

Affix Caremark Refill Label or Print
Caremark Prescription Number



Reminder: Refills can be ordered by phone.
Call 1-800-213-0879

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If space is needed for additional
labels, please apply to any piece
of paper and enclose it with this
order form.



Instructions for New Prescriptions:

For new prescriptions being submitted through the mail, complete section (A) and patient information section (B).
One Patient Information section must be completed for each person submitting a prescription.

A

PARTICIPANT INFORMATION

Check one: Employee Retiree COBRA Medicare B

Participant Social Security Number _____ Company Name _____
Last Name _____ First Name _____ Initial _____

SHIP TO THIS ADDRESS: Please check here if this is a change of address
Street Address _____ Apt. or Suite _____ City _____
State _____ Zip Code _____ Daytime Phone Number _____ Evening Phone Number _____

METHOD OF PAYMENT (if applicable)
 Check (Payable to Prescription Service Division)
 Caremark Credit Memo Number _____
 Money Order or Cashier's Check
 VISA MasterCard Discover
Credit Card Number _____ Expiration Date _____
Signature _____

PRESCRIPTIONS ENCLOSED
Quantity of New Prescriptions _____
Quantity of Refill Labels _____
Total Quantity (New + Refill) _____
Copayment Amount Enclosed \$ _____

B

PATIENT NO. 1 INFORMATION

Last Name _____ First Name _____ Initial _____
Birthday _____ Sex Male Female Check if this is patient's first Caremark order.

PHYSICIAN INFORMATION
Last Name _____ First Name _____ Initial _____
Physician's Phone Number _____ Please, no child-proof caps

Drug Allergies
 None [10] Codeine [97] Sulfonamides [40]
 Aspirin [4] Penicillin [31] Other _____
Relationship to Participant
 Self Spouse Daughter Sponsored Depender
 Son Widowed Full-time Student
Health Conditions (to determine drug/disease interactions)
 Thyroid [246] High Blood Pressure [402] Glaucoma [365]
 Diabetes [250] Intestinal Disorders [564] Heart Condition [42]
 Arthritis [714] Asthma [493] Other _____
List other prescription/non-prescription drugs being taken: _____

PATIENT NO. 2 INFORMATION

Last Name _____ First Name _____ Initial _____
Birthday _____ Sex Male Female Check if this is patient's first Caremark order.

PHYSICIAN INFORMATION
Last Name _____ First Name _____ Initial _____
Physician's Phone Number _____ Please, no child-proof caps

Drug Allergies
 None [10] Codeine [97] Sulfonamides [40]
 Aspirin [4] Penicillin [31] Other _____
Relationship to Participant
 Self Spouse Daughter Sponsored Depender
 Son Widowed Full-time Student
Health Conditions (to determine drug/disease interactions)
 Thyroid [246] High Blood Pressure [402] Glaucoma [365]
 Diabetes [250] Intestinal Disorders [564] Heart Condition [42]
 Arthritis [714] Asthma [493] Other _____
List other prescription/non-prescription drugs being taken: _____

CAREMARK
MAIL ORDER ADDRESS:
800 BIRERMAN COURT
MT. PROSPECT, IL 60056

Participant Signature _____ Date _____
Certification: I certify that information on this form is correct and further understand that any benefits under the Prescription Service programs are subject to my eligibility for and participation in the medical plan, and certify that I or my dependents for whom prescriptions are enclosed do not have primary prescription drug coverage under any other group medical plan. I also agree to reimburse the Plan sponsor to the extent of any benefit which is in excess of the amount payable under the medical plan.

WEBSITE ADDRESS: www.rxrequest.com