



MAIL SERVICE ORDER FORM

Mail order form to:


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

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

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 www.caremark.com or call toll-free 1-800-824-6349

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

Last Name First Name MI Suffix (JR, SR)

Street Address Apt./Suite#

City State Zip Code

 -

Daytime Phone#: - -

Fill in oval if one time only address.

Evening 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

Caremark wants to provide you with high quality medicines at the best possible price. In order to do this, we will substitute equivalent generic medicines for brand name medicines whenever possible. If you do not want us to substitute generics, please provide specific instructions, including drug names, in the "Comments/Special Instructions" section of this form.

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.



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