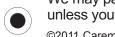
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	Mail this form to:
Enter ID # below if not shown or if different from above	I.IIIIIIIII.II.II.II.II.II.
Prescription Plan Sponsor or Company Name	
Please use blue or black ink, capital letters, and fill New Prescriptions - Mail your new prescriptions with Refills - Order by Web, phone, or write in Rx number(s FOR FASTEST SERVICE, order refills at www.carembenefit identification card.	n this form. Number of New prescriptions: S) below. Number of Refill prescriptions: nark.com or call the number on your prescription
	from the one printed above, please make changes here.
Last Name	First Name MI Suffix (JR, SR)
Street Name	Apt./Suite # Use this address for this order only.
City	State ZIP Code
Daytime Phone #:	Evening Phone #:
B Refills. To order mail service refills, enter your pre	scription number(s) here.
1) 2)	3)4)
5)6)	7)8)





1st person with a refill or new prescription. This person needs: Last Name First Name	○ Spanish forms and labels
First Name	Suffix (JR,SR)
NICKNAME Gender: () M () F Date of Bir MM-DD-YYY	th:
	ate new prescription written:
Doctor's Last Name Doctor's First Name	Doctor's Phone #
Tell us about new allergies or health information for this perseallergies: None Aspirin Cephalosporin Codeine Sulfa Other:	e () Erythromycin () Peanuts () Penicillin
Health Information: Arthritis Asthma Diabetes Acid High Blood Pressure High Cholesterol Migraine Other:	d Reflux
2nd person with a refill or new prescription. This person needs: Last Name First Name Output Date of Birt MM-DD-YY Your E-Mail: Date of Birt MM-DD-YY Page 1981	Suffix (JR,SR)
Doctor's Last Name Doctor's First Name	Doctor's Phone #
Tell us about new allergies or health information for this personal part of the personal pa	d Reflux
Special Instructions:	
How would you like to pay for this order? Fill in the oval to ch	noose a payment.
() Electronic Check. Pay from your bank account. First time us	• •
() Bill Me Later®. Works like a credit card. First time users regis	•
O Credit or Debit Card. (VISA®, MasterCard®, Discover®, or Ar	merican Express®)
O Fill in this oval to use your card on file.	
O Fill in this oval to use a new card or to update your card exp	piration date.
Exp.Date MMYY	
Check or Money Order. Amount: \$	Credit Card Holder Signature/Date
 Make check or money order out to CVS Caremark. Write your prescription benefit ID number on your check or money order. If your check is returned, we will charge you up to \$40. 	Regular delivery is free and will take 7 to 10 days from the day you send this form. If you want faster delivery, choose: O 2nd Business Day (\$17) Business days are only
Payment for Balance Due and Future Orders: If you chose Electronic Check, Bill Me Later®, or a Credit or Debit Card, we will also use it to pay for any balance that you owe and for future orders.	 Next Business Day (\$23) Monday-Friday Faster delivery charges may change. Faster delivery is for shipping time, not processing time Faster delivery can only be sent to a street address, not a PO box.
() Fill in this oval if you DO NOT want to use this payment	