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:*

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 your 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 www.RxMedicarePlans.com or call Customer Care toll-free at the phone numbers below. TTY/TDD users call 711.

Connecticut	1-888-620-1747	**Rhode Island**	1-888-620-1748
Massachusetts	1-888-543-4917	**Vermont**	1-888-620-1746

RESET FORM PRINT FORM

CVS caremark®

Mail Service Pharmacy Order Form

Mail this form to:

CVS Caremark Mail Service Pharmacy
PO BOX 2110
PITTSBURGH, PA 15230-2110

Member ID # (if not shown or if different from above)

Prescription Plan Sponsor or Company Name

Please fold here →

Instructions:

Please use **blue or black ink** and **print in capital letters.** Fill in **both sides** of this form.

New Prescriptions - Mail your new prescriptions with this form. Number of **New** prescriptions:

Refills - Order by Web, phone, or write in Rx number(s) below. Number of **Refill** prescriptions:

TO RECEIVE YOUR ORDER SOONER request refills or new prescriptions online at www.caremark.com or call the toll-free number on your member ID card.

A Shipping Address. To ship to an address different 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 | State | ZIP Code

Daytime Phone #: - - Evening Phone #: - -

B Refills. To order mail service refills, enter your prescription number(s) here.

1) 2) 3) 4)

5) 6) 7) 8)

CVS Caremark Mail Service Pharmacy wants to provide you with high quality medicines at the best possible price. In order to do this, we will substitute equivalent generic medicines for brand name medicines whenever possible. If you do not want us to substitute generics, please provide specific instructions, including drug names, in the "Special Instructions" section of this form.

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.

* WEB *

C **Tell us about the people ordering prescriptions.** If there are more than two people, please complete another form.

First person with a refill or new prescription. ◯ Spanish forms and labels

Last Name | First Name | MI | Suffix (JR,SR)

Nickname | 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:

Second person with a refill or new prescription. ◯ Spanish forms and labels

Last Name | First Name | MI | Suffix (JR,SR)

Nickname | 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.)

◯ **Credit or debit card.** (VISA®, MasterCard®, Discover®, or American Express®)

◯ Use your card on file.

◯ Use a new card or update your card's expiration date.

Exp.Date MMYY

Credit card holder signature/Date

◯ **Check or money order.** Amount: $.

- Make check or money order payable 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 choose electronic check or a credit or debit card, we will use it to pay for any balance due and for future orders unless you provide another form of payment.

◯ Fill in this oval if you **DO NOT** want us to use this payment method for future orders.

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)**

Faster delivery can only be sent to a street address, not a PO Box

Expected processing time from receipt of this form:

- Refills: 1-2 days
- New/renewed prescriptions: Within 5 days unless additional information is needed from your doctor

(Charges subject to change)

Please fold here →

* WEB *