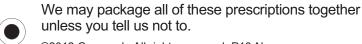
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	Mail this form to:
	I.IIIIIIIIII.II.II.II.II.III.II.IIII
Enter ID # below if not shown or if different from above	
Prescription Plan Sponsor or Company Name	
Please use blue or black ink, capital letters, and fi	
New Prescriptions - Mail your new prescriptions with Refills - Order by Web, phone, or write in Rx numbers FOR FASTEST SERVICE, order refills at www.caren benefit identification card.	s) below. Number of Refill prescriptions:
A Shipping Address. To ship to an address differen	t from the one printed above, please make changes here.
Last Name	First Name MI Suffix (JR, SR)
Street Name	Apt./Suite # Use this address for this order only.
City Douting Phase #:	State ZIP Code
Daytime Phone #: - -	Evening Phone #:
B Refills. To order mail service refills, enter your pre	escription number(s) here.
1)2)	3) 4)
5)6)	7) 8)







1st person with a refill or new prescription. This person needs Last Name First Name	:
	Suffix (JR,SR)
NICKNAME Gender: () M () F Date of Bi MM-DD-YY	irth:
	Pate new prescription written:
Doctor's Last Name Doctor's First Name	Doctor's Phone #
Tell us about new allergies or health information for this pers Allergies: None Aspirin Cephalosporin Codeir Sulfa Other:	ne 🔾 Erythromycin 🔾 Peanuts 🔾 Penicillin
Health Information: Arthritis Asthma Diabetes Ac High Blood Pressure High Cholesterol Migraine Other:	Osteoporosis O Prostate Issues O Thyroid
2nd person with a refill or new prescription. This person needs Last Name NICKNAME Gender: M F Date of Bi MM-DD-YY Your E-Mail:	rth:
Doctor's Last Name Doctor's First Name	Doctor's Phone #
Osulfa Other: Health Information: Arthritis Asthma Diabetes Ac High Blood Pressure High Cholesterol Migraine Other:	id Reflux
Special Instructions:	
How would you like to pay for this order? (If your copay is \$0.) Electronic Check. Pay from your bank account. First time u	
() Bill Me Later®. Works like a credit card. First time users reg	•
O Credit or Debit Card. (VISA®, MasterCard®, Discover®, or A	
Fill in this oval to use your card on file.	,
() Fill in this oval to use a new card or to update your card ex	xpiration date.
Exp.Date MMYY	
O Check or Money Order. Amount: \$	Credit Card Holder Signature/Date
 Make check or money order out to CVS Caremark. Write your prescription benefit ID number on your check or money order. If your check is returned, we will charge you up to \$40. 	Regular delivery is free and will take up to 10 days from the day you send this form. If you want faster delivery, choose: 2nd Business Day (\$17) Business days are only Next Business Day (\$23) Monday-Friday
Payment for Balance Due and Future Orders: If you chose Electronic Check, Bill Me Later®, or a Credit or Debit Card, we will also use it to pay for any balance that you owe and for future orders.	 Faster delivery charges may change. Faster delivery is for shipping time, not processing time Faster delivery can only be sent to a street address,
ioi iuture orders.	not a PO box.