CAREMARK®

MAIL SERVICE ORDER FORM

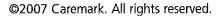
		Mail order form to:	
Please fold here	Enter ID # below if not shown or if different from above	Ilmiliilmiliilmiliilmiliilmiliilmiliilmiliilmiliilmiliilmiliilmiliilmiliilmiliilmiliilmiliilmiliilmiliilmilii PO BOX 659541 SAN ANTONIO, TX 78265-9541	Please fold here
	Use this form to order NEW and/or REFILL mail service prescrilletters only. FOR FASTEST SERVICE: Order refills and verify be call the number on your prescription benefit identification can	nefit information at www.caremark.com or	Plea
\	Address Change/Shipping Information (Complete ONLY	IF DIFFERENT or not shown above)	,
	Last Name Street Address City	First Name Apt./Suite# Use this address for this order only. State Zip Code Ptime Phone#:	
Please fold here	Prescription Plan Sponsor or Company Name Eve	ning 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.		Please fold here
► Please	Apply Caremark Refill Label here or write prescription number above	Apply Caremark Refill Label here or write prescription number above	✓— Please
	Apply Caremark Refill Label here or	Apply Caremark Refill Label here or	
	write prescription number above	write prescription number above	
		·	

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.







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

