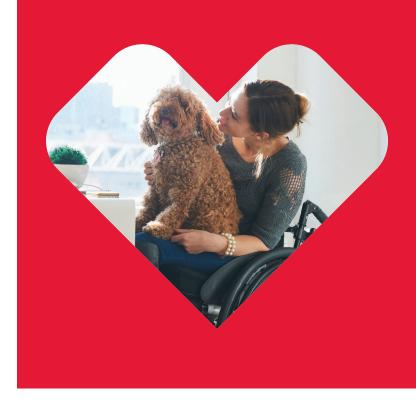


CVS Caremark[®] Mail Service Pharmacy

We deliver quality and convenience.



Save time getting prescription medication you take regularly (like high blood pressure or diabetes drugs) by getting up to 90-day supplies from CVS Caremark Mail Service Pharmacy.

Medications when you need them.

There's no need to drive to the pharmacy each month. We deliver up to 90-day supplies by mail to your home, office and even your vacation spot. Your doctor can send us your refills directly to save you even more time.

Get worry-free shipping with every delivery.

You get the medication you need with no-cost shipping. Your prescription is filled by a licensed pharmacist and checked for quality. Our packages are discreet, secure and hold up in any weather.

Avoid missing a dose with refill reminders.

Need a reminder? We'll send you a text message 10 days before every refill to confirm your order, make changes or cancel at any time. Download our mobile app to manage and track your prescriptions on your own time.

Sign up today at Caremark.com.

Your privacy is important to us. Our employees are trained regarding the appropriate way to handle your private health information. ©2020 CVS Caremark. All rights reserved. 106-51798A 051120 FRM060749EP00 (11/22)



Three easy ways to get started

- Online
 Register or sign in at
 Caremark.com.
- Phone

Call 1-888-624-1139, 24-hours a day, seven days a week. Have your member ID number ready when you call.

• Mail

Fill out and send in a mail service form. Be sure to include your original prescription for up to a 90-day supply.



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	Mail this form to:						
Member ID # (if not shown or if different from above	וויויויוויוויוויוויוויוויוויוויוויוויוו						
Instructions:							
Please use blue or black ink and print in capita							
New Prescriptions - Mail your new prescriptions with this form. Number of New prescriptions:							
Refills - Order by Web, phone, or write in Rx number(s) below. Number of Refill prescriptions: TO RECEIVE YOUR ORDER SOONER request refills or new prescriptions online at www.caremark.com or call toll-free 1-888-624-1139. TTY 711, 24 hours a day, 7 days a week.							
A Shipping Address. To ship to an address diffe	rent from the one printed above, enter the changes here.						
	First Name MI Suffix (JR, SR) Image: Second						
Street Address	Apt./Suite # Use shipping address for this order only.						
	State ZIP Code Image:						
Daytime Phone #:	Evening Phone #:						
B Refills. To order mail service refills, enter your prescription number(s) here.							
1)2)	3)4)						
5)6)	7) 8)						
CVS Caremark wants to provide you with high que this, we will substitute equivalent generic medicin do not want us to substitute generics, please prove "Special Instructions" section of this form.	ality medicines at the best possible price. In order to do les for brand name medicines whenever possible. If you vide specific instructions, including drug names, in the						
We may package all of these prescriptions together unless you te	II us not to.						
All claims for prescriptions submitted to CVS Caremark Mail Serv will be submitted to your prescription benefit plan for payment. If y to your plan, do not use this form. You may call Customer Care to for submission of your order and payment.	ice Pharmacy using this form you do not want them submitted make alternate arrangements						
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C Tell us about the people ordering prescriptions. If there are more than two people, please complete another form.

	First person with a refill or new prescription. O Spanish form				n forms and l	abels	
	Last Name F	First Name			Suffix (JR,SR)		
		Date of birth					
	E-mail address: Gender: () M () F MM-DD-YYYY Date new prescription written:						
	· ·						
	Doctor's last name Doctor's first name Doctor's phone #						
	Tell us about new health information for 1st person if never provided or if changed. Allergies: None Aspirin Cephalosporin Codeine Erythromycin Penicillin Sulfa Other: Sulfa Other: Sulfa Sulfa <td< td=""></td<>						
•	Medical conditions: () Arthritis () Asthma () Diabete () High blood pressure () High cholesterol () Mig () Other:	raine 0 C	Osteoporosis) Prostate is:	° .		
	Second person with a refill or new prescription.			() Spanisł	h forms and la	abels	
	Last Name F	First Name					
Please fold here →	Nickname						
old	E-mail address:		e new prescripti	ion written:		Please fold here →	
se f			· ·			se f	
Plea	Doctor's last name Doctor's first n			or's phone #		Plea	
•	Tell us about new health information for 2nd person if never provided or if changed. Allergies: None Aspirin Cephalosporin Codeine Erythromycin Penicillin Sulfa Other: Other: Other: Other: Other:						
	Medical conditions: Arthritis Asthma Diabetes Acid reflux Glaucoma Heart problem High blood pressure High cholesterol Migraine Osteoporosis Prostate issues Thyroid Other: Image: Content issue Other: Image: Content issue Image: Content issue Image: Content issue						
D	Special instructions:						
						()	
E	How would you like to pay for this order? (If your co					lion.)	
	O Electronic check. Pay from your bank account. (Y	ou must firs	st register online	or call Custo	omer Care.)		
Please fold here -	 Credit or debit card. (VISA[®], MasterCard[®], Discov Use your card on file. 	′er [®] , or Ame	erican Express®)	I		Please fold here	
folc	O Use a new card or update your card's expiration date.						
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