CVS/caremark™

Mail Service Order Form

VIVA MEDICARE

Mail this form to:

CVS/caremark
PO BOX 94467
PALATINE, IL 60094-4467

Member ID # (if not shown or if different from above)

Prescription Plan Sponsor or Company Name

Please fold here

Instructions:

Please use **blue or black ink, capital letters,** and fill in **both sides** of this form.

New Prescriptions - Mail your new prescriptions with this form. Number of **New** prescriptions:

Refills - Order by Web, phone, or write in Rx number(s) below. Number of **Refill** prescriptions:

TO RECEIVE YOUR ORDER SOONER request refills or new prescriptions online at www.vivahealth.com or call toll-free 1-866-788-5146 or TTY 1-866-236-1069.

A Shipping Address. To ship to an address different from the one printed above, please make changes here.

Last Name | First Name | MI | Suffix (JR, SR)

Street Address | Apt./Suite #

○ **Use shipping address for this order only.**

City | State | ZIP Code

Daytime Phone #: - - Evening Phone #: - -

B Refills. To order mail service refills, enter your prescription number(s) here.

1) 2) 3) 4)

5) 6) 7) 8)

CVS/caremark wants to provide you with high quality medicines at the best possible price. In order to do this, we will substitute equivalent generic medicines for brand name medicines whenever possible. If you do not want us to substitute generics, please provide specific instructions, including drug names, in the "Special Instructions" section of this form.

We may package all of these prescriptions together unless you tell us not to.

All claims for prescriptions submitted to CVS Caremark Mail Service Pharmacy using this form will be submitted to your prescription benefit plan for payment. If you do not want them submitted to your plan, do not use this form. You may call Customer Care to make alternate arrangements for submission of your order and payment.

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

1st 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: _____

2nd 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: _____

Please fold here →

Please fold here →

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.)

○ **Use my PayPal Credit account.** Works like a credit card. (You must first register online or call Customer Care.)

○ **Credit or Debit Card.** (VISA®, MasterCard®, Discover®, or American Express®)

○ Fill in this oval to use your card on file.

○ Fill in this oval to use a new card or to update your card expiration date.

CARD NUMBER _____ Exp. Date MMYY

Credit Card Holder Signature/Date

○ **Check or Money Order.** Amount: $ ____ . __

- Make check or money order out 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 chose Electronic Check, PayPal Credit, or a Credit or Debit Card, we will also use it to pay for any balance that you owe and for future orders.

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

Regular delivery is free and will take up to 10 days from the day you send this form.

If you want faster delivery, choose:

○ **2nd Business Day ($17)**

○ **Next Business Day ($23)**

Business days are only Monday-Friday

- Faster delivery charges may change.
- Faster delivery is for shipping time only, not processing.
- Faster delivery can only be sent to a street address, not a PO Box.