CAREMARK®
It all starts with care®

MAIL SERVICE ORDER FORM

LAURA SCHULTZ

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12259517110884

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

Mail order form to:

CAREMARK
P O BOX 94467
PALATINE IL 60094-4467

LCSCN

Please fold here

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 1-800-776-1355.

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

Daytime Phone#:

Evening Phone#:

O Fill in oval if one time only address.

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.

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

Please fold here

* WEB *

Visit www.caremark.com for the fastest refills. Log in to check order status and access personalized information about your prescription benefits.

IMPORTANT NOTICE: When getting a new prescription, be sure to ask your doctor to write your prescription for the maximum amount allowed by your benefit plan, usually a 90-day supply. Make sure your doctor SIGNS and DATES all new prescriptions.

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.

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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: MM - DD - YYYY

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

#2: ◯ 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: MM - DD - YYYY

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: _____

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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 MM - YY

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 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.

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