MAIL SERVICE ORDER FORM

Mail order form to:

CAREMARK
PO BOX 659541
SAN ANTONIO, TX 78265-9541

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

Use this form to order NEW and/or REFILL mail service prescriptions. Please print in BLUE or BLACK INK using CAPITAL letters only. FOR FASTEST SERVICE: Order refills and verify benefit information at www.caremark.com or call the number on your prescription benefit identification card.

Address Change/Shipping Information (Complete ONLY IF DIFFERENT or not shown above)

Last Name
First Name
MI Suffix (JR, SR)
Apt./Suite#
City
State Zip Code

Use this address for this order only.

Daytime Phone#: 
Evening Phone#: 

Prescription Plan Sponsor or Company Name

NEW prescriptions - Mail Rx(s) with this form. REFILLS - Put refill sticker(s) below.

If space is needed for more refill labels, you may: 1) attach labels to a blank piece of paper and send with this order form, or 2) print a Refill Order Continuation Form at our Web site above, or 3) call Caremark Customer Care number on your prescription benefit identification card.

Apply Caremark Refill Label here
or write prescription number above

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or write prescription number above

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or write prescription number above

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or write prescription number above

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### Fill in for up to two individuals who will receive prescriptions with this order.

**#1:**

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>MI</th>
<th>Suffix (JR, SR)</th>
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</thead>
<tbody>
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<table>
<thead>
<tr>
<th>Alternate Name (Nickname)</th>
<th>Gender</th>
<th>Date of Birth: MM-DD-YYYY</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td></td>
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</tbody>
</table>

E-mail Address: 

Doctor / Prescriber’s Last Name: 

Doctor / Prescriber’s First Name: 

Doctor / Prescriber’s Telephone #: 

#### COMPLETE ALLERGY/HEALTH INFORMATION ONLY IF CHANGED OR NOT PREVIOUSLY REPORTED

**Allergies:**  
- Aspirin  
- Cephalosporin  
- Codeine  
- Erythromycin  
- Peanuts  
- Penicillin  
- Sulfonamides/Sulfa

- None  
- Other:

**Health Conditions:**  
- Arthritis  
- Asthma  
- Diabetes  
- GERD (Acid Reflux)  
- Glaucoma  
- Heart Condition  
- High Blood Pressure  
- High Cholesterol  
- Migraine  
- Osteoporosis  
- Prostate Disorders  
- Thyroid

- None  
- Other:

**Other:**

Comments/Special Instructions:

- Date of Birth: MM-DD-YYYY
- Gender: M / F
- Suffix (JR, SR)
- First Name
- Last Name
- Alternate Name (Nickname)
- Doctor / Prescriber’s Last Name
- Doctor / Prescriber’s First Name
- Doctor / Prescriber’s Telephone #

**#2:**

<table>
<thead>
<tr>
<th>Last Name</th>
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- Prostate Disorders  
- Thyroid

- None  
- Other:

**Other:**

Comments/Special Instructions:

- Date of Birth: MM-DD-YYYY
- Gender: M / F
- Suffix (JR, SR)
- First Name
- Last Name
- Alternate Name (Nickname)
- Doctor / Prescriber’s Last Name
- Doctor / Prescriber’s First Name
- Doctor / Prescriber’s Telephone #

### Method of Payment/Shipping Information

Please make check or money order payable to **Caremark**. Include ID# on check/money order.

- [ ] Check  
- [ ] Money Order/Cashier’s Check  
- [ ] Voucher/Coupon  

**Amt. of check/money order:** $______

OR pay by credit or debit card (preferred). We accept VISA®, MasterCard®, Discover®, and American Express®.

- [ ] Fill in oval to charge most recently used credit card for this order and future orders for all individuals included in the family.
- [ ] Fill in oval to charge most recently used credit card for this order only.

To add, change or update your credit card information, write in below:

<table>
<thead>
<tr>
<th>Credit/Debit Card Number</th>
<th>Expiration Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

Credit Card Holder Signature: 

Date: 

Your credit card will be billed for prescription costs and expedited shipping (if requested).

**Regular delivery is FREE** (allow up to 10 days for delivery). For faster delivery, mark the appropriate oval below.

- [ ] 2nd Business Day = $13 (per order)  
- [ ] Next Business Day = $18 (per order)

(Charges subject to change.)

By submitting this form you acknowledge that eligibility under the prescription benefit is subject to plan verification and that you/your dependents do not have primary prescription coverage under any other plan.