MAIL SERVICE ORDER FORM

Please fold here

Mail order form to:

CVS CAREMARK NALC
P.O. BOX 94467
PALATINE, IL 60094-4467

Enter ID# if not shown or different from above

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 toll-free 1-800-933-NALC.

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.

FILL IN FOR UP TO TWO PEOPLE WHO WILL RECEIVE PRESCRIPTIONS WITH THIS ORDER

1st PERSON ORDERING A PRESCRIPTION

○ Easy open caps ○ Print in Spanish

LAST NAME _____ FIRST NAME _____ M Suffix (JR,SR) ___

NICKNAME ___ Gender: ○ M ○ F Date of Birth: MM-DD-YYYY

Your E-mail: _____ Date new prescription written: _____

Doctor's Last Name _____ Doctor's First Name _____ Doctor's Phone # _____

Please fold here

ALLERGY/HEALTH INFORMATION: COMPLETE ONLY IF CHANGED OR NOT PREVIOUSLY REPORTED

Allergies: ○ None ○ Aspirin ○ Cephalosporin ○ Codeine ○ Erythromycin ○ Peanuts ○ Penicillin
○ Sulfa ○ Other: _____

Conditions: ○ Arthritis ○ Asthma ○ Diabetes ○ Acid Reflux ○ Glaucoma ○ Heart Problem
○ High Blood Pressure ○ High Cholesterol ○ Migraine ○ Osteoporosis ○ Prostate Issues ○ Thyroid
○ Other: _____

Please fold here

2nd PERSON ORDERING A PRESCRIPTION

○ Easy open caps ○ Print in Spanish

LAST NAME _____ FIRST NAME _____ M Suffix (JR,SR) ___

NICKNAME ___ Gender: ○ M ○ F Date of Birth: MM-DD-YYYY

Your E-mail: _____ Date new prescription written: _____

Doctor's Last Name _____ Doctor's First Name _____ Doctor's Phone # _____

Please fold here

ALLERGY/HEALTH INFORMATION: COMPLETE ONLY IF CHANGED OR NOT PREVIOUSLY REPORTED

Allergies: ○ None ○ Aspirin ○ Cephalosporin ○ Codeine ○ Erythromycin ○ Peanuts ○ Penicillin
○ Sulfa ○ Other: _____

Conditions: ○ Arthritis ○ Asthma ○ Diabetes ○ Acid Reflux ○ Glaucoma ○ Heart Problem
○ High Blood Pressure ○ High Cholesterol ○ Migraine ○ Osteoporosis ○ Prostate Issues ○ Thyroid
○ Other: _____

Special Instructions: _____

Please fold here

PAYMENT INFORMATION: Select one payment method below.

○ Electronic Check Processing (Please pre-register at Caremark.com or call Customer Care)

○ Bill Me Later® (Subject to credit approval. Please pre-register at Caremark.com or call Customer Care)

○ Credit/Debit Card (VISA, MasterCard, Discover or American Express)

- ○ **Charge most recently used credit card**
- ○ **Charge new/updated credit/debit card (provide info below)**

CREDIT CARD# _____ Exp. Date MMYY

_____
Credit Card Holder Signature/Date

○ Check/Money Order: Amount $ ____ . __

Make check or money order payable to CVS Caremark and write your ID# on the check/money order. Returned checks will be subject to a fee of up to $40, depending on state law.

The selected payment method (unless paying by check) will be charged for future orders, unless a different form of payment is provided. It will also be charged for any outstanding balance due.

○ Fill in oval if you DO NOT want the selected payment method to be automatically charged for future orders.

REGULAR DELIVERY IS FREE
(Allow up to 10 days for delivery)

Fill in oval for faster delivery:

○ 2nd Business Day $17 per order

○ Next Business Day $23 per order
(Charges subject to change)

Faster delivery options only affect shipping time, not processing time and can only be sent to a street address, not a P.O. box.