

C Tell us about the people ordering prescriptions. If there are more than two people, please complete another form.

First person with a refill or new prescription.

Spanish forms and labels

LAST NAME

FIRST NAME

M

Suffix (JR,SR)

NICKNAME

Gender: M F

Date of birth: MM-DD-YYYY

E-mail address: _____ Date new prescription written: _____

Doctor's last name

Doctor's first name

Doctor's phone #

Tell us about new health information for 1st person if never provided or if changed.

Allergies: None Aspirin Cephalosporin Codeine Erythromycin Peanuts Penicillin Sulfa Other: _____

Medical conditions: Arthritis Asthma Diabetes Acid reflux Glaucoma Heart problem High blood pressure High cholesterol Migraine Osteoporosis Prostate issues Thyroid Other: _____

Second person with a refill or new prescription.

Spanish forms and labels

LAST NAME

FIRST NAME

M

Suffix (JR,SR)

NICKNAME

Gender: M F

Date of birth: MM-DD-YYYY

E-mail address: _____ Date new prescription written: _____

Doctor's last name

Doctor's first name

Doctor's phone #

Tell us about new health information for 2nd person if never provided or if changed.

Allergies: None Aspirin Cephalosporin Codeine Erythromycin Peanuts Penicillin Sulfa Other: _____

Medical conditions: Arthritis Asthma Diabetes Acid reflux Glaucoma Heart problem High blood pressure High cholesterol Migraine Osteoporosis Prostate issues Thyroid Other: _____

D Special instructions: _____

E How would you like to pay for this order? (If your copay is \$0, you do not need to provide payment information.)

Electronic check. Pay from your bank account. (You must first register online or call Customer Care.)

Credit or debit card. (VISA®, MasterCard®, Discover®, or American Express®)

Use your card on file.

Use a new card or update your card's expiration date.

CARD NUMBER

Exp. Date MMY Y

Check or money order. Amount: \$ _____

- Make check or money order payable to CVS Caremark.
- Write your prescription benefit ID number on your check or money order.
- If your check is returned, we will charge you up to \$40.

Payment for balance due and future orders: If you choose electronic check or a credit or debit card, we will use it to pay for any balance due and for future orders unless you provide another form of payment.

Fill in this oval if you **DO NOT** want us to use this payment method for future orders.

49-MOF 0316 AETNA MEDICAID

Credit card holder signature/Date

Regular delivery is free and takes up to 5 days after your order is processed.

If you want faster delivery, choose:

2nd business day (\$17)

Faster delivery can only be sent to a street address, not a PO Box

Next business day (\$23)

Expected processing time from receipt of this form:

- Refills: 1-2 days
- New/renewed prescriptions: Within 5 days unless additional information is needed from your doctor (Charges subject to change)



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