


	<p><b>Mail this form to:</b></p> <p style="text-align: center;">                   CVS Caremark                  PO BOX 94467                  PALATINE, IL 60094-4467             </p>
Member ID # (if not shown or if different from above) <input style="width:100%; height: 20px;" type="text"/>	
Prescription Plan Sponsor or Company Name <input style="width:100%; height: 20px;" type="text"/>	

**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(s) below.

Number of **Refill** prescriptions:

**TO RECEIVE YOUR ORDER SOONER** request refills or new prescriptions online at [www.caremark.com](http://www.caremark.com) or call the toll-free number on your member ID card.

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

Last Name <input style="width:100%; height: 20px;" type="text"/>	First Name <input style="width:100%; height: 20px;" type="text"/>	MI <input style="width: 20px; height: 20px;" type="text"/>	Suffix (JR, SR) <input style="width:100%; height: 20px;" type="text"/>
Street Address <input style="width:100%; height: 20px;" type="text"/>	Apt./Suite # <input style="width: 40px; height: 20px;" type="text"/>	<input type="radio"/> <b>Use shipping address for this order only.</b>	
City <input style="width:100%; height: 20px;" type="text"/>	State <input style="width: 20px; height: 20px;" type="text"/>	ZIP Code <input style="width: 40px; height: 20px;" type="text"/> - <input style="width: 40px; height: 20px;" type="text"/>	
Daytime Phone #: <input style="width: 20px; height: 20px;" type="text"/> - <input style="width: 20px; height: 20px;" type="text"/> - <input style="width: 40px; height: 20px;" type="text"/>	Evening Phone #: <input style="width: 20px; height: 20px;" type="text"/> - <input style="width: 20px; height: 20px;" type="text"/> - <input style="width: 40px; height: 20px;" type="text"/>		

**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 quality medicines at the best possible price. In order to do this, we will substitute equivalent generic medicines for brand name medicines whenever possible. If you do not want us to substitute generics, please provide specific instructions, including drug names, in the "Special Instructions" section of this form.

Please fold here →

Please fold here →

Please fold here →

Please fold here →

\* WEB \*

\* WEB \*

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.



