CAREMARK Mail Service Order Form

BC 27131

Mail this form to:

CAREMARK
PO BOX 94467
PALATINE, IL 60094-4467

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

Prescription Plan Sponsor or Company Name

Please fold here

Please use **blue or black ink, capital letters,** and 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(s) below. Number of **Refill** prescriptions:

FOR FASTEST SERVICE, order refills at www.caremark.com or call the number on your prescription benefit ID Card.

A Shipping Address. To ship to an address different from the one printed above, please make changes here.

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

Street Name | Apt./Suite #

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

City | State | ZIP Code

Daytime Phone #: - - Evening Phone #: - -

B Refills. To order mail service refills, enter your prescription number(s) here.

1)_____ 2)_____ 3)_____ 4)_____

5)_____ 6)_____ 7)_____ 8)_____

Generic Medicines: Choosing generics is an excellent way to save money. With generics, you get the same quality as brand-name medicines, at a lower cost. To help you save money, Caremark will substitute generic medicines for brand-name medicines whenever possible. If you have been prescribed a brand-name medicine with a generic equivalent and you DO NOT want us to substitute the generic medicine, please provide specific instructions, including the names of your brand-name medicines, in the Comments/Special Instructions section of this form. Your health plan has chosen Caremark, an independent company, to administer its Mail Service Prescription program. For more information, visit your health plan's Web site as listed on your member ID card, or call Caremark at 1-888-963-7290.

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

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C **Tell us about the people getting prescriptions.** If there are more than two people, please complete another form.

1st person with a refill or new prescription. This person needs: ○ Easy open caps ○ Spanish forms and labels

LAST NAME _____ FIRST NAME _____ M 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 # _____

Tell us about **new** allergies or health information for this person. Only tell us about **new** information.

Allergies: ○ None ○ Aspirin ○ Cephalosporin ○ Codeine ○ Erythromycin ○ Peanuts ○ Penicillin ○ Sulfa ○ Other: _____

Health Information: ○ Arthritis ○ Asthma ○ Diabetes ○ Acid Reflux ○ Glaucoma ○ Heart Problem ○ High Blood Pressure ○ High Cholesterol ○ Migraine ○ Osteoporosis ○ Prostate Issues ○ Thyroid ○ Other: _____

2nd person with a refill or new prescription. This person needs: ○ Easy open caps ○ Spanish forms and labels

LAST NAME _____ FIRST NAME _____ M 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 # _____

Tell us about **new** allergies or health information for this person. Only tell us about **new** information.

Allergies: ○ None ○ Aspirin ○ Cephalosporin ○ Codeine ○ Erythromycin ○ Peanuts ○ Penicillin ○ Sulfa ○ Other: _____

Health Information: ○ Arthritis ○ Asthma ○ Diabetes ○ Acid Reflux ○ Glaucoma ○ Heart Problem ○ High Blood Pressure ○ High Cholesterol ○ Migraine ○ Osteoporosis ○ Prostate Issues ○ Thyroid ○ Other: _____

Please fold here →

Please fold here →

D **Special Instructions:** _____

E **How would you like to pay for this order?** Fill in the oval to choose a payment.

○ **Electronic Check.** Pay from your bank account. First time users register online or call Customer Care.

○ **Bill Me Later®.** Works like a credit card. First time users register online or call Customer Care.

○ **Credit or Debit Card.** (VISA®, MasterCard®, Discover®, or American Express®)

- ○ Fill in this oval to use your card on file.
- ○ Fill in this oval to use a new card or to update your card expiration date.

CARD NUMBER _____ Exp. Date MMYY

Credit Card Holder Signature/Date

○ **Check or Money Order.** Amount: $ ____ . __

- Make check or money order out to Caremark.
- Write your prescription benefit ID number on your check or money order.
- If your check is returned, we will charge you up to $40.

Payment for Balance Due and Future Orders: If you chose Electronic Check, Bill Me Later®, or a Credit or Debit Card, we will also use it to pay for any balance that you owe and for future orders.

○ Fill in this oval if you **DO NOT** want to use this payment method for future orders.

Regular delivery is free and will take 7 to 10 days from the day you send this form.

If you want faster delivery, choose:

○ **2nd Business Day ($17)**

○ **Next Business Day ($23)**

Business days are only Monday-Friday

- Faster delivery charges may change.
- Faster delivery is for shipping time, not processing time.
- Faster delivery can only be sent to a street address, not a PO box.