RESET FORM PRINT FORM

CVS caremark®
Mail Service Order Form

Mail this form to:

CVS Caremark
PO BOX 2110
PITTSBURGH, PA 15230-2110

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

A A A A A A A A A A A A A A A A A A A A

Please use blue or black ink and print in capital lettersPlease use blue

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: A S

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

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: a a a a a a a a a a a a a a a a a a a a

First Name: a a a a a a a a a a

MI: a

Suffix (JR, SR): a a a

Street Address: a a a a a a a a a a a a a a a a a a a a a a a a

Apt./Suite #: a a a a

☐ **Use shipping address for this order only.**

City: a a a a a a a a a a a a a a a a a a a a a a a a

State: AR

ZIP Code: 2 2 3 1 2 — 1 3 2 1

Daytime Phone #: 1 2 1 - 1 3 2 - 1 3 2 1

Evening Phone #: 1 2 3 - 1 2 3 - 1 2 3 1

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

1) Please use blue or black ink ar
2) Please use blue or black ink ar
3) Please use blue or black ink ar
4) Please use blue or black ink a
5) Please use blue or black ink ar
6) Please use blue or black ink ar
7) Please use blue or black ink ar
8) Please use blue or black ink a

CVS Caremark 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.

Please fold here →

* WEB *

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.

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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: AAAAAAAAAAAAAAAAAA

First Name: AAAAAAAAAA

MI: A

Suffix (JR,SR): AAA

Nickname: AAAAAAAAAA

Gender: ○ M ● F

Date of birth: MM-DD-YYYY: 12-31-2020

E-mail address: Please use blue or black ink and print in capital lettersPle

Date new prescription written: 08/25/2020

Please use blue or black ink and print in ca — Doctor's last name

Please use blue or black ink and print in ca — Doctor's first name

(123) 132-1321 — 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: Please use blue or black ink and print in capital lettersPlease use blue or black ink and print in capital lett

Medical conditions: ● Arthritis ● Asthma ● Diabetes ● Acid reflux ● Glaucoma ● Heart problem ● High blood pressure ● High cholesterol ● Migraine ● Osteoporosis ● Prostate issues ● Thyroid ● Other: Please use blue or black ink and print in capital lettersPlease use blue or black ink and print in capital lettersPlease use blue or black ink

Second person with a refill or new prescription.

Spanish forms and labels

Last Name: AAAAAAAAAAAAAAAAAA

First Name: SSSSSSSSSS

MI: D

Suffix (JR,SR): SDG

Nickname: AAAAAAAAAA

Gender: ○ M ● F

Date of birth: MM-DD-YYYY: 12-31-2020

E-mail address: Please use blue or black ink and print in capital lettersPle

Date new prescription written: 08/25/2020

Please use blue or black ink and print in ca — Doctor's last name

Please use blue or black ink and print in ca — Doctor's first name

(123) 123-1231 — 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: Please use blue or black ink and print in capital lettersPlease use blue or black ink and print in capital lett

Medical conditions: ● Arthritis ● Asthma ● Diabetes ● Acid reflux ● Glaucoma ● Heart problem ● High blood pressure ● High cholesterol ● Migraine ● Osteoporosis ● Prostate issues ● Thyroid ● Other: Please use blue or black ink and print in capital lettersPlease use blue or black ink and print in capital lettersPlease use blue or black ink

D Special instructions: Please use blue or black ink and print in capital lettersPlease use blue or black ink and print in capital lettersPlease use b

Please use blue or black ink and print in capital lettersPlease use blue or black ink and print in capital lettersPlease use blue or black ink and print in ca

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.

Credit card number: AAAAAAAAAAAAAAAA

Exp.Date MMYY: 1220

Please use blue or black ink and print in capita 08/25/2020

Credit card holder signature/Date

● **Check or money order.** Amount: $ Plea . Pl

- 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)

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