CVS CAREMARK | CAREMARK

MEDICARE Part D
Confidential Mail Service Enrollment Form

Toll Free Number: 1-800-311-0577
TTY/TDD: 1-800-311-0533

For more information, visit us at www.caremark.com

Hours of Operation:
24 hours a day Mon - Fri
9 a.m. to 8 p.m. Sat (ET)
9 a.m. to 6 p.m. Sun (ET)

Member Information

Member ID

Date of Birth (M M / D D / Y Y Y Y)

Daytime Telephone Number ( ) - ( ) - ( )

Employer / Plan Name

Last Name

First Name

MI

Permanent Address

Gender:
- ☐ Male
- ☐ Female

City

State

ZIP Code

E-mail Address

Drug Allergies:

- ☐ None
- ☐ Codeine
- ☐ Iodine
- ☐ Sulfa [03]
- ☐ Aspirin [04]
- ☐ Erythromycin
- ☐ Penicillin [01]
- ☐ Other _____

Health Conditions:

- ☐ Arthritis
- ☐ Diabetes [06]
- ☐ Glaucoma [07]
- ☐ High Blood Pressure [09]
- ☐ Hypertension
- ☐ Asthma
- ☐ Depression
- ☐ Heart Condition [08]
- ☐ High Cholesterol
- ☐ Thyroid-Low/High [05]
- ☐ Other _____

☐ List diabetic supplies _____

Prescription Order Form For New Participant

Please write the Member ID on the back of each prescription and **remember to include the prescription from the prescriber in the envelope.**

Credit Card

Provide the credit card number and expiration date. We accept JCPenney, Discover, MC, VISA and AMEX. This credit card will be used for all orders, unless we are notified otherwise.

Credit Card Number

Expiration Date (M M / Y Y)

Signature _____ Date _____

Please Read and Sign to Complete Order

I certify that the information provided on this form is correct and I authorize the release of all information to the Plan Sponsor.

Signature _____ Date _____

This form is read by machine. Please print the numbers and letters as shown below:

A B C D E F G H I J

1 2 3 4 5 6 7 8 9 0