



Mail Service Order Form Drug Discount Program

Mail this form to:



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

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

RxGroup # (Refer to RxGRP on your card)

Instructions:

Please use **blue or black ink** and **print in capital letters**. 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:

TO RECEIVE YOUR ORDER SOONER request refills online at www.caremark.com or call the toll-free number on your member ID card.

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 your prescription number(s) here.

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

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

This is a discount program, not an insurance plan. Discounts are available through CVS Caremark Mail Service Pharmacy.

Please fold here →

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* WEB *

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We may package all of these prescriptions together unless you tell us not to.



C Tell us about the people ordering prescriptions. If there are more than two people, please complete another form.

First person with a refill or new prescription.

Spanish forms and labels

Last Name [Grid]

First Name [Grid]

MI [Grid]

Suffix (JR,SR) [Grid]

Nickname [Grid]

Gender: M F

Date of birth: MM-DD-YYYY [Grid]

E-mail address: _____ Date new prescription written: _____

Doctor's last name _____

Doctor's first name _____

Doctor's phone # _____

Tell us about new health information for 1st person 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: _____

Second person with a refill or new prescription.

Spanish forms and labels

Last Name [Grid]

First Name [Grid]

MI [Grid]

Suffix (JR,SR) [Grid]

Nickname [Grid]

Gender: M F

Date of birth: MM-DD-YYYY [Grid]

E-mail address: _____ Date new prescription written: _____

Doctor's last name _____

Doctor's first name _____

Doctor's phone # _____

Tell us about new health information for 2nd person 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? Fill in the oval to choose a payment method.

Electronic check. Pay from your bank account. (You must first register online 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.

[Grid] Exp.Date MMY [Grid]

Check or money order. Amount: \$ [Grid] . [Grid]

• Make check or money order payable 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 choose 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.

_____ Credit card holder signature/Date

Regular delivery is free and takes up to 5 days after your order is processed.

If you want faster delivery, choose:

2nd business day (\$17)

Faster delivery can only be sent to a street address, not a PO Box

Next business day (\$23)

Expected processing time from receipt of this form:

- Refills: 1-2 days
- New/renewed prescriptions: Within 5 days unless additional information is needed from your doctor (Charges subject to change)



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