditions: Arthritis Asthma Diabetes Acid reflux Glaucoma Heart problem High blood pressure High cholesterol Migraine Osteoporosis Prostate issues Thyroid Other:

Medicare part D members do not need to complete the section below.

LAST NAME

FIRST NAME

M

Suffix (JR,SR)

NICKNAME

Gender: M F

Date of birth: MM-DD-YYYY

E-mail address:

Doctor's last name

Doctor's first name

Doctor's phone #

Tell us about new health information if never provided or if changed.

Allergies: None Aspirin Cephalosporin Codeine Erythromycin Peanuts Penicillin Sulfa Other:

Medical conditions: Arthritis Asthma Diabetes Acid reflux Glaucoma Heart problem High blood pressure High cholesterol Migraine Osteoporosis Prostate issues Thyroid Other:

D Special instructions:

E How would you like to pay for this order? (If your copay is \$0, you do not need to provide payment information.)

Electronic check. Pay from your bank account. (You must first register at Caremark.com or call Customer Care.)

Credit or debit card. (VISA®, MasterCard®, Discover®, or American Express®)

Use your card on file.

Use a new card or update your card's expiration date.

CARD NUMBER

Exp. Date MMYY

Check or money order. Amount: \$

Credit card holder signature/date

- Make check or money order payable to CVS Caremark.
- Write your member 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 choose to pay by electronic check or a credit or debit card, we will use it to pay for any balance due and for future orders unless you provide another form of payment.

Fill in this oval if you **DO NOT** want us to use this payment method for future orders.

Processing time takes up to 5 days. Shipping options:

Free shipping (takes 3-5 days)

2nd business day (\$17)

Next business day (\$23)

2nd day or next day delivery:

- Can only be sent to a street address, not a PO Box.
- Applies to shipping time only, not processing.
- Charges may change

