



MAIL SERVICE ORDER FORM

Please fold here

Please fold here

Mail order form to:


 CVS CAREMARK MTP STD
 PO BOX 94467
 PALATINE IL 60094-4467

Enter ID# if not shown or different from above

Input field for ID#

Prescription Plan Sponsor or Company Name

DIRECTIONS: Print in **BLUE** or **BLACK** ink, using CAPITAL letters. Fill in ovals completely (●). Complete both sides of form.

To order new prescriptions: Mail your prescription(s) with this form. # of new prescriptions:

To order refills: Order by Web, phone, or write in Rx number(s) below. # of refill prescriptions:

FOR FASTEST SERVICE, order refills at www.caremark.com or call the number on your prescription benefit identification card.

SHIPPING ADDRESS IF NOT SHOWN OR DIFFERENT FROM 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 #: - - Evening Phone #: - -

REFILL INFORMATION:

To order mail service refills, enter your prescription number(s) here:

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

Prescriptions sent in one envelope may be shipped together unless you request otherwise.



Please fold here

Please fold here

