



# MAIL SERVICE ORDER FORM

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Mail order form to:

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

Enter ID# if not shown or different from above

Prescription Plan Sponsor or Company Name

**DIRECTIONS:** Print in **BLUE** or **BLACK** ink, using CAPITAL letters. Fill in ovals completely (●). Complete both sides of form.

**To order new prescriptions:** Mail your prescription(s) with this form. # of new prescriptions:

**To order refills:** Order by Web, phone, or write in Rx number(s) below. # of refill prescriptions:

**FOR FASTEST SERVICE,** order refills at [www.caremark.com](http://www.caremark.com) or call the number on your prescription benefit identification card.

## SHIPPING ADDRESS IF NOT SHOWN OR DIFFERENT FROM 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 #:  -  -  Evening Phone #:  -  -

## REFILL INFORMATION:

To order mail service refills, enter your prescription number(s) here:

- 1) \_\_\_\_\_ 2) \_\_\_\_\_ 3) \_\_\_\_\_ 4) \_\_\_\_\_
- 5) \_\_\_\_\_ 6) \_\_\_\_\_ 7) \_\_\_\_\_ 8) \_\_\_\_\_

Prescriptions sent in one envelope may be shipped together unless you request otherwise.



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**FILL IN FOR UP TO TWO PEOPLE WHO WILL RECEIVE PRESCRIPTIONS WITH THIS ORDER**

**1st PERSON ORDERING A PRESCRIPTION**

Easy open caps  Print in Spanish

LAST NAME

FIRST NAME

M

Suffix (JR,SR)

NICKNAME

Gender:  M  F

Date of Birth: MM-DD-YYYY

Your E-mail: \_\_\_\_\_

Date new prescription written: \_\_\_\_\_

Doctor's Last Name

Doctor's First Name

Doctor's Phone #

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

Allergies:  None  Aspirin  Cephalosporin  Codeine  Erythromycin  Peanuts  Penicillin  Sulfa  Other: \_\_\_\_\_

Conditions:  Arthritis  Asthma  Diabetes  Acid Reflux  Glaucoma  Heart Problem  High Blood Pressure  High Cholesterol  Migraine  Osteoporosis  Prostate Issues  Thyroid  Other: \_\_\_\_\_

**2nd PERSON ORDERING A PRESCRIPTION**

Easy open caps  Print in Spanish

LAST NAME

FIRST NAME

M

Suffix (JR,SR)

NICKNAME

Gender:  M  F

Date of Birth: MM-DD-YYYY

Your E-mail: \_\_\_\_\_

Date new prescription written: \_\_\_\_\_

Doctor's Last Name

Doctor's First Name

Doctor's Phone #

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

Allergies:  None  Aspirin  Cephalosporin  Codeine  Erythromycin  Peanuts  Penicillin  Sulfa  Other: \_\_\_\_\_

Conditions:  Arthritis  Asthma  Diabetes  Acid Reflux  Glaucoma  Heart Problem  High Blood Pressure  High Cholesterol  Migraine  Osteoporosis  Prostate Issues  Thyroid  Other: \_\_\_\_\_

Special Instructions: \_\_\_\_\_

**PAYMENT INFORMATION: Select one payment method below.**

- Electronic Check Processing (Please pre-register at Caremark.com or call Customer Care)
- Bill Me Later® (Subject to credit approval. Please pre-register at Caremark.com or call Customer Care)
- Credit/Debit Card (VISA, MasterCard, Discover or American Express)
  - Charge most recently used credit card
  - Charge new/updated credit/debit card (provide info below)

CREDIT CARD#

Exp. Date MMY Y

Check/Money Order: Amount \$

Credit Card Holder Signature/Date

Make check or money order payable to CVS Caremark and write your ID# on the check/money order. Returned checks will be subject to a fee of up to \$40, depending on state law.

The selected payment method (unless paying by check) will be charged for future orders, unless a different form of payment is provided. It will also be charged for any outstanding balance due.

Fill in oval if you DO NOT want the selected payment method to be automatically charged for future orders.

SAT-MOF-1208

**REGULAR DELIVERY IS FREE**  
 (Allow up to 10 days for delivery)  
**Fill in oval for faster delivery:**  
 2nd Business Day \$17 per order  
 Next Business Day \$23 per order  
 (Charges subject to change)  
 Faster delivery options only affect shipping time, not processing time and can only be sent to a street address, not a P.O. box.



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