

Mail Service Order Form

	Mail this form to:																		
																			
	CVS/caremark PO BOX 94467 PALATINE, IL 60094-4467																		
Member ID # (if not shown or if different from above)																			
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Prescription Plan Sponsor or Company Name																			

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 1-866-611-5961.

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 #:										- -										

○ Use shipping address for this order only.

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

1) _____ 2) _____ 3) _____ 4) _____

5) _____ 6) _____ 7) _____ 8) _____

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.

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.



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

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: _____

Second 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.)

☐ **Use my PayPal Credit account.** Works like a credit card. (You must first register online.)

☐ **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.

CARD NUMBER Exp. Date MMYY

☐ **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, PayPal Credit, or a Credit Card 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.

49-MOF 0715 WELLMARK

Credit Card Holder Signature/Date

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.

