



	Mail this form to:  CVS Caremark Mail Service Pharmacy PO BOX 659541 SAN ANTONIO, TX 78265-9541																		
Member ID # (if not shown or if different from above) <table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>																			
----- Prescription Plan Sponsor or Company Name																			

Please use **blue or black ink** and **print in capital letters**. Fill in **both sides** of this form.

Number of **New** prescriptions:Number of **Refill** prescriptions:

TO RECEIVE YOUR ORDER SOONER request refills or new prescriptions online at www.caremark.com or call 1-800-922-NALC or 1-800-922-6252.

A Shipping Address. To ship to an address different from the one printed above, enter the changes here.

Last Name												First Name												MI			Suffix (JR, SR)		
Street Address																		Apt./Suite #						☐ Use shipping address for this order only.					
City																		State						ZIP Code					
																								-					
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) _____

Visit www.caremark.com for the fastest refills. Log in to check order status and access personalized information about your prescription benefits. If you choose to receive a brand name drug when a federally-approved generic drug is available, and your physician has not specified "Dispense as Written" for the brand name drug, you have to pay the difference in cost between the brand name drug and the generic. If you do not want us to substitute generics, please provide specific instructions, including drug names, in the "Special Instructions" section of this form.

We may package all of these prescriptions together unless you tell us not to.

All claims for prescriptions submitted to CVS Caremark Mail Service Pharmacy using this form will be submitted to your prescription benefit plan for payment. If you do not want them submitted to your plan, do not use this form. You may call Customer Care to make alternate arrangements for submission of your order and payment.

©2023 CVS Caremark. All rights reserved. P13-N



please fold here →

Please fold here →

WEB

please fold here →

Please fold here →

*** WEB ***

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.

☐ Spanish forms and labels

Last Name

Nickname

First Name

Date of birth: MM-DD-YYYY

MI Suffix (JR,SR)

E-mail address: 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 ☐ Peanuts ☐ Penicillin
☐ Sulfa ☐ Other:

Medical conditions: ☐ Arthritis ☐ Asthma ☐ Diabetes ☐ Acid reflux ☐ Glaucoma ☐ Heart problem
☐ High blood pressure ☐ High cholesterol ☐ Migraine ☐ Osteoporosis ☐ Prostate issues ☐ Thyroid
☐ Other:

Second person with a refill or new prescription.

☐ Spanish forms and labels

Last Name

Nickname

First Name

Date of birth: MM-DD-YYYY

MI Suffix (JR,SR)

E-mail address: Date new prescription written:

Doctor's last name Doctor's first name Doctor's phone #

Tell us about new health information for 2nd person if never provided or if changed.

Allergies: ☐ None ☐ Aspirin ☐ Cephalosporin ☐ Codeine ☐ Erythromycin ☐ Peanuts ☐ Penicillin
☐ Sulfa ☐ Other:

Medical conditions: ☐ Arthritis ☐ Asthma ☐ Diabetes ☐ Acid reflux ☐ Glaucoma ☐ Heart problem
☐ High blood pressure ☐ High cholesterol ☐ Migraine ☐ Osteoporosis ☐ Prostate issues ☐ Thyroid
☐ Other:

D Special instructions:

E How would you like to pay for this order? (If your copay is \$0, you do not need to provide payment information.)

☐ **Electronic check.** Pay from your bank account. (You must first register online or call Customer Care.)

☐ **Credit or debit card.** (VISA®, MasterCard®, Discover®, or American Express®)

☐ Use your card on file.

☐ Use a new card or update your card's expiration date.

Exp.Date MMYY

☐ **Check or money order.** Amount: \$

- Make check or money order payable 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.

Payment for Balance Due and Future Orders: If you choose electronic check or a credit or debit card, we will use it to pay for any balance due and for future orders unless you provide another form of payment.

☐ Fill in this oval if you **DO NOT** want us to use this payment method for future orders.

Credit card holder signature/Date

Regular delivery is free and takes up to 5 days after your order is processed.

If you want faster delivery, choose:

☐ **2nd business day (\$17)**

Faster delivery can only be sent to a street address, not a PO Box

☐ **Next business day (\$23)**

Expected processing time from receipt of this form:

- Refills: 1-2 days
- New/renewed prescriptions: Within 5 days unless additional information is needed from your doctor (Charges subject to change)

