CAREMARK®
It all starts with care®

MAIL SERVICE ORDER FORM

NORTH CAROLINA
ASSOCIATION OF COUNTY COMMISSIONERS

Please fold here

Mail order form to:

CAREMARK NCACC
PO BOX 94467
PALATINE, IL 60094-4467

Primary Plan Participant ID Number (refer to Rx card):

(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.caremark.com or call toll-free# 1-866-209-6409

Shipping Information (Complete **ONLY IF DIFFERENT** or not shown above)

Last Name

First Name

MI

Suffix (JR, SR)

Street Address

Apt./Suite#

City

State

Zip Code

O Fill in oval if one time only address.

Daytime Phone#:

Evening Phone#:

Rx Information **(If space is needed for more refill labels use Refill Order Continuation Form and send with this order)**

To order NEW prescriptions, mail the doctor's prescription with this form. Number of Rx's: New Refill Total

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

Visit www.caremark.com for the fastest refills. Log in to check order status and access personalized information about your prescription benefits. IMPORTANT NOTICE: When getting a new prescription, be sure to ask your doctor to write your prescription for the maximum amount allowed by your benefit plan, usually a 90-day supply. Make sure your doctor SIGNS and DATES all new prescriptions.

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.

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Plan Participant Information: Fill in for plan participants receiving a prescription with this order.

#1: ○ Fill in oval if enrolled in Medicare Part B. ○ Easy open caps. ○ Print mail service materials in Spanish.

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

Alternate Name (Nickname) | Gender: ○ M ○ F | Date of Birth: MM - DD - YYYY

E-mail address: _____

Doctor / Prescriber's Last Name | Doctor / Prescriber's First Name | Doctor / Prescriber's Telephone # ___ - ___ - ____

COMPLETE ALLERGY/HEALTH INFORMATION ONLY IF CHANGED OR NOT PREVIOUSLY REPORTED

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

Health Conditions: ○ Arthritis ○ Asthma ○ Diabetes ○ GERD (Acid Reflux) ○ Glaucoma ○ Heart Condition ○ High Blood Pressure ○ High Cholesterol ○ Migraine ○ Osteoporosis ○ Prostate Disorders ○ Thyroid ○ Other: _____

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#2: ○ Fill in oval if enrolled in Medicare Part B. ○ Easy open caps. ○ Print mail service materials in Spanish.

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

Alternate Name (Nickname) | Gender: ○ M ○ F | Date of Birth: MM - DD - YYYY

E-mail address: _____

Doctor / Prescriber's Last Name | Doctor / Prescriber's First Name | Doctor / Prescriber's Telephone # ___ - ___ - ____

COMPLETE ALLERGY/HEALTH INFORMATION ONLY IF CHANGED OR NOT PREVIOUSLY REPORTED

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

Health Conditions: ○ Arthritis ○ Asthma ○ Diabetes ○ GERD (Acid Reflux) ○ Glaucoma ○ Heart Condition ○ High Blood Pressure ○ High Cholesterol ○ Migraine ○ Osteoporosis ○ Prostate Disorders ○ Thyroid ○ Other: _____

Please fold here

Comments/Special Instructions: _____

Method of Payment/Shipping Information

Please make check or money order payable to **Caremark**. Include ID# on all checks and money orders.

○ Check ○ Money Order or Cashier's Check ○ Voucher/Coupon **Total payment enclosed:** $ ___ . __

Checks returned for insufficient funds will be subject to a processing fee of up to $40, depending on state law. (Excluding credit card payments)

OR pay by credit or debit card (preferred). We accept VISA®, MasterCard®, Discover® and American Express®.

○ **Fill in oval to charge most recently used credit card for this order and future orders for all participants included in the family.**

○ **Fill in oval to charge most recently used credit card for this order only.**

To add, change, or update your credit card information, write in below:

Credit/Debit Card Number | Expiration Date MM - YY

Credit Card Holder Signature _____ Date _____

Your credit card will be billed for Rx costs and expedited shipping (if requested).

Your order will be shipped standard delivery at no charge. Allow 10 to 14 days for standard delivery. If you require faster delivery, mark the appropriate oval below. Expedited delivery only affects shipping time, not processing time of your order. Expedited shipments can only be sent to a street address, not a P.O. Box.

Fill in oval for expedited delivery:

○ 2nd Business Day = $13 (per order) ○ Next Business Day = $18 (per order)

(Charges subject to change.)

Plan participant acknowledges that eligibility under the prescription benefit is subject to Plan verification and that you/your dependents do not have primary prescription coverage under any other plan.