# MAIL SERVICE ORDER FORM

Please fold here

Mail order form to:

CAREMARK
PO BOX 3234
WILKES-BARRE, PA 18773-3234
WB STD

Enter ID # below if not shown or if different from above

Use this form to order NEW and/or REFILL mail service prescriptions. Please print in **BLUE** or **BLACK** INK using CAPITAL letters only. FOR FASTEST SERVICE: Order refills and verify benefit information at www.caremark.com or call the number on your benefit ID card

**Address Change/Shipping Information** (Complete **ONLY IF DIFFERENT** or not shown above)

Last Name

First Name

MI

Suffix (JR, SR)

Street Address

Apt./Suite#

○ **Use this address for this order only.**

City

State

Zip Code

Daytime Phone#:

Evening Phone#:

Prescription Plan Sponsor or Company Name

**NEW prescriptions - Mail Rx(s) with this form. REFILLS - Put refill sticker(s) below.**

**If space is needed for more refill labels, you may: 1) attach labels to a blank piece of paper and send with this order form, or 2) print a Refill Order Continuation Form at our Web site above, or 3) call Caremark Customer Care at the toll-free number above.**

Apply Caremark Refill Label here
or
write prescription number above

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or
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Apply Caremark Refill Label here
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write prescription number above

Unless otherwise directed, all prescriptions received on a single order form or in a single envelope may be shipped together in one package.
**Please turn over to provide additional information.**

## Fill in for up to two individuals who will receive prescriptions with this order.

**#1:**

◯ Easy open caps ◯ Print materials in Spanish

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

Alternate Name (Nickname) | Gender: ◯ M ◯ F | Date of Birth: __ - __ - ____

E-mail address: _____ Date new prescription(s) received from doctor: _____

Doctor / Prescriber's Last Name | Doctor / Prescriber's First Name | Doctor / Prescriber's Telephone # ___ - ___ - ____

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

**Allergies:** ◯ Aspirin ◯ Cephalosporin ◯ Codeine ◯ Erythromycin ◯ Peanuts ◯ Penicillin ◯ Sulfonamides/Sulfa
◯ None ◯ Other: _____

**Health Conditions:** ◯ Arthritis ◯ Asthma ◯ Diabetes ◯ GERD (Acid Reflux) ◯ Glaucoma ◯ Heart Condition
◯ High Blood Pressure ◯ High Cholesterol ◯ Migraine ◯ Osteoporosis ◯ Prostate Disorders ◯ Thyroid
◯ Other: _____

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**#2:**

◯ Easy open caps ◯ Print materials in Spanish

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

Alternate Name (Nickname) | Gender: ◯ M ◯ F | Date of Birth: __ - __ - ____

E-mail address: _____ Date new prescription(s) received from doctor: _____

Doctor / Prescriber's Last Name | Doctor / Prescriber's First Name | Doctor / Prescriber's Telephone # ___ - ___ - ____

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

**Allergies:** ◯ Aspirin ◯ Cephalosporin ◯ Codeine ◯ Erythromycin ◯ Peanuts ◯ Penicillin ◯ Sulfonamides/Sulfa
◯ None ◯ Other: _____

**Health Conditions:** ◯ Arthritis ◯ Asthma ◯ Diabetes ◯ GERD (Acid Reflux) ◯ Glaucoma ◯ Heart Condition
◯ High Blood Pressure ◯ High Cholesterol ◯ Migraine ◯ Osteoporosis ◯ Prostate Disorders ◯ Thyroid
◯ Other: _____

Please fold here

Comments/Special Instructions: _____

## Method of Payment/Shipping Information

Please make check or money order payable to **Caremark**. Include ID# on check/money order.

◯ Check ◯ Money Order/Cashier's Check ◯ Voucher/Coupon **Amt. of check/money order:** $ ___ . __

(Checks returned for insufficient funds will be subject to a processing fee of up to $40, depending on state law.)

OR pay by credit or debit card (preferred). We accept VISA®, MasterCard®, Discover®, and American Express®.

◯ **Fill in oval to charge most recently used credit card for this order and future orders for all individuals included in the family.**

◯ **Fill in oval to charge most recently used credit card for this order only.**

To add, change or update your credit card information, write in below:

Credit/Debit Card Number | Expiration Date __ - __

Credit Card Holder Signature _____ Date _____

Your credit card will be billed for prescription costs and expedited shipping (if requested).

**Standard delivery is FREE** (allow 10-14 days for delivery).
For faster delivery, mark the appropriate oval below.
Note: Expedited delivery only affects shipping time, not processing time of your order.

**Fill in oval for faster delivery:**

◯ 2nd Business Day = $13 (per order) ◯ Next Business Day = $18 (per order)

(Charges subject to change.)

By submitting this form you acknowledge that eligibility under the prescription benefit is subject to Plan verification and that you/your dependents do not have primary prescription coverage under any other plan.