MAIL SERVICE ORDER FORM

D MISHOE
2902 NW 62ND AVE
GAINESVILLE, FL 32653

yukimis@aol.com

14200577375750

Enter ID# if not shown or different from above

Prescription Plan Sponsor or Company Name

Mail order form to:

CAREMARK ATTRX
BOX 659541
SAN ANTONIO TX 78265-9541

Please fold here

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 1-800-378-8851.

SHIPPING ADDRESS IF NOT SHOWN OR DIFFERENT FROM 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 #: - -

Please fold here

REFILL INFORMATION:

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

1)____ 2)____ 3)____ 4)____

5)____ 6)____ 7)____ 8)____

* WEB *

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.

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

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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: ____

Please fold here

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: ____

Please fold here

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 card**
- ○ **Charge new/updated credit/debit card (provide information below)**

____ Exp.Date MMYY ____

Credit Card Holder Signature/Date ____

○ Check/Money Order: Amount $ ____ . ____

Make check or money order payable to CVS Caremark and write your identification number on it. Returned checks will be subject to a fee of up to $40, depending on state law.

The selected payment method (unless you sent a check or money order) will be charged for future orders unless a different form of payment is provided. It will also be charged for any outstanding balance due.

○ Fill in oval if you DO NOT want the selected payment method to be automatically charged for future orders.

REGULAR DELIVERY IS FREE
(Allow up 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.

* WEB *

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