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	Mail this form to:
	- - - - - - - - - - - - -
Member ID # (if not shown or if different from above) Prescription Plan Sponsor or Company Name	
Instructions:	
Please use blue or black ink and print in capital let	
New Prescriptions - Mail your new prescriptions with	
Refills - Order by Web, phone, or write in Rx number(s TO RECEIVE YOUR ORDER SOONER request refill website or phone number on your member ID card.	
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 pre	scription number(s) here.
1)2)	3)4)
5)6)	7)8)
We want to provide you with high quality medicines a substitute equivalent generic medicines for brand na us to substitute generics, please provide specific institions" section of this form.	at the best possible price. In order to do this, we will me medicines whenever possible. If you do not want tructions, including drug names, in the "Special Instruc-

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.



First person with a refill or new prescription.	O Spanish forms and labe
Last Name Nickname First Name	Suffix (JR,SR)
E-mail address: Da	te 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 properties: Allergies: None Other:	•
Medical conditions: Arthritis Asthma Diabetes Acid High blood pressure High cholesterol Migraine Other:	Osteoporosis
Second person with a refill or new prescription.	○ Spanish forms and labe
Last Name Nickname Gender: M F Date of birth MM-DD-YYY	Suffix (JR,SR)
E-mail address: Da	te 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 particles: Allergies: None Aspirin Cephalosporin Codeine	
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Medical conditions: ○ Arthritis ○ Asthma ○ Diabetes ○ Acid ○ High blood pressure ○ High cholesterol ○ Migraine ○ ○	reflux
Medical conditions: Arthritis Asthma Diabetes Acid High blood pressure High cholesterol Migraine Other:	reflux
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