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	Mail this form to:
	լիդրժեսկրդորդիկիկիկիկիկիկիկիկիկիկիկի CVS Caremark PO BOX 659541 SAN ANTONIO, TX 78265-9541
Member ID # (if not shown or if different from above) W	
Prescription Plan Sponsor or Company Name	
Instructions: Please use blue or black ink and print in capital let	tters. Fill in both sides of this form.
New Prescriptions - Mail your new prescriptions with	n this form. Number of New prescriptions:
Refills - Order by Web, phone, or write in Rx number(s TO RECEIVE YOUR ORDER SOONER request refill website or phone 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	First Name MI Suffix (JR, SR)
Street Address	Apt./Suite # Use shipping 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)
We want to provide you with high quality medicines a substitute equivalent generic medicines for brand na	

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.



First person with a refill or new prescription.	○ Spanish forms and labels
Last Name First Name	Suffix (JR,SR)
Nickname Date of bir MM-DD-YY	rth:
	Pate 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 particles: Allergies: None Other:	provided or if changed. ne
Medical conditions: Arthritis Asthma Diabetes Ac High blood pressure High cholesterol Migraine Other:	Osteoporosis O Prostate issues O Thyroid
Second person with a refill or new prescription.	○ Spanish forms and labels
Last Name Nickname Gender: M F Date of bir MM-DD-YY	MI Suffix (JR,SR)
	Pate new prescription written:
Doctor's last name Doctor's first name	Doctor's phone #
Osulfa Other:	ne
○ High blood pressure ○ High cholesterol ○ Migraine ○	•
	Osteoporosis O Prostate issues O Thyroid
○ High blood pressure○ Other:	Osteoporosis O Prostate issues O Thyroid , you do not need to provide payment information.)
O High blood pressure O High cholesterol O Migraine O Other: Special instructions: How would you like to pay for this order? (If your copay is \$0,	Osteoporosis O Prostate issues O Thyroid you do not need to provide payment information.) first register online or call Customer Care.)
High blood pressure High cholesterol Migraine Other: Special instructions: How would you like to pay for this order? (If your copay is \$0, Electronic check. Pay from your bank account. (You must for the control of th	Osteoporosis O Prostate issues O Thyroid you do not need to provide payment information.) first register online or call Customer Care.)
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High blood pressure High cholesterol Migraine Other: Special instructions: How would you like to pay for this order? (If your copay is \$0, Electronic check. Pay from your bank account. (You must for the continuous cont	Osteoporosis O Prostate issues O Thyroid you do not need to provide payment information.) first register online or call Customer Care.) merican 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: O 2nd business day (\$17) Next business day (\$23)