



# MAIL SERVICE ORDER FORM

Mail order form to:

  
CAREMARK OPTIMA  
PO BOX 94467  
PALATINE, IL 60094-4467

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

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.optimahealth.com/mailorder](http://www.optimahealth.com/mailorder) or call toll free# 1-888-766-5495

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

Last Name First Name MI Suffix (JR, SR)

   

Street Address Apt./Suite# **Use this address for this order only.**

 

City State Zip Code

  - 

Daytime Phone#:  -  -

Prescription Plan Sponsor or Company Name Evening Phone#:  -  -

### Rx Information - To order NEW prescriptions, mail the doctor's prescription(s) with this form.

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 [Caremark.com](http://Caremark.com), or 3) call Caremark Customer Care.

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

write prescription number above

Apply Caremark Refill Label here

or

write prescription number above

Please fold here

\* WEB \*

Please fold here

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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.**



