CAREMARK
It all starts with care®

MAIL SERVICE ORDER FORM

Please print in **BLUE** or **BLACK INK** numbers and letters as shown in the example to the right: 1 2 3 4 A B C D

Order refills and verify benefit information at **www.caremark.com** or call Caremark at:

1-800-378-7040

CAREMARK CVTY
PO BOX 659574
SAN ANTONIO, TX 78265-9574

Please fold here

STEP 1 – ORDER SUMMARY

How many prescriptions? New ☐ + Refill ☐ = Total ☐

Primary Participant Information

Primary Participant ID Number:

Plan Sponsor:

Complete below if the information to the left is incorrect or incomplete

Primary Participant ID **(required if not shown to the left)**

Plan Sponsor or company name

STEP 2 – ADDRESS (Complete **ONLY IF DIFFERENT** than the information above)

Last Name | First Name | MI | Suffix (Sr, Jr)

Street Address | Number | ☐ Apt. ☐ Suite

City | State | Zip Code

This is a ☐ one time address or ☐ permanent address

Email address: _____

Daytime phone #: ☐☐☐-☐☐☐-☐☐☐☐

Evening phone #: ☐☐☐-☐☐☐-☐☐☐☐

STEP 3 – METHOD OF PAYMENT (Complete if applicable)

Please make check or money order payable to Caremark Inc. (Include ID# on all checks and money orders)

☐ Check ☐ Money Order or Cashier's Check ☐ Voucher/Coupon **Total payment enclosed:** (excluding credit card payments) $ ☐☐☐.☐☐

☐ Visa® ☐ Discover® ☐ MasterCard® ☐ American Express®

Credit/Debit Card Number | Expiration Date ☐☐-☐☐

Credit Card Holder Signature: _____ Date: _____

By checking the box below you are designating the last card # previously provided to be used on this current order. For future orders, this box must be checked each time you submit an order that you want to be charged to your Credit Card on File. If your Credit Card on File has expired then the card # and new expiration date must be shown on this form.If you use a credit/debit card, the charge to the card will reflect the payment designated by your plan.

Credit Card on File ☐

Important Information: Unless otherwise directed, all prescriptions received on a single order or in a single envelope will be shipped together in one package.

Please turn over to provide your prescription information.

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Please visit www.caremark.com

STEP 4 – PRESCRIPTION INFORMATION

Participant 1 Information: Gender: ☐ M ☐ F Date of Birth: MM-DD-YYYY

Last Name | First Name | MI | Suffix (Sr, Jr)

Alternate Name (Nickname)

Participant is enrolled, process eligible Rx's through Medicare ☐ (check here)

Check boxes below ONLY if not previously reported.

Relationship to participant:
- ☐ Self
- ☐ Spouse
- ☐ Daughter
- ☐ Son
- ☐ Sponsored Dependent
- ☐ Widowed
- ☐ Full Time Student
- ☐ Other

Drug Allergies:
- ☐ None [10]
- ☐ Aspirin [4]
- ☐ Codeine [97]
- ☐ Cephalosporin [8]
- ☐ Erythromycin [72]
- ☐ Penicillin [31]
- ☐ Sulfonamides/Sulfa [40]
- ☐ Other _____

Health Conditions:
- ☐ Arthritis [716.9]
- ☐ Asthma [493]
- ☐ Diabetes [250]
- ☐ GERD [530.11]
- ☐ Glaucoma [365]
- ☐ Thyroid [246]
- ☐ Heart Condition [429]
- ☐ High Blood Pressure [401]
- ☐ High Cholesterol [272.4]
- ☐ Migraine [346.9]
- ☐ Osteoporosis [733]
- ☐ Prostate Disorders [601]
- ☐ Other _____

☐ **PLEASE INCLUDE EASY-OPEN CAPS** (All orders are shipped with safety caps)

Doctor / Prescriber's Last Name | Doctor / Prescriber's First Name | Doctor / Prescriber's Telephone # ___-___-____

Please fold here

Participant 2 Information: Gender: ☐ M ☐ F Date of Birth: MM-DD-YYYY

Last Name | First Name | MI | Suffix (Sr, Jr)

Alternate Name (Nickname)

Participant is enrolled, process eligible Rx's through Medicare ☐ (check here)

Check boxes below ONLY if not previously reported.

Relationship to participant:
- ☐ Self
- ☐ Spouse
- ☐ Daughter
- ☐ Son
- ☐ Sponsored Dependent
- ☐ Widowed
- ☐ Full Time Student
- ☐ Other

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- ☐ Osteoporosis [733]
- ☐ Prostate Disorders [601]
- ☐ Other _____

☐ **PLEASE INCLUDE EASY-OPEN CAPS** (All orders are shipped with safety caps)

Doctor / Prescriber's Last Name | Doctor / Prescriber's First Name | Doctor / Prescriber's Telephone # ___-___-____

Please fold here

STEP 5 – REFILL INFORMATION

Apply Caremark Refill Label here

or

write prescription number above

Apply Caremark Refill Label here

or

write prescription number above

Apply Caremark Refill Label here

or

write prescription number above

Apply Caremark Refill Label here

or

write prescription number above

By submitting this completed form to Caremark, you acknowledge that you and/or your dependents' eligibility to participate under the prescription benefit administered by Caremark is subject to verification by the Plan and that you and/or your dependents do not have primary prescription coverage under any other group Plan.