

MAIL SERVICE ORDER FORM

	Mail order form to:
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Please fold here	Enter ID # below if not shown or if different from above
Ple	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 or call toll-free# 1-800-824-6349
٧	Shipping Information (Complete ONLY IF DIFFERENT or not shown above)
	Last Name First Name MI Suffix (JR, SR) Street Address Apt./Suite#
	City State Zip Code (
	O Fill in oval if one time only address. Daytime Phone#: Evening Phone#:
Please fold here	Rx Information - To order NEW prescriptions, mail the doctor's prescription(s) with this form. 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 Caremark.com, or 3) call Caremark Customer Care.
✓ Please	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 Apply Caremark Refill Label here Or Or
	write prescription number above 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.





benefit is subject to Plan verification and that you/your dependents do not have

primary prescription coverage under any other plan.

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