

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: Easy open caps Spanish forms and labels

Last Name

First Name

MI

Suffix (JR,SR)

NICKNAME

Gender: M F

Date of Birth: MM-DD-YYYY - -

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: Easy open caps Spanish forms and labels

Last Name

First Name

MI

Suffix (JR,SR)

NICKNAME

Gender: M F

Date of Birth: MM-DD-YYYY - -

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 MMYY

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
- 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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