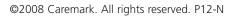


## MAIL SERVICE ORDER FORM

Enter ID# if not	<u>shown or different fron</u>	CVS PO B SAN	II.II.II.I.I.I.I.I.I.I.I.I.I.I.I.	SAT STD
Prescription Pla	n Sponsor or Company I	Name		
<b>DIRECTIONS:</b> P both sides of fo		nk, using CAPITAL letters	. Fill in ovals completely ( $lacksquare$	). Complete
		prescription(s) with this	form. # of new prescrip	tions:
	SERVICE, order refills at		below. <b># of refill prescrip</b> all the number on your pres	
SHIPPING ADI	DRESS IF NOT SHOWN	OR DIFFERENT FROM	ABOVE:	
Last Name		First Name	e MI Sut	ffix (JR, SR)
Street Address		A	pt./Suite# <b>Use this ad</b> for this ord	
City		St	ate ZIP Code	
Daytime Phone	#:	Evening Ph	one #:	
<b>REFILL INFORM</b>				
	5	our prescription num		
1)	2)	3)	4)	
5)	6)	7)	8)	





FILL IN FOR UP TO TWO PEOPLE WHO WILL REG	CEIVE PRESCRIPTIONS WITH THIS ORDER
<b>1st PERSON ORDERING A PRESCRIPTION</b>	🔘 Easy open caps \mid O Print in Spanish
LASTNAME	IRSTNAME Suffix (JR,SR)
NICKNAME Gender: () M () F Date	
Your E-mail:	Date new prescription written:
Doctor's Last Name Doctor's First Na	me Doctor's Phone #
ALLERGY/HEALTH INFORMATION: COMPLETE ON	
Allergies: () None () Aspirin () Cephalosporin ()	
O Sulfa O Other:   Conditions: O Arthritis	
O High Blood Pressure O High Cholesterol O Migra	
O Other:	
2nd PERSON ORDERING A PRESCRIPTION	O Easy open caps O Print in Spanish
LASTNAME	IRSTNAME Suffix (JR,SR)
NICKNAME Gender: () M () F Date	e of Birth: MM-DD-YYYY
Your E-mail:	Date new prescription written:
Doctor's Last Name Doctor's First Na	me Doctor's Phone #
ALLERGY/HEALTH INFORMATION: COMPLETE ON	LY IF CHANGED OR NOT PREVIOUSLY REPORTED
Allergies:   O   None   O   Aspirin   O   Cephalosporin   O     O   Sulfa   O   Other:	
<u>Conditions:</u> O Arthritis O Asthma O Diabetes	
O High Blood Pressure O High Cholesterol O Migra	
O Other:	
Special Instructions:	
<b>PAYMENT INFORMATION: Select one payment n</b>	nethod below.
O Electronic Check Processing (Please pre-register at a	Caremark.com or call Customer Care)
) Bill Me Later <sup>®</sup> (Subject to credit approval. Please pre-	register at Caremark.com or call Customer Care)
O Credit/Debit Card (VISA, MasterCard, Discover or A	merican Express)
O Charge most recently used credit card	
O Charge new/updated credit/debit card (prov	vide info below)
CREDIT CARD# Exp. M	Credit Card Holder Signature/Date
O Check/Money Order: Amount \$	REGULAR DELIVERY IS FREE
Make check or money order payable to CVS Caremark write your ID# on the check/money order. Returned ch	
will be subject to a fee of up to \$40, depending on st	ate () 2nd Business Day \$17 per order
law. The selected payment method (unless paying by check	() will () Next Business Day \$23 per order (Charges subject to change)
be charged for future orders, unless a different form c payment is provided. It will also be charged for any	Faster delivery options only affect shipping time
outstanding balance due.	not processing time and can only be sent to a street address, not a P.O. box.
Fill in oval if you DO NOT want the selected paymen method to be automatically charged for future ord	
SAT-MOF-1208	