

# MAIL SERVICE ORDER FORM

Mail order form to:

  
 CAREMARK SAT STD  
 PO BOX 659541  
 SAN ANTONIO, TX 78265-9541

Enter ID # below if not shown or if different from above

Use this form to order NEW and/or REFILL mail service prescriptions. Please print in **BLUE** or **BLACK INK** using CAPITAL letters only. FOR FASTEST SERVICE: Order refills and verify benefit information at [www.caremark.com](http://www.caremark.com) or call the number on your prescription benefit identification card.

**Address Change/Shipping Information** (Complete **ONLY IF DIFFERENT** or not shown above)

Last Name

First Name

MI Suffix (JR, SR)

 

Street Address

Apt./Suite#

**Use this address for this order only.**

City

State

Zip Code

 - 

Daytime Phone#:  -  -

Prescription Plan Sponsor or Company Name

Evening Phone#:  -  -

**NEW prescriptions - Mail Rx(s) with this form. REFILLS - Put refill sticker(s) below.**

If space is needed for more refill labels, you may: 1) attach labels to a blank piece of paper and send with this order form, or 2) print a Refill Order Continuation Form at our Web site above, or 3) call Caremark Customer Care at the toll-free number above.

Apply Caremark Refill Label here

or

write prescription number above

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or

write prescription number above

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or

write prescription number above

Unless otherwise directed, all prescriptions received on a single order form or in a single envelope may be shipped together in one package.

**Please turn over to provide additional information.**



**Fill in for up to two individuals who will receive prescriptions with this order.**

**#1:**  Easy open caps  Print materials in Spanish

Last Name  First Name  MI  Suffix (JR, SR)

Alternate Name (Nickname)  Gender:  M  F Date of Birth:

E-mail address:  Date new prescription(s) received from doctor:

Doctor / Prescriber's Last Name  Doctor / Prescriber's First Name  Doctor / Prescriber's Telephone #  -  -

**COMPLETE ALLERGY/HEALTH INFORMATION ONLY IF CHANGED OR NOT PREVIOUSLY REPORTED**

**Allergies:**  Aspirin  Cephalosporin  Codeine  Erythromycin  Peanuts  Penicillin  Sulfonamides/Sulfa  
 None  Other:

**Health Conditions:**  Arthritis  Asthma  Diabetes  GERD (Acid Reflux)  Glaucoma  Heart Condition  
 High Blood Pressure  High Cholesterol  Migraine  Osteoporosis  Prostate Disorders  Thyroid  
 Other:

**#2:**  Easy open caps  Print materials in Spanish

Last Name  First Name  MI  Suffix (JR, SR)

Alternate Name (Nickname)  Gender:  M  F Date of Birth:

E-mail address:  Date new prescription(s) received from doctor:

Doctor / Prescriber's Last Name  Doctor / Prescriber's First Name  Doctor / Prescriber's Telephone #  -  -

**COMPLETE ALLERGY/HEALTH INFORMATION ONLY IF CHANGED OR NOT PREVIOUSLY REPORTED**

**Allergies:**  Aspirin  Cephalosporin  Codeine  Erythromycin  Peanuts  Penicillin  Sulfonamides/Sulfa  
 None  Other:

**Health Conditions:**  Arthritis  Asthma  Diabetes  GERD (Acid Reflux)  Glaucoma  Heart Condition  
 High Blood Pressure  High Cholesterol  Migraine  Osteoporosis  Prostate Disorders  Thyroid  
 Other:

Comments/Special Instructions:

**Method of Payment/Shipping Information**

Please make check or money order payable to **Caremark**. Include ID# on check/money order.

Check  Money Order/Cashier's Check  Voucher/Coupon **Amt. of check/money order:** \$   .

(Checks returned for insufficient funds will be subject to a processing fee of up to \$40, depending on state law.)

OR pay by credit or debit card (preferred). We accept VISA®, MasterCard®, Discover®, and American Express®.

**Fill in oval to charge most recently used credit card for this order and future orders for all individuals included in the family.**

**Fill in oval to charge most recently used credit card for this order only.**

To add, change or update your credit card information, write in below:

-

Credit/Debit Card Number Expiration Date

Credit Card Holder Signature  Date

Your credit card will be billed for prescription costs and expedited shipping (if requested).

**Standard delivery is FREE** (allow 10-14 days for delivery).

For faster delivery, mark the appropriate oval below.

Note: Expedited delivery only affects shipping time, not processing time of your order.

**Fill in oval for faster delivery:**

2nd Business Day = \$13 (per order)  Next Business Day = \$18 (per order)

(Charges subject to change.)

By submitting this form you acknowledge that eligibility under the prescription benefit is subject to Plan verification and that you/your dependents do not have primary prescription coverage under any other plan.

