



**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.  
Last Name  First Name  MI  Suffix (JR, SR)

Alternate Name (Nickname)  Gender:  M  F Date of Birth:  -  -

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

Alternate Name (Nickname)  Gender:  M  F Date of Birth:  -  -

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 \$25 processing fee. (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

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.

