

MAIL SERVICE ORDER FORM

	Mail order form to:
Enter ID # below if not shown or if different from above	I.IIIIIIII.II.II.II.II.III.IIIIII
Use this form to order NEW and/or REFILL mail service preso letters only. FOR FASTEST SERVICE: Order refills and verify b www.optimahealth.com/mailorder or call toll free# 1-888-7	
Address Change/Shipping Information (Complete ONL	LY IF DIFFERENT or not shown above)
Last Name Street Address City	First Name Apt./Suite# State Zip Code MI Suffix (JR, SR) Use this address for this order only.
D	aytime Phone#:
Prescription Plan Sponsor or Company Name	vening Phone#:
Rx Information - To order NEW prescriptions, mail the If space is needed for more refill labels, you may: 1) attach labels Refill Order Continuation Form at Caremark.com, or 3) call Carema	to a blank piece of paper and send with this order form, or 2) print a
Apply Caremark Refill Label here or write prescription number above	Apply Caremark Refill Label here or write prescription number above
Apply Caremark Refill Label here or	Apply Caremark Refill Label here or
write prescription number above	write prescription number above

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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Last Name First N	
Alternate Name (Nickname)	Date of Birth: MM - DD - YYYYY
Gender: OM OF	Date of Birtii. IVIIIVII - DD - TTTTT
E-mail address: Date new	
Doctor / Prescriber's Last Name Doctor / Prescriber's First N	
COMPLETE ALLERGY/HEALTH INFORMATION ONLY IF CHANGEI Aspirin Cephalosporin Codeine Erythromy	
None Other:	
Health Conditions: Arthritis Asthma Diabetes GERD High Blood Pressure High Cholesterol Migraine Osteo	oporosis O Prostate Disorders O Thyroid
#2: O Enrolled in Medicare Part B O Easy ope	en caps () Print materials in Spanish
Last Name First N	
Alternate Name (Nickname) Gender: OM OF	Date of Birth: MM - DD - YYYY
E-mail address: Date new	prescription(s) received from doctor:
Doctor / Prescriber's Last Name Doctor / Prescriber's First Na Doctor / Prescriber's First Na	me Doctor / Prescriber's Telephone #
COMPLETE ALLERGY/HEALTH INFORMATION ONLY IF CHANGED	O OR NOT PREVIOUSLY REPORTED
Allergies: O Aspirin O Cephalosporin O Codeine O Erythromy	
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