



MAIL SERVICE ORDER FORM

Mail order form to:


CAREMARK OPTIMA
PO BOX 94467
PALATINE, IL 60094-4467

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.optimahealth.com/mailorder or call toll free# 1-888-766-5495

Address Change/Shipping Information (Complete ONLY IF DIFFERENT or not shown above)

Last Name First Name MI Suffix (JR, SR)

Street Address Apt./Suite# **Use this address for this order only.**

Daytime Phone#: - -

Prescription Plan Sponsor or Company Name Evening Phone#: - -

Rx Information - To order NEW prescriptions, mail the doctor's prescription(s) with this form.

If space is needed for more refill labels, you may: 1) attach labels to a blank piece of paper and send with this order form, or 2) print a Refill Order Continuation Form at Caremark.com, or 3) call Caremark Customer Care.

Apply Caremark Refill Label here

or

write prescription number above

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or

write prescription number above

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or

write prescription number above

Apply Caremark Refill Label here

or

write prescription number above

* WEB *

* WEB *

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.



