




**CVS** Mail Service  
**CAREMARK** Order Form

6393-00001_PM <b>JOHN Q SAMPLE</b> <b>9501 E. Shea Blvd</b> <b>SCOTTSDALE, AZ 85260</b>	<b>Mail this form to:</b>   CVS Caremark PO BOX 52099 PHOENIX, AZ 85072-2099																
Enter ID # below if not shown or if different from above <table border="1" style="width:100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width:12.5%;"></td><td style="width:12.5%;"></td><td style="width:12.5%;"></td><td style="width:12.5%;"></td><td style="width:12.5%;"></td><td style="width:12.5%;"></td><td style="width:12.5%;"></td><td style="width:12.5%;"></td><td style="width:12.5%;"></td><td style="width:12.5%;"></td><td style="width:12.5%;"></td><td style="width:12.5%;"></td><td style="width:12.5%;"></td><td style="width:12.5%;"></td><td style="width:12.5%;"></td><td style="width:12.5%;"></td> </tr> </table>																	
Prescription Plan Sponsor or Company Name																	

Please use **blue or black ink, capital letters**, and fill in **both sides** of this form.

**New Prescriptions** - Mail your new prescriptions with this form.      Number of **New** prescriptions:

**Refills** - Order by Web, phone, or write in Rx number(s) below.      Number of **Refill** prescriptions:

**FOR FASTEST SERVICE**, order refills at [www.caremark.com](http://www.caremark.com) or call toll-free 1-855-802-4381.

**A Shipping Address.** To ship to an address different from the one printed above, please make changes here.

Last Name	First Name	MI	Suffix (JR, SR)
<input style="width:100%;" type="text"/>	<input style="width:100%;" type="text"/>	<input style="width:20px;" type="text"/>	<input style="width:20px;" type="text"/> <input style="width:20px;" type="text"/>
Street Name	Apt./Suite #	<input type="radio"/> <b>Use this address for this order only.</b>	
<input style="width:100%;" type="text"/>	<input style="width:20px;" type="text"/> <input style="width:20px;" type="text"/> <input style="width:20px;" type="text"/>		
City	State	ZIP Code	
<input style="width:100%;" type="text"/>	<input style="width:20px;" type="text"/> <input style="width:20px;" type="text"/>	<input style="width:20px;" type="text"/> <input style="width:20px;" type="text"/> - <input style="width:20px;" type="text"/> <input style="width:20px;" type="text"/>	
Daytime Phone #:	<input style="width:20px;" type="text"/> <input style="width:20px;" type="text"/> <input style="width:20px;" type="text"/> - <input style="width:20px;" type="text"/> <input style="width:20px;" type="text"/> <input style="width:20px;" type="text"/>	Evening Phone #:	<input style="width:20px;" type="text"/> <input style="width:20px;" type="text"/> <input style="width:20px;" type="text"/> - <input style="width:20px;" type="text"/> <input style="width:20px;" type="text"/> <input style="width:20px;" type="text"/>

**B Refills.** To order mail service refills, enter your prescription number(s) here.

1) _____	2) _____	3) _____	4) _____
5) _____	6) _____	7) _____	8) _____

\* WEB \*

\* WEB \*

We may package all of these prescriptions together unless you tell us not to.

