CAREMARK

Participant Profile / 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 and Refill Prescriptions by Mail

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

- Complete all of the information in sections A and B on page two of this form. For new prescriptions one Participant Information section must be completed for each person submitting a prescription.
- Include check, money order, or VISA, MasterCard, or Discover Card number for copayment (if applicable).
- Enclose original prescription or affix refill labels in the space provided. If space is needed for additional labels, please apply to any piece of paper and enclose it with this order form.
- Mail order to:
  Caremark
  PO Box 659529
  San Antonio, TX 78265-9529
- Include signature in the certification section on the bottom of this form.
- Checks returned for insufficient funds shall be subject to a $15 processing fee.

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

"No Refills Remain ... Call Your Doctor"
If your refill label notes the above, please contact your doctor and request a new prescription.

Important Information

The submission of this form, for you or any of your dependents, authorizes the release of all information to the Plan Sponsor, Administrator or Underwriter and authorizes the prescription to be filled with the generic equivalent when available and permissible by law, in accordance with your benefit plan design.

Caremark can not 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 can not 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.

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

Caremark Customer Service

7:00 a.m. - 9:00 p.m. Monday-Friday (CST)
8:00 a.m. -noon Saturday (CST)
www.caremark.com

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Certification: I certify that information on this form is correct and further understand that any benefits under the Prescription Service programs 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** _____

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A - PARTICIPANT INFORMATION

☐ Medicare B
Please check if applicable

PRIMARY CARDHOLDER SSN/ID#:

COMPANY

SHIP TO THIS ADDRESS

☐ Check if change of address
☐ Check if temporary address for this order only

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 Prescription Service Division)
☐ Caremark Credit Voucher Number: _____
☐ Money Order or Cashier's Check

Credit Card: ☐ VISA ☐ MasterCard ☐ Discover Card

Credit Card Number

Expiration Date

/

Copayment Amount Enclosed: $_____

Signature: _____

B - PARTICIPANT No.1 INFORMATION

Last Name Initial

First Name Nickname

Birthday 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 Primary Participant:
☐ Self ☐ Full-time Student ☐ Daughter ☐ Son ☐ Sponsored Dependent ☐ Widowed ☐ Spouse

Drug Allergies:
☐ None (10) ☐ Codeine (97) ☐ Sulfonamides (40) ☐ Aspirin (4) ☐ Penicillin (31) ☐ Other _____

Health Conditions:
☐ Thyroid (246) ☐ High Blood Pressure (402) ☐ Glaucoma (365) ☐ Diabetes (250) ☐ Intestinal Disorders (564) ☐ Heart Condition (428) ☐ Arthritis (714) ☐ Asthma (493) ☐ Other _____

List other prescription /non-prescription drugs being taken:

_____

PARTICIPANT No.2 INFORMATION

Last Name Initial

First Name Nickname

Birthday 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 Primary Participant:
☐ Self ☐ Full-time Student ☐ Daughter ☐ Son ☐ Sponsored Dependent ☐ Widowed ☐ Spouse

Drug Allergies:
☐ None (10) ☐ Codeine (97) ☐ Sulfonamides (40) ☐ Aspirin (4) ☐ Penicillin (31) ☐ Other _____

Health Conditions:
☐ Thyroid (246) ☐ High Blood Pressure (402) ☐ Glaucoma (365) ☐ Diabetes (250) ☐ Intestinal Disorders (564) ☐ Heart Condition (428) ☐ Arthritis (714) ☐ Asthma (493) ☐ Other _____

List other prescription /non-prescription drugs being taken:

_____

Affix Refill Label or Print Prescription Number

Reminder: Refills can be ordered online at ***RxRequest.com*** or by dialing 1-800-213-0879 on your touch tone phone.

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