

	Mail this form to:
	-
Member ID # (if not shown or if different from above)	
Prescription Plan Sponsor or Company Name	
Instructions:	
Please use blue or black ink and print in capital le	
New Prescriptions – Mail your new prescriptions wit	
Refills – Order by Web, phone, or write in Rx numbers TO RECEIVE YOUR ORDER SOONER request refil	
or call the toll-free 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

B Refills. To order mail service refills, enter your prescription number(s) here.

1)	2)	3)	4)

Evening Phone #:

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.





Daytime Phone #:

	cription.			() Spanish to	orms and labels
LASTNAME	F	IRST	NAME	M Sι (JR	ıffix ,SR)
NICKNAME	[Date of birth:	MM-DD-	YYYY	
E-mail address:		Date r	ew prescription	n written:	
Doctor's last name	Doctor's first na	ame	Doctor	s phone #	
Tell us about new health information Allergies: None Aspirin C Sulfa Other:	ephalosporin (Oodeine	_		s () Penicillin
Medical conditions: () Arthritis () Asth () High blood pressure () High cho () Other:	lesterol () Migr	raine () Ost			Heart problemes (Thyroid
Second person with a refill or new pre	escription.			O Spanish fo	orms and labels
LASTNAME	F	IRST	NAME		offix (SR)
NICKNAME	[Date of birth:	MM-DD-	YYYY	
E-mail address:		Date r	ew prescription	n written:	
Doctor's last name	Doctor's first na	ame		s phone #	
Tell us about new health information	for 2nd person	if never provi		-	
Medical conditions: Arthritis Asth High blood pressure High cho Other:	lesterol () Migr		T	•	Heart problemes (Thyroid
Special instructions:					
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