CAREMARK
It all starts with care®

MAIL SERVICE ORDER FORM

Mail order form to:

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

Primary Plan Participant ID Number (refer to Rx card):

(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 toll-free# 1-800-824-6349

Shipping Information (Complete **ONLY IF DIFFERENT** or not shown above)

Last Name | First Name | MI | Suffix (JR, SR)

Street Address | Apt./Suite#

City | State | Zip Code

○ Fill in oval if one time only address.

Daytime Phone#: - -

Evening Phone#: - -

Rx Information **(If space is needed for more refill labels use Refill Order Continuation Form and send with this order)**

To order NEW prescriptions, mail the doctor's prescription with this form. **Number of Rx's: New** **Refill** **Total**

Apply Caremark Refill Label here
or
write prescription number above

Apply Caremark Refill Label here
or
write prescription number above

Apply Caremark Refill Label here
or
write prescription number above

Apply Caremark Refill Label here
or
write prescription number above

Please fold here

Please fold here

Please fold here

Please fold here

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.

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