

MAIL SERVICE ORDER FORM

Primary Plan Participant ID Number (refer to Rx card): (Enter ID # below if not shown or if different from above	
	rescriptions. Please print in BLUE or BLACK INK using CAPITAL by benefit information at www.caremark.com or call toll-free
Shipping Information (Complete ONLY IF DIFFERENT	r or not shown above)
Last Name Street Address City	First Name MI Suffix (JR, SR) Apt./Suite# State Zip Code
Fill in oval if one time only address.	Daytime Phone#: Evening Phone#:
Rx Information (If space is needed for more refill labels use	Refill Order Continuation Form and send with this order)
To order NEW prescriptions, mail the doctor's prescripti	on with this form. Number of Rx's: New Refill Total
Apply Caremark Refill Label here or write prescription number above	Apply Caremark Refill Label here or write prescription number above
Apply Caremark Refill Label here or write prescription number above	Apply Caremark Refill Label here or 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.

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Plan Participant Information: Fill in for plan participants rece	iving a prescription with this order.
	open caps. t Name MI Suffix (JR, SR)
Alternate Name (Nickname) Gender: OM F	Date of Birth: MM - DD - YYYY
E-mail address:	
Doctor / Prescriber's Last Name Doctor / Prescriber's Firs	st Name Doctor / Prescriber's Telephone #
COMPLETE ALLERGY/HEALTH INFORMATION ONLY IF CHANG Allergies: Aspirin Cephalosporin Codeine Erythro None Other:	
	ERD (Acid Reflux)
Last Name Firs Alternate Name (Nickname) Gender: M F	open caps. t Name MI Suffix (JR, SR) Date of Birth: MM - DD - YYYY
E-mail address: Doctor / Prescriber's Last Name Doctor / Prescriber's First COMPLETE ALLERGY/HEALTH INFORMATION ONLY IF CHANG Allergies: Aspirin Cephalosporin Codeine Erythro None Other:	ED OR NOT PREVIOUSLY REPORTED
Health Conditions: Arthritis Asthma Diabetes GE	ERD (Acid Reflux)
Comments/Special Instructions: Method of Payment/Shipping Information Please make check or money order payable to Caremark. Include ID	D# on all checks and money orders.
Check Money Order or Cashier's Check Voucher/Coup Checks returned for insufficient funds will be subject to a \$25 processing OR pay by credit or debit card (preferred). We accept VISA®, Maste Fill in oval to charge most recently used credit card for this order and	fee. (Excluding credit card payments) rCard®, Discover® and American Express®.
Fill in oval to charge most recently used credit card for this order onl To add, change, or update your credit card information, write in below:	Your order will be shipped standard delivery at no charge. Allow 10 to 14 days for standard delivery. If you require faster delivery, mark the appropriate oval below. Expedited delivery only affects shipping time, not processing time of your order. Expedited shipments can only be sent to a street address, not P.O. Box.
Credit/Debit Card Number Expiration Date Credit Card Holder Signature Date	Fill in oval for expedited delivery: 2nd Business Day = \$13 (per order) Next Business Day = \$18 (per order)
Your credit card will be billed for Rx costs and expedited shipping ((Charges subject to change.)

Plan participant acknowledges 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.

requested).

