Mail Service Order Form instructions

The CVS Caremark[®] Mail Service Order Form may be used to order new prescriptions or to refill existing prescriptions. For the fastest service on refills, go to **Caremark.com** or call us at 1-866-362-4009.

- Please PRINT in CAPITAL letters using BLACK or BLUE ink only.
- Fill in the applicable ovals completely, like this:
- Fill in each box with the appropriate information including last name, first name, nickname, date of birth, and credit card information.
- Please note: Some boxes may already have letters inside them. For example:

Please write in your personal information in each box directly on top of these letters. The pre-printed letters will not obstruct your written information.

Mail this completed form along with the doctor's signed and dated prescription(s), if you are ordering new
prescriptions, and your payment to CVS Caremark in the envelope provided or to the address located at the
top of the order form.

If the correct name and shipping address are printed here, then you don't need to enter your name and shipping ···. address in Section A.

CVS caremark[®]

Enter your member ID which ... can be found on your member ID card if not shown above.

Enter the name of your …… prescription insurance plan or your employer name.

If the correct name and shipping address are preprinted in the top left section of this form, leave Section A blank. If no address is preprinted or if the pre-printed address is not correct, enter the address you want your prescription(s) to be mailed to.

In Section B, enter the prescription number(s) you want us to refill. The prescription number is found on the prescription label on your medication bottle.

Mail Service Order Form		
Member ID # ((f not shown or if different from above)	Mail this form to: Ideal International Inte	
Prescription Plan Sponsor or Company Name Instructions: Plasse use blue or black ink and print in capital letters. Fill in both sides of this form. New Prescriptions – Mail your new prescriptions multitude for the prescriptions. Pdfills – Order by Web, phone, or write in Rx number(s) below. Number of Refill prescriptions: TO RECEIVE YOUR ORDER SOQUER request refills or new prescriptions online at www.caremark.com or call us at 168-3632-409.		
A Shipping Address. To ship to an address different Last Name Street Address City Daytime Phone #: Refills. To order mail service refills, enter your pre-	First Name MI Suffix (JR, SF Apt/Suite # Use shipping address State ZIP Orde Evening Phone #:	
2)6) 5)6)6 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 "Special Instructions" section of this form.	3) 4) 7) 8) y medicines at the best possible price. In order to do for brand name medicines whenever possible. If you specific instructions, including drug names, in the	

Mail your order form and prescription(s) to this address. If you are using a window envelope, be sure the address shows through the window.

•Enter the number of new prescriptions you are sending in with this form.

. **Enter** the number of refill prescriptions you are requesting (Note: please write the refill prescription number(s) in Section B). Even if you have taken this medication in the past, if your doctor gave you a new written prescription, please count it in the "Number of New prescriptions" box.

• If the address entered in Section A is a one-time address to be used for this order only, fill in the oval.

• Enter your daytime and evening phone numbers (if they are different). We need this so we can contact you if we have questions about your order. In Section C, enter the information for the person(s) you are ordering prescriptions for.

Enter your email address. We will email you with information on your ···. prescription, if necessary.

Fill in the oval before the name of any medications listed that you may be allergic to. If you are not allergic to any medications, fill in the oval before "None". If you are allergic to a medication that is not listed, fill in the "Other" oval and write the name of the medication you are allergic to on the line.

In Section D, write any special instructions about your prescription order. You can write things like: "I only want the brand-name version of Lipitor", "Hold my prescription until I call to request it", "I need easy open caps", etc.

In Section E, tell us how you want to pay for your order.
Fill in the oval before either: electronic check, credit or debit card (including HSA/
FSA card), or check or money order. If you've ordered from us before and you have a credit card on file, fill in the oval indicating you want us to use the card on file. If you are providing a new credit card number or need to update the expiration date, fill in the card number and expiration date.

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	c	Tell us about the people ordering prescriptions. If there are more	e than two people, please complete another form.
	\odot	First person with a refill or new prescription.	OSpanish forms and labels
•		LAST NAME FIRST NICKNAME Gender: OM OF Date of birt	NAME M Suffix h: MM-DD-YYYY Image: Comparison of the second
			te new prescription written:
•	•	Doctor's last name Doctor's first name	Doctor's phone #
		Tell us about new health information for 1st person if never pro Allergies: O None O Aspirin O Cephalosporin O Codeine O Sulfa O Other:	
		Medical conditions: () Arthritis () Asthma () Diabetes () Acid () High blood pressure () High cholesterol () Migraine () (() Other:	reflux O Glaucoma O Heart problem Osteoporosis O Postate issues O Thyroid
		Second person with a refill or new prescription.	() Spanish forms and labels
	ere 🔸		
LASTNAME Gender () M () F Date of birth: Wol- E-mail address: Date new pre- Doctor's list name Doctor's list name Tell us about new health information for Apreson if never provided or Tell us about new health information for Apreson if never provided or			Image: Second
	ease	Doctor's last name Doctor's first name	Doctor's phone #
Tell us about new health information for 2nd person if never provided or if cl Allergies: O None O Aspirin O Cephalosporin O Codeine O Erythrom O Other			ovided or it changed.
	D	Special instructions:	··.
	-	Special instructions.	··.
How would you like to pay for this order? (If your copay is \$0, you do not need to provide payment information.)			
	0 Electronic check. Pay from your bank account. (You must first register online or call Customer Care.)		
Credit or debit card. (VISA®, MasterCard®, Discover®, or American Express®)		arican Express®)	
	O Use your card on file.		
	Please fold her	O Use a new card or update your card's expiration date.	arican Express ^e)
	leas	O Check or money order. Amount:	Credit card holder spature/Date
	a.	Make check or money order payable to CVS Caremark. Write your prescription benefit ID number on your	Regular delivery is free and takes up to 5 days after your order is processed. If you want faster delivery, choose:
		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 choose 	O and business day (\$17) can only be Sent to a sent to a
		electronic check or a credit or debit card, we will use it to pay for any balance due and for future orders unless you provide another form of payment.	Expected processing time from receipt of this form: Reflis: 1-2 days Newifenewed prescriptions: Within 5 days unless additional information is needed from your doctor (Charters subject to chance)
		Fill in this oval if you DO NOT want us to use this payment method for future orders.	
	\odot	49-MOF 0224 Pacific Source	

Fill in the oval if you want to receive your prescription label and order documents in Spanish.

Enter the date your doctor wrote the prescription.

. **Enter** the information for the doctor who wrote your prescription. If you are sending more than one prescription and they are written by different doctors, enter the doctor information for one of the prescriptions.

Fill in the ovals before any of these medical conditions you may have. If you have a condition that is not listed, fill in the "Other" oval and write the name of your medical condition on the line.

• If you are ordering prescriptions for more than one person, fill in the information for the second person in this section.

• If you are paying by credit card, sign your name and write the date here.

Regular delivery is provided at no cost. If you want to pay for a faster delivery method, fill in the oval to tell us if you want 2nd day or next day delivery.

For information or questions, visit **Caremark.com** or call us at 1-866-362-4009.

