

STEP 5 – METHOD OF PAYMENT

1. Fill in the appropriate oval for your method of payment. If you are paying by check or money order, please write your Plan Participant ID Number on the check. If you are paying by credit card, be sure to include your signature. By checking the Credit Card on File box, the credit card number you provide will be used on future orders. We accept VISA®, MasterCard®, Discover®, or American Express®. **DO NOT SEND CASH.**

STEP 6 – ENCLOSE YOUR PRESCRIPTION

6. Make sure you enclose the original prescription(s) you receive from your doctor (not photocopies).

Last Name		First Name	
Alternate Name (Nickname)		Gender: <input type="radio"/> M <input type="radio"/> F	Date of Birth: [] [] - [] []
E-mail address:			
Doctor / Prescriber's Last Name		Doctor / Prescriber's First Name	
COMPLETE ALLERGY/HEALTH INFORMATION ONLY IF CHANGED OR NOT PREVIOUSLY REPORTED			
Allergies: <input type="radio"/> Aspirin <input type="radio"/> Cephalosporin <input type="radio"/> Codeine <input type="radio"/> Erythromycin <input type="radio"/> Peanuts <input type="radio"/> Penicillin			
Health Conditions: <input type="radio"/> Arthritis <input type="radio"/> Asthma <input type="radio"/> Diabetes <input type="radio"/> GERD (Acid Reflux) <input type="radio"/> Glaucoma			
<input type="radio"/> High Blood Pressure <input type="radio"/> High Cholesterol <input type="radio"/> Migraine <input type="radio"/> Osteoporosis <input type="radio"/> Prostate Disorders			
Comments/Special Instructions:			
Method of Payment/Shipping Information			
Please make check or money order payable to Caremark. Include ID# on all checks and money orders			
<input type="radio"/> Check <input type="radio"/> Money Order or Cashier's Check <input type="radio"/> Voucher/Coupon Total payment enclosed:			
<input type="radio"/> Fill in oval to charge most recently used credit card for this order and future orders for all participants in			
<input type="radio"/> Fill in oval to charge most recently used credit card for this order only.			
Your order will be shipped standard 10 to 14 days for standard delivery. mark the appropriate oval below. Ex shipping time, not processing time			
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).			
Plan participant acknowledges 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.			

That's It!

Now, simply mail your order form along with your prescription(s) and payment in the pre-addressed envelope.

3 Ways to Refill

Online. You can order your mail service refills by using Caremark.com. Register online to receive refill reminders, informative newsletters, and other e-mail alerts. Have your benefit ID number handy to register.

By Phone. Call your Customer Care number for fully automated refill service. Have your benefit ID number ready.

By Mail. Once you receive your medication, keep your refill labels to use on your next order form. Attach the refill label provided to the mail service order form and enclose your payment with your order, if your plan requires a payment.

Questions?

Contact Caremark Customer Care toll-free at the number listed on your benefits card or in your welcome kit. We are here to serve you.



**Getting Started
With Caremark
Mail Service
For First Time Users**



www.caremark.com

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Your Caremark Mail Service Program

How would you like to have your long-term medication conveniently delivered to your home or office? Not only will it save you time and trips to a participating retail pharmacy, you may also save money! With mail service, you can receive up to a 90-day supply of your medication for a co-pay that is significantly less than the three 30-day co-pays at a participating retail pharmacy.

With the Caremark Mail Service Program you can:

- Receive an extended supply of medicine
- Enjoy the ease of having a prescription delivered to a location of your choice – home, office, vacation spot, etc.
- Speak to a registered pharmacist 24 hours a day, seven days a week
- Order prescription refills and get health information online at www.caremark.com

Getting Started

Make sure you talk with your doctor first to determine if mail service is right for you. If it is, ask your doctor to write two prescriptions:

- One for a short-term supply (e.g., 30 days) to be filled immediately at a participating retail pharmacy
- One for the maximum days' supply allowed (e.g., 90 days) with as many as three refills (if appropriate) to mail to Caremark

Filling Out the Mail Service Order Form

Follow these six steps to fill out your mail service order form:

STEP 1 – PLAN PARTICIPANT INFORMATION

1. Fill in the Primary Plan Participant ID Number. Your Primary Plan Participant ID is the number on your prescription benefit card. (On your next order, your Primary Participant ID Number will be pre-printed here.)

STEP 2 – ADDRESS

2. Fill in your address in its entirety. Be sure to fill in the oval if you want your prescription to go to a one-time address.

Mail order form to:

Primary Plan Participant ID Number (refer to Rx card):
(Enter ID # below if not shown or 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

Shipping Information (Complete ONLY IF DIFFERENT or not shown above)

Last Name First Name MI Suffix (JR,)
Street Address Apt./Suite#
City State Zip Code
Daytime Phone#: - -
Evening Phone#: - -
 Fill in oval if one time only address.

Rx Information (If space is needed for more refill labels use Refill Order Continuation Form and send with this order)

To order NEW prescriptions, mail the doctor's prescription with this form. Number of Rx's: New Refill Total

Apply Caremark Refill Label here
or
write prescription number above

STEP 3 – ORDER SUMMARY

3. Indicate how many New and/or Refill prescriptions you are going to have filled. Add together the New and Refill boxes to get the Total.

STEP 4 – PRESCRIPTION INFORMATION

4. Provide Participant #1 information for whom the prescription is being submitted.

- Indicate if you would like your order to include Easy-Open Caps. All orders are normally shipped with safety caps.
- Add your e-mail address if you would like to receive e-mail confirmations about your prescription (e.g., when your prescription is mailed to you).
- Be sure to completely fill out your Doctor/Prescriber's First Name, Last Name and Telephone Number.
- Fill in the ovals under Drug Allergies if you are allergic to any drugs. If you do not see the drug you are allergic to, fill in the Other oval and write it in.
- Fill in the ovals if you have any Health Conditions. If you do not see your health condition, fill in the Other oval and write it in.

Plan Participant Information: Fill in for plan participants receiving a prescription with this order.

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

Last Name First Name MI
Alternate Name (Nickname) Gender: M F Date of Birth: - - - -
E-mail address:
Doctor / Prescriber's Last Name Doctor / Prescriber's First Name Doctor / Prescriber's T

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

Allergies: Aspirin Cephalosporin Codeine Erythromycin Peanuts Penicillin S

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

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

Last Name First Name MI
Alternate Name (Nickname) Gender: M F Date of Birth: - - - -
E-mail address:
Doctor / Prescriber's Last Name Doctor / Prescriber's First Name Doctor / Prescriber's T

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

Allergies: Aspirin Cephalosporin Codeine Erythromycin Peanuts Penicillin S

4a. (Optional) Provide Participant #2 information if you are submitting prescriptions for two participants. If this is the case, provide the same information as STEP 4.

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