



MAIL SERVICE ORDER FORM

Mail order form to:


CAREMARK MTP STD
PO BOX 94467
PALATINE, IL 60094-4467

Enter ID # below if not shown or if different from above

Use this form to order NEW and/or REFILL mail service prescriptions. Please print in **BLUE** or **BLACK INK** using CAPITAL letters only. FOR FASTEST SERVICE: Order refills and verify benefit information at www.caremark.com or call the number on your prescription benefit identification card.

Address Change/Shipping Information (Complete ONLY IF DIFFERENT or not shown above)

Last Name <input type="text"/>	First Name <input type="text"/>	MI <input type="text"/>	Suffix (JR, SR) <input type="text"/>
Street Address <input type="text"/>	Apt./Suite# <input type="text"/>	Use this address for this order only.	
City <input type="text"/>	State <input type="text"/>	Zip Code <input type="text"/>	
Prescription Plan Sponsor or Company Name <input type="text"/>	Daytime Phone#: <input type="text"/> - <input type="text"/> - <input type="text"/>	Evening Phone#: <input type="text"/> - <input type="text"/> - <input type="text"/>	

NEW prescriptions - Mail Rx(s) with this form. REFILLS - Put refill sticker(s) below.

If space is needed for more refill labels, you may: 1) attach labels to a blank piece of paper and send with this order form, or 2) print a Refill Order Continuation Form at our Web site above, or 3) call Caremark Customer Care number on your prescription benefit identification card.

Apply Caremark Refill Label here

or
write prescription number above

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or
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or
write prescription number above

* WEB *

* WEB *

Unless otherwise directed, all prescriptions received on a single order form or in a single envelope may be shipped together in one package.
Please turn over to provide additional information.



