

C Tell us about the member who the prescriptions are for:

Fill in oval to receive mail service forms and prescription drug labels in Spanish:

LAST NAME

FIRST NAME

M

Suffix (JR,SR)

NICKNAME

Date of birth: MM-DD-YYYY

E-mail address:

Doctor's last name

Doctor's first name

Doctor's phone #

Tell us about new health information if never provided or if changed.

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

Medical conditions: Arthritis Asthma Diabetes Acid reflux Glaucoma Heart problem High blood pressure High cholesterol Migraine Osteoporosis Prostate issues Thyroid Other:

Medicare part D members do not need to complete the section below.

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FIRST NAME

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D Special instructions:

E How would you like to pay for this order? (If your copay is \$0, you do not need to provide payment information.)

Electronic check. Pay from your bank account. (You must first register at Caremark.com or call Customer Care.)

Credit or debit card. (VISA®, MasterCard®, Discover®, or American Express®)

Use your card on file.

Use a new card or update your card's expiration date.

CARD NUMBER

Exp. Date MMY Y

Check or money order. Amount: \$

- Make check or money order payable to CVS Caremark.
- Write your member ID number on your check or money order.
- If your check is returned, we will charge you up to \$40.

Payment for balance due and future orders: If you choose to pay by electronic check or a credit or debit card, we will use it to pay for any balance due and for future orders unless you provide another form of payment.

Fill in this oval if you **DO NOT** want us to use this payment method for future orders.

Credit card holder signature/date

Processing time takes up to 5 days. Shipping options:

- Free shipping (takes 3-5 days)**
- 2nd business day (\$17)**
- Next business day (\$23)**

2nd day or next day delivery:

- Can only be sent to a street address, not a PO Box.
- Applies to shipping time only, not processing.
- Charges may change



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