



**C Tell us about the people ordering prescriptions.** If there are more than two people, please complete another form.

**First person with a refill or new prescription.**

Spanish forms and labels

LAST NAME

FIRST NAME

M

Suffix (JR,SR)

NICKNAME

Gender:  M  F

Date of birth: MM-DD-YYYY

E-mail address: \_\_\_\_\_ Date 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 provided or if changed.

Allergies:  None  Aspirin  Cephalosporin  Codeine  Erythromycin  Peanuts  Penicillin  Sulfa  Other: \_\_\_\_\_

Medical conditions:  Arthritis  Asthma  Diabetes  Acid reflux  Glaucoma  Heart problem  High blood pressure  High cholesterol  Migraine  Osteoporosis  Prostate issues  Thyroid  Other: \_\_\_\_\_

**Second person with a refill or new prescription.**

Spanish forms and labels

LAST NAME

FIRST NAME

M

Suffix (JR,SR)

NICKNAME

Gender:  M  F

Date of birth: MM-DD-YYYY

E-mail address: \_\_\_\_\_ Date 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 provided or if changed.

Allergies:  None  Aspirin  Cephalosporin  Codeine  Erythromycin  Peanuts  Penicillin  Sulfa  Other: \_\_\_\_\_

Medical conditions:  Arthritis  Asthma  Diabetes  Acid reflux  Glaucoma  Heart problem  High blood pressure  High cholesterol  Migraine  Osteoporosis  Prostate issues  Thyroid  Other: \_\_\_\_\_

**D Special instructions:** \_\_\_\_\_

**E How would you like to pay for this order?** (If your copay is \$0, you do not need to provide payment information.)

**Electronic check.** Pay from your bank account. (You must first register online or call Customer Care.)

**Credit or debit card.** (VISA®, MasterCard®, Discover®, or American Express®)

Use your card on file.

Use a new card or update your card's expiration date.

CARD NUMBER

Exp. Date MMY Y

**Check or money order.** Amount: \$ \_\_\_\_\_ . \_\_\_\_\_

• Make check or money order payable to CVS Caremark.

• Write your prescription benefit ID number on your check or money order.

• If your check is returned, we will charge you up to \$40.

**Payment for balance due and future orders:** If you choose electronic check or a credit or debit card, we will use it to pay for any balance due and for future orders unless you provide another form of payment.

Fill in this oval if you **DO NOT** want us to use this payment method for future orders.

Credit card holder signature/Date

**Regular delivery is free** and takes up to 5 days after your order is processed.

**If you want faster delivery, choose:**

**2nd business day (\$17)**

Faster delivery can only be sent to a street address, not a PO Box

**Next business day (\$23)**

**Expected processing time from receipt of this form:**

- Refills: 1-2 days
- New/renewed prescriptions: Within 5 days unless additional information is needed from your doctor (Charges subject to change)



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# Discrimination is Against the Law

Capital District Physicians' Health Plan, Inc. (CDPHP®) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. CDPHP does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

## CDPHP:

- ▶ Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - » Qualified sign language interpreters
  - » Written information in other formats (large print, audio, accessible electronic formats, other formats)
- ▶ Provides free language services to people whose primary language is not English, such as:
  - » Qualified interpreters
  - » Information written in other languages

If you need these services, contact the CDPHP Civil Rights Coordinator.

If you believe that CDPHP has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: CDPHP Civil Rights Coordinator, 500 Patroon Creek Blvd., Albany, NY 12206, 1-844-391-4803 (TTY/TDD: 711), Fax (518) 641-3401. You can file a grievance by mail, fax, or electronically at <https://www.cdphp.com/customer-support/email-cdphp>. If you need help filing a grievance, the CDPHP Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019 (TDD 1-800-537-7697).

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

## Multi-language Interpreter Services



ATTENTION: If you speak a non-English language, language assistance services, free of charge, are available to you. Call 1-888-248-6522 (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-248-6522 (TTY: 711)

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-248-6522 (TTY: 711)

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-248-6522 (телетайп: 711)

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-888-248-6522 (TTY: 711)

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-248-6522 (TTY: 711)번으로 전화해 주십시오.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-888-248-6522 (TTY: 711)

טפּור. לאצפּא וּפּ יירפּ סעסיוורעס פּליה דאַרפּש קייא ראפּ נאָהראפּ נענעז, שידיא טדער ריא ביוא: מאזקרעמפּיוא  
1-888-248-6522 (TTY: 711).

লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১-৮৮৮-২৪৮-৬৫২২ (TTY: 711)।

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-888-248-6522 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-248-6522 (رقم هاتف الصم والبكم: 117)

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-248-6522 (ATS : 711).

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔ کال کریں۔ 1-888-248-6522 (TTY: 711)

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-248-6522 (TTY: 711).

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-888-248-6522 (TTY: 711)

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-888-248-6522 (TTY: 711)