

**MAIL SERVICE  
ORDER FORM**  
**DRUG DISCOUNT  
PROGRAM**

Mail order form to:



CAREMARK SAT STD  
PO BOX 659541  
SAN ANTONIO, TX 78265-9541

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

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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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 at [www.caremark.com](http://www.caremark.com) or call the number on your prescription card.

**Address Change/Shipping Information** (Complete **ONLY IF DIFFERENT** or not shown above)

Last Name	First Name	MI	Suffix (JR, SR)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Street Address	Apt./Suite#	<b>Use this address for this order only.</b>	
<input type="text"/>	<input type="text"/>		
City	State	Zip Code	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Daytime Phone#:	<input type="text"/>	<input type="text"/>
RxGroup # (Refer to RxGRP on your card)	Evening Phone#:	<input type="text"/>	<input type="text"/>

**NEW prescriptions - Mail Rx(s) with this form. REFILLS - Put refill sticker(s) below.**

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 our Web site above, or 3) call Caremark Customer Care at the toll-free number above.

<p>Apply Caremark Refill Label here</p> <input type="text"/> <p>or</p> <p>write prescription number above</p>	<p>Apply Caremark Refill Label here</p> <input type="text"/> <p>or</p> <p>write prescription number above</p>
<p>Apply Caremark Refill Label here</p> <input type="text"/> <p>or</p> <p>write prescription number above</p>	<p>Apply Caremark Refill Label here</p> <input type="text"/> <p>or</p> <p>write prescription number above</p>

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.**



**Fill in for up to two individuals who will receive prescriptions with this order.**

**#1:**  Easy open caps  Print materials in Spanish  
Last Name  First Name  MI  Suffix (JR, SR)

Alternate Name (Nickname)  Gender:  M  F Date of Birth:  -  -

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:

**#2:**  Easy open caps  Print materials in Spanish  
Last Name  First Name  MI  Suffix (JR, SR)

Alternate Name (Nickname)  Gender:  M  F Date of Birth:  -  -

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:

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

Credit Card Holder Signature Date

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

**Regular delivery is FREE** (allow up to 10 days for delivery).  
For faster delivery, mark the appropriate oval below.  
Note: Expedited delivery only affects shipping time, not processing time of your order.

**Fill in oval for faster delivery:**

2nd Business Day = \$13 (per order)  Next Business Day = \$18 (per order)  
(Charges subject to change.)



This is a discount program and not an insurance plan. Discounts are available through Caremark Mail Service Pharmacy.

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