


CVS/caremark™

Mail Service Order Form

PM 324 GROUP JOHN Q SAMPLE 9501 E. Shea Blvd SCOTTSDALE, AZ 85260	Mail this form to:  CVS/caremark PO BOX 659541 SAN ANTONIO, TX 78265-9541
123456789 Member ID # (if not shown or if different from above)	
Prescription Plan Sponsor or Company Name	

Please fold here →

Please fold here →

Instructions:

Please use **blue or black ink, capital letters**, and 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 or call toll-free 1-844-432-0696.

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

Last Name	First Name	MI	Suffix (JR, SR)
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>

Street Address	Apt./Suite #
<input style="width: 100%;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>

Use shipping address for this order only.

City	State	ZIP Code
<input style="width: 100%;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/>	<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"/>
--	--

Please fold here →

Please fold here →

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.

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.

©2014 Caremark. All rights reserved. P13-N



