


# MAIL SERVICE ORDER FORM

Mail order form to:

  
 CAREMARK WB STD  
 PO BOX 3234  
 WILKES-BARRE, PA 18773-3234

Enter ID # below if not shown or if different from above

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------

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.caremark.com](http://www.caremark.com) or call the number on your prescription benefit identification card.

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

Last Name	First Name	MI	Suffix (JR, SR)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Street Address	Apt./Suite#	<b>Use this address for this order only.</b>	
<input type="text"/>	<input type="text"/>		
City	State	Zip Code	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Daytime Phone#:	<input type="text"/>	<input type="text"/>
Prescription Plan Sponsor or Company Name	Evening Phone#:	<input type="text"/>	<input type="text"/>

**NEW prescriptions - Mail Rx(s) with this form. REFILLS - Put refill sticker(s) below.**

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 our Web site above, or 3) call Caremark Customer Care number on your prescription benefit identification card.

Apply Caremark Refill Label here <input type="text"/> or write prescription number above	Apply Caremark Refill Label here <input type="text"/> or write prescription number above
Apply Caremark Refill Label here <input type="text"/> or write prescription number above	Apply Caremark Refill Label here <input type="text"/> or write prescription number above

PENNSYLVANIA LAW PERMITS PHARMACISTS TO SUBSTITUTE A LESS EXPENSIVE GENERALLY EQUIVALENT DRUG FOR A BRAND NAME DRUG UNLESS YOU OR YOUR PHYSICIAN DIRECT OTHERWISE. IF YOU DO NOT WANT A LESS EXPENSIVE BRAND OR GENERIC DRUG "PRODUCT", PLEASE PROVIDE SPECIFIC INSTRUCTIONS, INCLUDING DRUG NAMES, IN THE "COMMENTS/SPECIAL INSTRUCTIONS" SECTION OF THIS FORM.

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.**



Please fold here

Please fold here

Please fold here

Please fold here

**\* WEB \***

**\* WEB \***

