


## Mail Service Order Form

	<b>Mail this form to:</b>   CVS/caremark PO BOX 94467 PALATINE, IL 60094-4467
Member ID # (if not shown or if different from above) <input type="text"/>	
Prescription Plan Sponsor or Company Name <input type="text"/>	

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**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](http://www.caremark.com) or call the toll-free number on your member ID card.

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

Last Name <input type="text"/>	First Name <input type="text"/>	MI <input type="text"/>	Suffix (JR, SR) <input type="text"/>
Street Address <input type="text"/>	Apt./Suite # <input type="text"/>	<input type="radio"/> Use shipping address for this order only.	
City <input type="text"/>	State <input type="text"/>	ZIP Code <input type="text"/> - <input type="text"/>	
Daytime Phone #: <input type="text"/> - <input type="text"/> - <input type="text"/>	Evening Phone #: <input type="text"/> - <input type="text"/> - <input type="text"/>		

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

1) _____	2) _____	3) _____	4) _____
5) _____	6) _____	7) _____	8) _____

\* WEB \*

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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.

