CAREMARK®
It all starts with care®

MAIL SERVICE ORDER FORM

Mail order form to:

CAREMARK ZMD
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.cdphp.com or call toll-free 1-866-289-2319.

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

Daytime Phone#:

Evening Phone#:

○ Fill in oval if one time only address.

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

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or
write prescription number above

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Generic Medicines: Caremark wants to provide you with high quality medicines at the best possible price. In order to do this, we will substitute generic medicines for brand name products whenever possible. No change to a generic will be made if your doctor specified that a brand name medicine should be dispensed. If you do not want us to substitute generics, please provide specific instructions, including drug names, in the "Comments/Special Instructions" section of this form.

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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Plan Participant Information: Fill in for plan participants receiving a prescription with this order.

#1: ○ Fill in oval if enrolled in Medicare Part B. ○ Easy open caps. ○ Print mail service materials in Spanish.

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

Alternate Name (Nickname) | Gender: ○ M ○ F | Date of Birth: MM - DD - YYYY

E-mail address: _____

Doctor / Prescriber's Last Name | Doctor / Prescriber's First Name | Doctor / Prescriber's Telephone # ___-___-____

COMPLETE ALLERGY/HEALTH INFORMATION ONLY IF CHANGED OR NOT PREVIOUSLY REPORTED

Allergies: ○ Aspirin ○ Cephalosporin ○ Codeine ○ Erythromycin ○ Peanuts ○ Penicillin ○ Sulfonamides/Sulfa ○ None ○ Other: _____

Health Conditions: ○ Arthritis ○ Asthma ○ Diabetes ○ GERD (Acid Reflux) ○ Glaucoma ○ Heart Condition ○ High Blood Pressure ○ High Cholesterol ○ Migraine ○ Osteoporosis ○ Prostate Disorders ○ Thyroid ○ Other: _____

#2: ○ Fill in oval if enrolled in Medicare Part B. ○ Easy open caps. ○ Print mail service materials in Spanish.

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

Alternate Name (Nickname) | Gender: ○ M ○ F | Date of Birth: MM - DD - YYYY

E-mail address: _____

Doctor / Prescriber's Last Name | Doctor / Prescriber's First Name | Doctor / Prescriber's Telephone # ___-___-____

COMPLETE ALLERGY/HEALTH INFORMATION ONLY IF CHANGED OR NOT PREVIOUSLY REPORTED

Allergies: ○ Aspirin ○ Cephalosporin ○ Codeine ○ Erythromycin ○ Peanuts ○ Penicillin ○ Sulfonamides/Sulfa ○ None ○ Other: _____

Health Conditions: ○ Arthritis ○ Asthma ○ Diabetes ○ GERD (Acid Reflux) ○ Glaucoma ○ Heart Condition ○ High Blood Pressure ○ High Cholesterol ○ Migraine ○ Osteoporosis ○ Prostate Disorders ○ Thyroid ○ Other: _____

Comments/Special Instructions: _____

Method of Payment/Shipping Information

Please make check or money order payable to **Caremark**. Include ID# on all checks and money orders.

○ Check ○ Money Order or Cashier's Check ○ Voucher/Coupon **Total payment enclosed:** $ ___.__

Checks returned for insufficient funds will be subject to a processing fee of up to $40, depending on state law. (Excluding credit card payments)

OR pay by credit or debit card (preferred). We accept VISA®, MasterCard®, Discover® and American Express®.

○ **Fill in oval to charge most recently used credit card for this order and future orders for all participants included in the family.**

○ **Fill in oval to charge most recently used credit card for this order only.**

To add, change, or update your credit card information, write in below:

Credit/Debit Card Number | Expiration Date MM - YY

Credit Card Holder Signature | Date

Your credit card will be billed for Rx costs and expedited shipping (if requested).

Your order will be shipped standard delivery at no charge. Allow 10 to 14 days for standard delivery. If you require faster delivery, mark the appropriate oval below. Expedited delivery only affects shipping time, not processing time of your order. Expedited shipments can only be sent to a street address, not a P.O. Box.

Fill in oval for expedited delivery:

○ 2nd Business Day = $13 (per order) ○ Next Business Day = $18 (per order)

(Charges subject to change.)

Plan participant acknowledges that eligibility under the prescription benefit is subject to Plan verification and that you/your dependents do not have primary prescription coverage under any other plan.

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