

Mail Service Order Form

	Mail this form to:
Member ID # (if not shown or if different from above)	
Prescription Plan Sponsor or Company Name	
Instructions: Please use blue or black ink and print in capital le	tters. Fill in both sides of this form.
New Prescriptions – Mail your new prescriptions with	
Refills – Order by Web, phone, or write in Rx number TO RECEIVE YOUR ORDER SOONER request refil or call the toll-free number on your member ID card.	· /
A Shipping Address. To ship to an address different	t 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 Daytime Phone #:	State ZIP Code Evening Phone #:
B Refills. To order mail service refills, enter your pre	escription number(s) here.
1)2)	3)4)
5)6)	7)8)
CVS Caremark wants to provide you with high qualit this, we will substitute equivalent generic medicines do not want us to substitute generics, please provide "Special Instructions" section of this form.	ty medicines at the best possible price. In order to do for brand name medicines whenever possible. If you e specific instructions, including drug names, in the

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

All claims for prescriptions submitted to CVS Caremark Mail Service Pharmacy using this form will be submitted to your prescription benefit plan for payment. If you do not want them submitted to your plan, do not use this form. You may call Customer Care to make alternate arrangements for submission of your order and payment.



	○ Spanish forms and labels
LAST NAME FIRS	T NAME Suffix (JR,SR)
MICKNAME Gender: () M () F Date of bir	rth: MM-DD-YYYY
	ate 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 properties: Allergies: None Other:	rovided or if changed. e () Erythromycin () Peanuts () Penicillin
Medical conditions: () Arthritis () Asthma () Diabetes () Acid () High blood pressure () High cholesterol () Migraine () Other:	
Second person with a refill or new prescription.	○ Spanish forms and labels
LAST NAME FIRS	T NAME Suffix (JR,SR)
NICKNAME Gender: () M () F Date of bir	
	ate 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 p	provided or if changed.
Allergies: None Aspirin Cephalosporin Codeine Sulfa Other:	
Medical conditions: () Arthritis () Asthma () Diabetes () Acid () High blood pressure () High cholesterol () Migraine () Other:	Osteoporosis O Prostate issues O Thyroid
Other: Special instructions:	
•	
How would you like to may for this and 2 //f your concuis \$0.	varide not need to provide normant information
	,
How would you like to pay for this order? (If your copay is \$0,	,
O Electronic check. Pay from your bank account. (You must fin	rst register online or call Customer Care.)
	rst register online or call Customer Care.)
 Electronic check. Pay from your bank account. (You must fine Credit or debit card. (VISA®, MasterCard®, Discover®, or Am 	rst register online or call Customer Care.)
 Electronic check. Pay from your bank account. (You must find the count of the count	rst register online or call Customer Care.)
 Credit or debit card. (VISA®, MasterCard®, Discover®, or Am Use your card on file. Use a new card or update your card's expiration date. Exp. MMYY Date	rst register online or call Customer Care.)
 Electronic check. Pay from your bank account. (You must find the count of the count of	credit card holder signature/Date Regular delivery is free and takes up to 5 days after your order is processed.
 Electronic check. Pay from your bank account. (You must find the count of the count of	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: Paster delivery Faster delivery Faster delivery Faster delivery
 Electronic check. Pay from your bank account. (You must find the count of the count of	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) Next business day (\$23) Street address, street address addre
 Electronic check. Pay from your bank account. (You must find the count of the count of	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