

[illegible]

Member ID # (if not shown or if different from above)

[illegible]Number of **New** prescriptions:

--	--

Number of **Refill** prescriptions:

--	--

Suffix (JR, SR)

[illegible][illegible]

7

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Apt./Suite #

[illegible]

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○ Use shipping address for this order only.

State

ZIP Code

[illegible]

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Daytime Phone #:

			-				-				
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Evening Phone #:

			-			-				
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1) _____ 2) _____ 3) _____ 4) _____

5) 6) _____ 7) 8)



C Tell us about the people getting prescriptions. If there are more than two people, please complete another form.

1st person with a refill or new prescription.

☐ Spanish forms and labels

LAST NAME

FIRST NAME

M

Suffix (JR,SR)

NICKNAME

Gender: ☐ M ☐ F

Date of Birth: MM-DD-YYYY

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: _____

2nd person with a refill or new prescription.

☐ Spanish forms and labels

LAST NAME

FIRST NAME

M

Suffix (JR,SR)

NICKNAME

Gender: ☐ M ☐ F

Date of Birth: MM-DD-YYYY

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.)
- ☐ **Use my ☒ BillMeLater[®] account.** Works like a credit card. (You must first register online or call Customer Care.)
a PayPal service
- ☐ **Credit or Debit Card.** (VISA[®], MasterCard[®], Discover[®], or American Express[®])
- ☐ Fill in this oval to use your card on file.
- ☐ Fill in this oval to use a new card or to update your card expiration date.

CARD NUMBER

Exp. Date MMYY

☐ **Check or Money Order.** Amount: \$

- 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.

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.

☐ 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 will take up to 10 days from the day you send this form.

If you want faster delivery, choose:

- ☐ **2nd Business Day (\$17)** Business days are only Monday-Friday
- ☐ **Next Business Day (\$23)** Monday-Friday

- Faster delivery charges may change.
- Faster delivery is for shipping time only, not processing.
- Faster delivery can only be sent to a street address, not a PO Box.

