CAREMARK
IT ALL STARTS WITH CARE℠

A – Participant Information

Please check if applicable ☐ Medicare B

PLEASE COMPLETE INFORMATION BELOW

Primary Cardholders Social Security Number/ID# (suffix)

Plan Sponsor

MAIL THIS FORM TO:
CAREMARK
PO BOX 659529
SAN ANTONIO TX 78265-9529

Caremark Customer Service
1-800-841-5550
www.caremark.com

Ship to this Address: ☐ Temporary ☐ Permanent

Last Name

First Name Initial

Street Address

Street Address

City State Zip Code

Daytime Phone Number (include area code) Evening Phone Number (include area code)

Method of Payment (if applicable)

☐ Check (Payable to Caremark Prescription Service/include SS#)
☐ Money Order or Cashier's Check (include SS#)
☐ Caremark Credit Voucher Number _____
Credit Card: ☐ VISA ☐ Discover Card ☐ MasterCard ☐ American Express

Credit Card Number

Expiration Date

Total co-payment enclosed $ _____

Signature _____

B – Participant No. 1 Information

Last Name Initial

First Name Nickname

Date of Birth

Sex ☐ Male ☐ Female

☐ Check if this is participant's first Caremark order

Prescribing Physician Information

Last Name First Name Initial

Physician's Phone Number (including area code)

☐ **Please include easy-open caps**
(All orders are shipped with safety caps.)

Relationship to Participant: ☐ Self ☐ Spouse ☐ Full-time Student ☐ Daughter ☐ Son ☐ Sponsored Dependent ☐ Widowed ☐ Significant other

Drug Allergies: ☐ None [10] ☐ Codeine [97] ☐ Sulfonamides [40] ☐ Aspirin [4] ☐ Penicillin [31] ☐ Other_____

Health Conditions:
☐ Arthritis [716.9] ☐ High Blood Pressure [401]
☐ Asthma [493] ☐ High Cholesterol [272.4]
☐ Diabetes [250] ☐ Migraine [346.9]
☐ GERD [530.11] ☐ Osteoporosis [733]
☐ Glaucoma [365] ☐ Prostate Disorders [601]
☐ Heart Condition [429] ☐ Thyroid [246]
☐ Other _____

Participant No. 2 Information

Last Name Initial

First Name Nickname

Date of Birth

Sex ☐ Male ☐ Female

☐ Check if this is participant's first Caremark order

Prescribing Physician Information

Last Name First Name Initial

Physician's Phone Number (including area code)

☐ **Please include easy-open caps**
(All orders are shipped with safety caps.)

Relationship to Participant: ☐ Self ☐ Spouse ☐ Full-time Student ☐ Daughter ☐ Son ☐ Sponsored Dependent ☐ Widowed ☐ Significant other

Drug Allergies: ☐ None [10] ☐ Codeine [97] ☐ Sulfonamides [40] ☐ Aspirin [4] ☐ Penicillin [31] ☐ Other_____

Health Conditions:
☐ Arthritis [716.9] ☐ High Blood Pressure [401]
☐ Asthma [493] ☐ High Cholesterol [272.4]
☐ Diabetes [250] ☐ Migraine [346.9]
☐ GERD [530.11] ☐ Osteoporosis [733]
☐ Glaucoma [365] ☐ Prostate Disorders [601]
☐ Heart Condition [429] ☐ Thyroid [246]
☐ Other _____

Affix Refill Label or Print Prescription Number

Please see the back side of this form for instructions

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Mail Service Order Form

Welcome to Caremark's Mail Service Prescription Program. This program offers a convenient, cost-effective way to order prescribed maintenance medication for direct delivery to your home or workplace. We are pleased to provide this service to you and look forward to fulfilling your prescription needs in the future.

Instructions for New Prescriptions

For new prescriptions being submitted through the mail, complete sections A and B on the reverse side of this form. One Participant Information section must be completed for each person submitting a prescription.

Instructions for Refill Prescriptions

Refill-by-Phone:

Call Caremark's toll-free Request Line using a touch-tone phone or visit **www.caremark.com** for your on-line prescription service. You may order refills for one or more of your prescriptions – 24 hours a day, 7 days a week. As an added feature you can also inquire on the status of any order recently submitted to Caremark.

When using Caremark's toll-free Request Line or **www.caremark.com** you will need the following information:

- Participant's ID number provided by your plan.
- Participant's date of birth.
- 9-digit prescription number located in the box on your prescription and refill labels.
- Your VISA, MasterCard, Discover Card, or American Express number if your plan requires a payment.

Refill-by-Mail:

Complete sections A and B on the back of this form. Affix the Caremark refill label(s) in the space provided.

"No Refills Remain…Call Your Doctor"

If your refill label notes the above, please contact your doctor and request a new prescription.

Important Information

Whether submitting a new or refill prescription through the mail, please remember to:

- Complete all of the information in sections A and B on the back of this form.
- Include check, money order, or VISA, MasterCard, Discover Card, or American Express number for payment (if applicable).
- Enclose original prescription or affix refill labels.
- Include signature in the certification section on the bottom of this form.
- Checks returned for insufficient funds shall be subject to a $25 processing fee.

An incomplete Mail Service Order Form will be returned to you with the original prescription unfilled, causing a delay in processing.

The submission of this form, for you or any of your dependents, authorizes the release of all information to applicable healthcare providers and all others involved in filling the prescriptions or processing the claims submitted (not applicable to research study program participants).

Caremark cannot at any one time dispense more than the exact amount prescribed by your doctor or the day supply limit specified by your benefits plan, whichever is less. Caremark cannot provide refills at the time of the original filling.

In connection with your benefit plan, Caremark may contact your doctor regarding your prescription. This may result in your doctor prescribing a different brand name product or a generic equivalent in place of your original prescription.

Texas law allows a less expensive generically equivalent drug to be substituted for certain brand name drugs unless your physician directs otherwise. You have a right to refuse such substitution. Consult your physician or pharmacist concerning the availability of a safe, less expensive drug for your use.

Please note: Consult your plan literature regarding possible differences in coverage or payment between brands and generics.

Consumer questions concerning Caremark Prescription Service on quality of service, order status, benefit plan design, and other related questions may be answered by calling Caremark's toll free number at 1-888-202-1657. Complaints concerning the practice of pharmacy may be filed with the Texas State Board of Pharmacy at: William P. Hobby Building, Suite 3-600, 333 Guadalupe, Box 21, Austin, TX 78701-3942, (512) 305-8000

To receive a complaint form, call 1-800-821-3205 or (512) 305-8080 in Austin (recorded information only) or log in to file a complaint at: **www.tsbp.state.tx.us**.

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Certification: I certify that information on this form is correct and further understand that any benefits under the Prescription Service program are subject to my eligibility for and participation in the medical plan, and certify that I or my dependents for whom prescriptions are enclosed do not have primary prescription drug coverage under any other group medical plan. I also agree to reimburse the Plan sponsor to the extent of any benefit which is in excess of the amount payable under the medical plan.

Participant Signature_____ Date _____