

## **MAIL SERVICE** ORDER FORM

		Mail orde	r form to:		·
		CVS CA PO BOX	<b>II.I.I.I.I.I.I.I.I.I</b> I REMARK 94467 E IL 60094-4467	MTP STD	
Enter ID# if not s	hown or different from abo	ove			
Prescription Plan	Sponsor or Company Nam	e			
DIRECTIONS: Prin both sides of form	nt in <b>BLUE</b> or <b>BLACK</b> ink, u	ising CAPITAL letters. F	ill in ovals complet	tely (). Complet	e
	• escriptions: Mail your pre	scription(s) with this fo	m #ofnewn	rescriptions	:  ר
	Order by Web, phone, or w	•	•	- 	-
	<b>RVICE,</b> order refills at www				- I I
		w.caremark.com or can	the number on ye	Jurprescription	
benefit identificat					
benefit identificat SHIPPING ADDI	ion card. RESS IF NOT SHOWN OR	DIFFERENT FROM AB	OVE:		
benefit identificat			OVE:	/I Suffix (JR, SR)	
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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
	14 DEDCAR ADDEDIRIC & DRECONDEAR	O Easy open caps O Print in Spanish
	EAST MAMERIE FIRS	
· ·	NICKNAME     Gender: OM OF Date of Bit	
۰.	Your E-mail: Date	
here	Doctor's Last Name Doctor's First Name	Doctor's Phone #
fold	ALLERGY/HEALTH INFORMATION: COMPLETE ONLY IF O	CHANGED OR NOT PREVIOUSLY REPORTED
Please fold here	Allergies: () None () Aspirin () Cephalosporin () Codeii () Sulfa () Other:	ne () Erythromycin () Peanuts () Penicillin
Ple	Conditions: () Arthritis () Asthma () Diabetes () Ac	
1	0 High Blood Pressure 0 High Cholesterol 0 Migraine C 0 Other:	Osteoporosis O Prostate Issues O Thyroid
¥	and REDCON ORDEDING A RECONSTRAN	
		O Easy open caps O Print in Spanish
	MINERAL Gender: () M       F       Date of Bir         Your E-mail:	new prescription written:
	·	
	Doctor's Last Name Doctor's First Name ALLERGY/HEALTH INFORMATION: COMPLETE ONLY IF C	Doctor's Phone # CHANGED OR NOT PREVIOUSLY REPORTED
( )	Allergies: () None () Aspirin () Cephalosporin () Codeir () Sulfa () Other:	ne () Erythromycin () Peanuts () Penicillin
here	<u>Conditions:</u> () Arthritis () Asthma () Diabetes () Ac	id Reflux () Glaucoma () Heart Problem
Please fold here	O High Blood Pressure O High Cholesterol O Migraine O	Osteoporosis O Prostate Issues O Thyroid - 및
ase	O Other:	ease f
- Ple		O
Ţ	PAYMENT INFORMATION: Select one payment method	
•	<ul> <li>O Electronic Check Processing (Please pre-register at Carema</li> <li>O Bill Me Later<sup>®</sup> (Subject to credit approval. Please pre-register)</li> </ul>	· · · · · · · · · · · · · · · · · · ·
	O Credit/Debit Card (VISA, MasterCard, Discover or America	
	O Charge most recently used credit card	
	O Charge new/updated credit/debit card (provide in	fo below)
		Credit Card Holder Signature/Date
	0 Check/Money Order: Amount \$	REGULAR DELIVERY IS FREE
	Make check or money order payable to CVS Caremark and write your ID# on the check/money order. Returned checks	(Allow up to 10 days for delivery) Fill in oval for faster delivery:
	will be subject to a fee of up to \$40, depending on state law.	() 2nd Business Day \$17 per order
	The selected payment method (unless paying by check) will be charged for future orders, unless a different form of	() Next Business Day \$23 per order (Charges subject to change)
	payment is provided. It will also be charged for any outstanding balance due.	Faster delivery options only affect shipping time, not processing time and can only be sent to a
	O Fill in oval if you DO NOT want the selected payment	street address, not a P.O. box.
$\bigcirc$	method to be automatically charged for future orders.	