




MAIL SERVICE ORDER FORM

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Mail order form to:


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

Enter ID# if not shown or different from above

Prescription Plan Sponsor or Company Name

DIRECTIONS: Print in **BLUE** or **BLACK** ink, using CAPITAL letters. Fill in ovals completely (●). Complete both sides of form.

To order new prescriptions: Mail your prescription(s) with this form. # of new prescriptions:

To order refills: Order by Web, phone, or write in Rx number(s) below. # of refill prescriptions:

FOR FASTEST SERVICE, order refills at www.caremark.com or call the number on your prescription benefit identification card.

SHIPPING ADDRESS IF NOT SHOWN OR DIFFERENT FROM ABOVE:

Last Name First Name MI Suffix (JR, SR)
 Street Address Apt./Suite# Use this address for this order only.
 City State ZIP Code -
 Daytime Phone #: - - Evening Phone #: - -

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REFILL INFORMATION:

To order mail service refills, enter your prescription number(s) here:

1) _____ 2) _____ 3) _____ 4) _____
 5) _____ 6) _____ 7) _____ 8) _____

* WEB *

* WEB *

Prescriptions sent in one envelope may be shipped together unless you request otherwise.



