CVS Caremark Mail Service Order Form Guide

Simply follow these steps to fill out your new mail service order form, and get started enjoying the convenience and savings of CVS Caremark Mail Service Pharmacy.

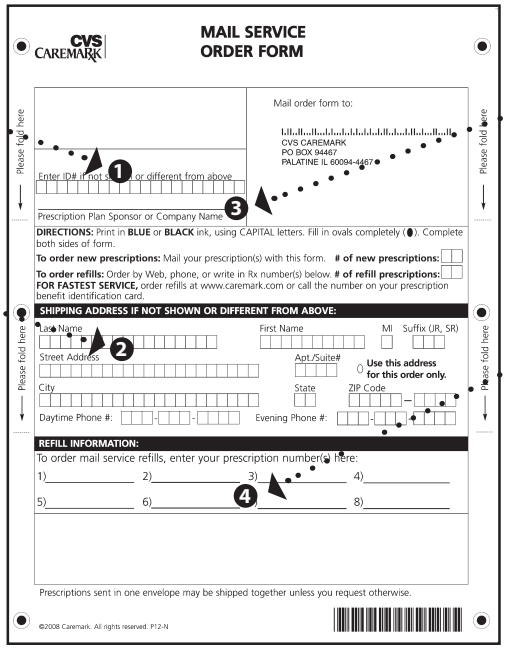
1. Fill in the ID number. The ID number is on your benefit ID card and it identifies the card holder. (On your next order, your ID number will be pre-printed above this field.)

2. Fill in your address and phone number. Be sure to fill in the oval if you want your prescription mailed to a one-time address.

5. Provide information for the first person submitting a prescription.

- Indicate if you would like your order to include easy-open caps.
- Be sure to completely fill out your doctor's first name and last name and telephone number.
- Fill in the ovals under "Allergies" if you are allergic to any drugs or foods; if you do not see the drug or food you are allergic to, fill in the "Other" oval and write it in.
- Fill in the ovals if you have any health conditions; if you do not see your health condition, fill in the "Other" oval and write it in.

Note: It is only necessary to report allergies and health conditions the first time you submit a mail service order to CVS Caremark, or if there are changes.



CVS CAREMARK

MAIL SERVICE ORDER FORM

Please fold here

Mail order form to:

CVS CAREMARK
PO BOX 94467
PALATINE IL 60094-4467

Enter ID# if not shown or different from above

Prescription Plan Sponsor or Company Name

DIRECTIONS: Print in **BLUE** or **BLACK** ink, using CAPITAL letters. Fill in ovals completely (●). Complete both sides of form.

To order new prescriptions: Mail your prescription(s) with this form. **# of new prescriptions:**

To order refills: Order by Web, phone, or write in Rx number(s) below. **# of refill prescriptions:**

FOR FASTEST SERVICE, order refills at www.caremark.com or call the number on your prescription benefit identification card.

SHIPPING ADDRESS IF NOT SHOWN OR DIFFERENT FROM 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 #: | Evening Phone #:

REFILL INFORMATION:

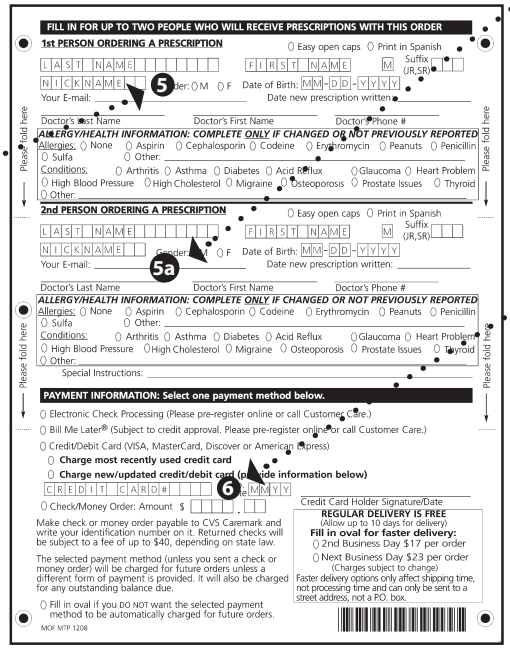
To order mail service refills, enter your prescription number(s) here:

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

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

Prescriptions sent in one envelope may be shipped together unless you request otherwise.

©2008 Caremark. All rights reserved. P12-N



FILL IN FOR UP TO TWO PEOPLE WHO WILL RECEIVE PRESCRIPTIONS WITH THIS ORDER

1st PERSON ORDERING A PRESCRIPTION ○ Easy open caps ○ Print in Spanish

LAST NAME | FIRST NAME | M | 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 #

ALLERGY/HEALTH INFORMATION: COMPLETE ONLY IF CHANGED OR NOT PREVIOUSLY REPORTED

Allergies: ○ None ○ Aspirin ○ Cephalosporin ○ Codeine ○ Erythromycin ○ Peanuts ○ Penicillin ○ Sulfa ○ Other:

Conditions: ○ Arthritis ○ Asthma ○ Diabetes ○ Acid Reflux ○ Glaucoma ○ Heart Problem ○ High Blood Pressure ○ High Cholesterol ○ Migraine ○ Osteoporosis ○ Prostate Issues ○ Thyroid ○ Other:

2nd PERSON ORDERING A PRESCRIPTION ○ Easy open caps ○ Print in Spanish

LAST NAME | FIRST NAME | M | 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 #

ALLERGY/HEALTH INFORMATION: COMPLETE ONLY IF CHANGED OR NOT PREVIOUSLY REPORTED

Allergies: ○ None ○ Aspirin ○ Cephalosporin ○ Codeine ○ Erythromycin ○ Peanuts ○ Penicillin ○ Sulfa ○ Other:

Conditions: ○ Arthritis ○ Asthma ○ Diabetes ○ Acid Reflux ○ Glaucoma ○ Heart Problem ○ High Blood Pressure ○ High Cholesterol ○ Migraine ○ Osteoporosis ○ Prostate Issues ○ Thyroid ○ Other:

Special Instructions:

PAYMENT INFORMATION: Select one payment method below.

○ Electronic Check Processing (Please pre-register online or call Customer Care.)

○ Bill Me Later® (Subject to credit approval. Please pre-register online or call Customer Care.)

○ Credit/Debit Card (VISA, MasterCard, Discover or American Express)

○ **Charge most recently used credit card**

○ **Charge new/updated credit/debit card (provide information below)**

CREDIT CARD # | EXP MMYY

Credit Card Holder Signature/Date

○ Check/Money Order: Amount $ . .

Make check or money order payable to CVS Caremark and write your identification number on it. Returned checks will be subject to a fee of up to $40, depending on state law.

The selected payment method (unless you sent a check or money order) will be charged for future orders unless a different form of payment is provided. It will also be charged for any outstanding balance due.

○ Fill in oval if you DO NOT want the selected payment method to be automatically charged for future orders.

REGULAR DELIVERY IS FREE
(Allow up to 10 days for delivery)
Fill in oval for faster delivery:
○ 2nd Business Day $17 per order
○ Next Business Day $23 per order
(Charges subject to change)
Faster delivery options only affect shipping time, not processing time and can only be sent to a street address, not a P.O. box.

MOF MTP 1208

3. Enter RxAmerica as the name of your prescription plan sponsor or company.

4. For new prescriptions, simply enclose the original prescription(s) with your order form. For refills, write in the prescription number(s) in the spaces provided. When you receive your prescription order, a refill order form will be enclosed that will list your refills. Simply fill in the ovals for the prescriptions you want to refill.

5a. (OPTIONAL) Provide information for the second person if you are submitting prescriptions for two family members. If this is the case, provide the same information as in step 4.

6. Fill in the appropriate oval for your method of payment. If you are paying by check or money order, please write your ID number on the check. If you are paying by credit card, be sure to include your signature. Do not send cash. Regular delivery is available at no added cost. Fill in the oval for optional expedited delivery.

7. Make sure you enclose the original prescription(s) you received from your doctor(s) and not photocopies.

That's it!

Now, simply mail your order form along with your prescription(s) and payment to CVS Caremark, PO Box 94467, Palatine, IL 60094-4467.

CVS CAREMARK

©2009 Caremark. All rights reserved. 49-18101a 08.09 [PP]