

MAIL SERVICE ORDER FORM

	Mail order form to:
Enter ID # below if not shown or if different from above	CAREMARK PO BOX 94467 PALATINE, IL 60094-4467
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	
Address Change/Shipping Information (Complete ONLY IF DIFFERENT or not shown 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#:	
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	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 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.





Your credit card will be billed for prescription costs and expedited shipping (if requested).

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.

