




Mail Service Order Form



BlueCross BlueShield

Federal Employee Program.

For Service Benefit Plan Members

	<p>Mail this form to:</p>  <p>CVS Caremark PO BOX 1590 PITTSBURGH, PA 15230-9607</p>
<p>Member ID # (if not shown or if different from above)</p> <input type="text"/>	
<p>Prescription Plan Sponsor or Company Name</p>	

Instructions:

Please use **blue or black ink** and **print in capital letters**. 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.fepblue.org or call the toll-free number on your member ID card.

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

Last Name <input type="text"/>	First Name <input type="text"/>	MI <input type="text"/>	Suffix (JR, SR) <input type="text"/>
Street Address <input type="text"/>	Apt./Suite # <input type="text"/>	<input type="radio"/> Use shipping address for this order only.	
City <input type="text"/>	State <input type="text"/>	ZIP Code <input type="text"/>	
Daytime Phone #: <input type="text"/> - <input type="text"/> - <input type="text"/>		Evening Phone #: <input type="text"/> - <input type="text"/> - <input type="text"/>	

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

1) <input type="text"/>	2) <input type="text"/>	3) <input type="text"/>	4) <input type="text"/>
5) <input type="text"/>	6) <input type="text"/>	7) <input type="text"/>	8) <input type="text"/>

If this prescription is for an injury that was work related, please call 1-800-262-7890.

On behalf of the Blue Cross and Blue Shield Federal Employee Program, CVS Caremark administers the Service Benefit Plan pharmacy benefit. CVS Caremark is an independent company which provides mail order prescription drugs to FEP members. CVS Caremark will substitute equivalent generic medicines for brand name medicines whenever possible. If you do not want generics, please provide 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.



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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 MI 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 MI 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.

Exp.Date MMY

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.

Credit card holder signature/Date

Regular delivery is free and will take up to 2 weeks from the day you send this form.
If you want faster delivery, choose:

- 2nd Business Day (\$17)** Business days are only Monday-Friday
- Next Business Day (\$23)** 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.



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