MAIL SERVICE ORDER FORM

Mail order form to:
CVS CAREMARK SAT STD
PO BOX 659541
SAN ANTONIO TX 78265-9541

Enter ID# if not shown or different from above

Prescription Plan Sponsor or Company Name

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 the number on your prescription benefit identification card.

SHIPPING ADDRESS IF NOT SHOWN OR DIFFERENT FROM ABOVE:

Last Name

First Name

MI

Suffix (JR, SR)

Apt./Suite#

Use this address for this order only.

Street Address

City

State

ZIP Code

Daytime Phone #:

Evening Phone #:

REFILL INFORMATION:

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

1) 2) 3) 4) 

5) 6) 7) 8) 

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

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1st PERSON ORDERING A PRESCRIPTION

LAST NAME | FIRST NAME | SUFFIX (JR,SR)
NICKNAME | Gender: M F | Date of Birth: MM-DD-YYYY

Your E-mail: ____________________________

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 Sulfas Other: ____________________________

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

Date new prescription written: ____________

2nd PERSON ORDERING A PRESCRIPTION

LAST NAME | FIRST NAME | SUFFIX (JR,SR)
NICKNAME | Gender: M F | Date of Birth: MM-DD-YYYY

Your E-mail: ____________________________

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 Sulfas 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 at Caremark.com or call Customer Care)

Bill Me Later® (Subject to credit approval. Please pre-register at Caremark.com 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 info below)

Check/Money Order: Amount $ ____________

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

The selected payment method (unless paying by check) 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.