




MAIL SERVICE ORDER FORM



	Mail order form to:  CAREMARK ZA966 P.O. BOX 2110 PITTSBURGH PA 15230-2110
Enter ID# if not shown or different from above <input type="text"/>	
Prescription Plan Sponsor or Company Name <input type="text"/>	

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DIRECTIONS: Print in **BLUE** or **BLACK** ink, using CAPITAL letters. Fill in ovals completely (●). Complete both sides of form.

To order new prescriptions: Mail your prescription(s) with this form. # of new prescriptions:

To order refills: Order by Web, phone, or write in Rx number(s) below. # of refill prescriptions:

FOR FASTEST SERVICE, order refills at www.caremark.com or call toll-free 1-800-896-4955.

SHIPPING ADDRESS IF NOT SHOWN OR DIFFERENT FROM ABOVE:

Last Name <input type="text"/>	First Name <input type="text"/>	MI <input type="text"/>	Suffix (JR, SR) <input type="text"/>
Street Address <input type="text"/>	Apt./Suite# <input type="text"/>	○ Use this address for this order only.	
City <input type="text"/>	State <input type="text"/>	ZIP Code <input type="text"/> - <input type="text"/>	
Daytime Phone #: <input type="text"/> - <input type="text"/> - <input type="text"/>	Evening Phone #: <input type="text"/> - <input type="text"/> - <input type="text"/>		

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REFILL INFORMATION:

To order mail service refills, enter your prescription number(s) here:

1) _____	2) _____	3) _____	4) _____
5) _____	6) _____	7) _____	8) _____

Visit www.caremark.com for the fastest refills. Log in to check order status and access personalized information about your prescription benefits.

IMPORTANT NOTICE: When getting a new prescription, be sure to ask your doctor to write your prescription for the maximum amount allowed by your benefit plan, usually a 90-day supply. Make sure your doctor SIGNS and DATES all new prescriptions.

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Prescriptions sent in one envelope may be shipped together unless you request otherwise.



FILL IN FOR UP TO TWO PEOPLE WHO WILL RECEIVE PRESCRIPTIONS WITH THIS ORDER

1st PERSON ORDERING A PRESCRIPTION

Easy open caps Print in Spanish

Last Name

First Name

MI Suffix (JR,SR)

NICKNAME

Gender: M F

Date of Birth: MM-DD-YYYY

Your E-mail:

Date new prescription written:

Doctor's Last Name

Doctor's First Name

Doctor's Phone #

ALLERGY/HEALTH INFORMATION: COMPLETE ONLY IF CHANGED OR NOT PREVIOUSLY REPORTED

Allergies: None Aspirin Cephalosporin Codeine Erythromycin Peanuts Penicillin
 Sulfa Other:

Conditions: Arthritis Asthma Diabetes Acid Reflux Glaucoma Heart Problem
 High Blood Pressure High Cholesterol Migraine Osteoporosis Prostate Issues Thyroid
 Other:

2nd PERSON ORDERING A PRESCRIPTION

Easy open caps Print in Spanish

Last Name

First Name

MI Suffix (JR,SR)

NICKNAME

Gender: M F

Date of Birth: MM-DD-YYYY

Your E-mail:

Date new prescription written:

Doctor's Last Name

Doctor's First Name

Doctor's Phone #

ALLERGY/HEALTH INFORMATION: COMPLETE ONLY IF CHANGED OR NOT PREVIOUSLY REPORTED

Allergies: None Aspirin Cephalosporin Codeine Erythromycin Peanuts Penicillin
 Sulfa Other:

Conditions: Arthritis Asthma Diabetes Acid Reflux Glaucoma Heart Problem
 High Blood Pressure High Cholesterol Migraine Osteoporosis Prostate Issues Thyroid
 Other:

Special Instructions:

PAYMENT INFORMATION: Select one payment method below.

- Electronic Check Processing (Please pre-register online or call Customer Care.)
- Bill Me Later® (Subject to credit approval. Please pre-register online or call Customer Care.)
- Credit/Debit Card (VISA®, MasterCard®, Discover® or American Express®)
 - Charge most recently used credit/debit card
 - Charge new/updated credit/debit card (provide information below)

Exp.Date MMY

Check/Money Order: Amount \$

Credit Card Holder Signature/Date

REGULAR DELIVERY IS FREE

(Allow 7 to 10 days for delivery)

Fill in oval for faster delivery:

2nd Business Day \$17 per order

Next Business Day \$23 per order
(Charges subject to change)

Faster delivery options only affect shipping time, not processing time and can only be sent to a street address, not a P.O. box.



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