MAIL SERVICE ORDER FORM

CVS CAREMARK | CAREMARK®

Please fold here

Mail order form to:

CAREMARK SAT STD
PO BOX 659541
SAN ANTONIO, TX 78265-9541

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

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 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 for this order only.**

City | State | Zip Code

Daytime Phone#: ___-___-____

Prescription Plan Sponsor or Company Name

Evening Phone#: ___-___-____

NEW prescriptions - Mail Rx(s) with this form. REFILLS - Put refill sticker(s) below.

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 our Web site above, or 3) call Caremark Customer Care at the toll-free number above.

Apply Caremark Refill Label here
or
write prescription number above

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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: ○ 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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#2: ○ 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 # ___-___-____

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○ 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).

Regular delivery is FREE (Allow up to 10 days for delivery).
For faster delivery, mark the appropriate oval below.
Note: Expedited delivery only affects shipping time, not processing time of your order.

Fill in oval for faster 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.

CRKOF-NUSTD5-1007

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