

Mail Service Order Form

The enclosed Mail Service Order Form may be used to order new prescriptions or to refill an existing prescription. For the fastest service on refills, go to www.caremark.com to order or call the number on your prescription benefit identification card.

Form Instructions:

- Please PRINT in CAPITAL letters using **BLACK** or **BLUE** ink only.
- Fill in the applicable ovals completely (●).
- Fill in each box with the appropriate information including last name, first name, nickname, date of birth, and credit card information.
 - **Please note:** *Some boxes that must be filled-in may already have letters inside them that are watermarks. For example:*

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Please write in your personal information in each box directly on top of these letters; the watermark will not obstruct your written information.

- **Prescription Information:** Medicare D Members are only allowed to submit the Mail Service Order Form for themselves. Medicare D Member should only fill in the section titled "1ST PERSON ORDERING A PRESCRIPTION" located on the back of the Mail Service Order Form. ***(Please disregard the second section on the back page of the form titled "2ND PERSON ORDERING A PRESCRIPTION". It is not applicable to Medicare D Members.)***
- **Payment Information:** Mail this completed form, the doctor's signed prescription(s), and your payment to CVS Caremark in the envelope provided or to the address located on the top of this form. If you are using the Credit Card payment option, please include you 16 digit credit card number and the expiration date in the boxes provided on the form. Make sure to fill in the oval applicable to the payment method you prefer.
 - **Please note:** If selecting the credit/debit card option, some boxes that must be filled in may already have letters inside them that are watermarks. Write your credit card information/expiration date in each designated box directly on top of these letters; the watermark will not obstruct your information.

For information or questions, visit our Web site at Groups.RxMedicarePlans.com or call Customer Care toll-free at 1-888-543-4917, 24 hours a day, 7 days a week. TTY users should call 1-866-236-1069.

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.

Spanish forms and labels

LAST NAME

FIRST NAME

M

Suffix (JR,SR)

NICKNAME

Gender: M F

Date of Birth: MM-DD-YYYY

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: _____

2nd person with a refill or new prescription.

Spanish forms and labels

LAST NAME

FIRST NAME

M

Suffix (JR,SR)

NICKNAME

Gender: M F

Date of Birth: MM-DD-YYYY

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? (If your copay is \$0, you do not need to provide payment information.)

Electronic Check. Pay from your bank account. (You must first register online or call Customer Care.)

Bill Me Later®. Works like a credit card. (You must first 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.

CARD NUMBER Exp. Date MMYY

Check or Money Order. Amount: \$ _____

Credit Card Holder Signature/Date

- 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 us to use this payment method for future orders.

Regular delivery is free and will take up to 10 days from the day you send this form.

If you want faster delivery, choose:

- 2nd Business Day (\$17)** Business days are only Monday-Friday
- Next Business Day (\$23)** Monday-Friday

- Faster delivery charges may change.
- Faster delivery is for shipping time only, not processing.
- Faster delivery can only be sent to a street address, not a PO Box.



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