

Fill in for individuals receiving a prescription with this order.

#1: Fill in oval if enrolled in Medicare Part B. Easy open caps. Print mail service 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:

Please fold here

Please fold here

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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 Rx costs and expedited shipping (if requested).

Your order will be shipped standard delivery at no charge. Allow 10 to 14 days for standard delivery. If you require faster delivery, mark the appropriate oval below. Expedited delivery only affects shipping time, not processing time of your order. Expedited shipments can only be sent to a street address, not a P.O. Box.

Fill in oval for expedited delivery:

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



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* WEB *