Please fold here →

	Mail this form to:	
Member ID # (if not shown or if different from above)		
Prescription Plan Sponsor or Company Name		
Instructions: Please use blue or black ink and print in capital letters. Fill in both sides of this form. New Prescriptions - Mail your new prescriptions with this form. Number of New prescriptions:		
Refills - Order by Web, phone, or write in Rx number(TO RECEIVE YOUR ORDER SOONER request refil or call the toll-free number on your member ID card.	,	
A Shipping Address. To ship to an address different	t from the one printed above, enter the changes here.	
Last Name Street Address	First Name MI Suffix (JR, SR) Apt./Suite # Use shipping address for this order only.	
City Daytime Phone #:	State ZIP Code Evening Phone #:	
B Refills. To order mail service refills, enter your prescription number(s) here.		
1), 2),	3)4)	
5)_ 6)_	7)8)	
CVS Caremark wants to provide you with high qualit this, we will substitute equivalent generic medicines do not want us to substitute generics, please provide	y medicines at the best possible price. In order to do for brand name medicines whenever possible. If you	

We may package all of these prescriptions together unless you tell us not to.

All claims for prescriptions submitted to CVS Caremark Mail Service Pharmacy using this form will be submitted to your prescription benefit plan for payment. If you do not want them submitted to your plan, do not use this form. You may call Customer Care to make alternate arrangements for submission of your order and payment.



Last Name First Name	Spanish forms and label
Gender: M F Date of birth MM-DD-YYY E-mail address: Date of birth MM-DD-YYY	h:
Doctor's last name Doctor's first name	Doctor's phone #
Tell us about new health information for 1st person if never pr Allergies: None Aspirin Cephalosporin Codeine Sulfa Other:	
Medical conditions: Arthritis Asthma Diabetes Acid High blood pressure High cholesterol Migraine Other:	
Second person with a refill or new prescription.) Spanish forms and label
Last Name N C K N A M E Gender: M F MM-DD-YYY	Suffix (JR,SR)
	te new prescription written:
Doctor's last name Doctor's first name	Doctor's phone #
	_
Other: Special instructions:	
How would you like to pay for this order? (If your copay is \$0, y	you do not need to provide payment information
Tiow would you like to pay for this order: (if your copay is ψο,)	• • •
 Electronic check. Pay from your bank account. (You must fir 	st register online or call Customer Care.)
 Electronic check. Pay from your bank account. (You must fin Credit or debit card. (VISA®, MasterCard®, Discover®, or Am Use your card on file. 	,
 Credit or debit card. (VISA®, MasterCard®, Discover®, or Am Use your card on file. Use a new card or update your card's expiration date. 	,
Credit or debit card. (VISA®, MasterCard®, Discover®, or Am Use your card on file. Use a new card or update your card's expiration date. Exp.Date MMYY	,
 Credit or debit card. (VISA®, MasterCard®, Discover®, or Am Use your card on file. Use a new card or update your card's expiration date. Exp.Date 	erican Express®) Credit card holder signature/Date Regular delivery is free and takes up to 5 days after your order is processed. If you want faster delivery, choose: 2nd business day (\$17) Faster delivery can only be sent to a
Credit or debit card. (VISA®, MasterCard®, Discover®, or Am Use your card on file. Use a new card or update your card's expiration date. Exp.Date MMYY Check or money order. Amount: \$ • Make check or money order payable to CVS Caremark. • Write your prescription benefit ID number on your check or money order.	erican Express®) Credit card holder signature/Date Regular delivery is free and takes up to 5 days after your order is processed. If you want faster delivery, choose: 2nd business day (\$17) Faster delivery can only be