

Mail this form to:

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

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

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Prescription Plan Sponsor or Company Name

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](http://www.caremark.com) or call the number on your prescription benefit identification 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) \_\_\_\_\_

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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                     
N I C K N A M E      
Gender:  M  F Date of Birth: MM-DD-YYYY   -   -      
MI  Suffix (JR,SR)     
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                     
N I C K N A M E      
Gender:  M  F Date of Birth: MM-DD-YYYY   -   -      
MI  Suffix (JR,SR)     
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: \_\_\_\_\_

**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.

Exp. 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.

Credit Card Holder Signature/Date \_\_\_\_\_

**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)** Business days are only Monday-Friday
- Next Business Day (\$23)** 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.

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