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		Mail this for	m to:
		CVS (PO B	ı
Member ID # (if no	ot shown or if different fr	rom above)	
Prescription Plan	Sponsor or Company N	Name	
Instructions:	or black ink and print	<b>in capital letters.</b> Fill in <b>bo</b>	oth sides of this form
	•	scriptions with this form.	Number of <b>New</b> prescriptions:
TO RECEIVE YO	Web, phone, or write in UR ORDER SOONER anumber on your mem	request refills or new pres	Number of <b>Refill</b> prescriptions: criptions online at www.caremark.com
A Shipping Addr	ess. To ship to an add	ress different from the one	printed above, enter the changes here.
Last Name		First Name	MI Suffix (JR, SR)
Street Address		Al	pt./Suite # Use shipping address for this order only.
City		Si	tate ZIP Code
Daytime Phone #:	-	Evening Pho	one #:
B Refills. To orde	er mail service refills, e	nter your prescription numb	per(s) here.
1)	2)	3)	4)
5)	6)	7)	8)
this, we will subside not want us to	titute equivalent generi	c medicines for brand name lease provide specific instru	t the best possible price. In order to do e medicines whenever possible. If you uctions, including drug names, in the

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  MI Suffix
NICKNAME Date of birt	(JR,SR)
Gender: () M () F MM-DD-YYY	
E-mail address: Da	ate 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 proceed the Allergies:  Allergies:  Outher:	
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
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N I C K N A M E Gondor: M O E Date of birth	h·
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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.	rst register online or call Customer Care.)  derican Express®)  Credit card holder signature/Date  Regular delivery is free and takes up to 5 days after your order is processed.
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<ul> <li>Electronic check. Pay from your bank account. (You must find the count) Credit or debit card. (VISA®, MasterCard®, Discover®, or Ame Use your card on file.</li> <li>Use a new card or update your card's expiration date.</li> <li>Exp.Date MMYY</li> <li>Check or money order. Amount: \$</li></ul>	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)  Next business day (\$23)  Expected processing time from receipt of this form Refills: 1-2 days New/renewed prescriptions: Within 5 days unless additional