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## BlueChoice HealthPlan Mail Service Order Form

For more information, visit our Web site at www.BlueChoiceSC.com or call 1-800-868-2528.

**Instructions:** Please PRINT in CAPITAL letters using BLACK ink only. Fill in the applicable ovals completely ( ). Mail this completed form, the doctor's signed prescription(s), and your payment to Caremark in the envelope provided. Rev. 02/05

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New Prescription Information Enclose original doctor-signed prescription(s) and payment with this form. Ask your doct write your mail order prescription for the maximum supply allowed by your plan (if appropriate prescription).	or to iate).
Prescriptions are for:  Member  Spouse of Member  Dependent(s)	
Total number of medications in this order:	
Doctor Name (Last Name) (First Name)	
Doctor Phone Number  ( )	
Prescription Bottle Cap: A child-resistant cap is included with every order.  Mark here if you would also like an easy-open cap.	
Caremark may contact your doctor regarding your prescription. This may result in your doctor prescribing a differer clinically-appropriate product in place of your original prescription. If you do not want your doctor contacted abour preferred, potentially cost-saving product, mark here.	nt t a
Quiere las instrucciones en español? (Spanish label instructions?)	
<b>Generic Medications:</b> We want to provide you with high quality medications at the best possible price. In order to do th may occasionally contact your doctor to obtain authorization to dispense the generic version of your brand-name drug. Receive generics often results in savings to you. No change to a generic will be made without the consent of your doctor. If you do want us to substitute a generic, when appropriate, please list the drug name(s) below that you do not want us to substitute	eiving o <b>not</b>
Drug Name(s) 1 2	
3 4	
Your order will be shipped standard delivery at no charge. Please allow 14 days from the date you mail your order for delivery of your medicine. If you prefer expedited delivery, mark the appropriate oval. Expedited shipping only affects shipping time, not processing time of your order.  2nd Business Day = \$10 (per order)  Next Business Day = \$15 (per order)	
All medications in this order will be sent in the same package to the address provided. If a family member doe want his or her medicine sent in the same package as that of other family members, he or she should complese parate order form.	
Payment, when applicable, is due with each order and may be made by credit card or check. Payment by credit of is preferred. If paying by check, make the check payable to Caremark. Please write your member identification number your check. There is a \$20 returned check charge. Do not send cash. Orders received without payment may result in a of processing.  Any outstanding balances will be the responsibility of the primary insured.  If you have questions about your payment amount, call the phone number printed on the front of this form.	on
Credit Card (provide information below)     Payment by Check or Money Order	
O MasterCard O Visa O Discover O American Express O If you want all future orders to be billed to this mark here.	card,
Credit Card # Exp. Date (MM-YYYY)	
Credit Cardholder Signature	
The credit card will be charged for drug costs, expedited shipping (if applicable) and any outstanding balances due.  By returning this form to Caremark, you consent to the use and release of your health information and that of	your

Mail your prescriptions to: Caremark • P.O. Box 830070 • Birmingham, AL 35283-0070

covered dependents (if you are their guardian or authorized representative) to your health plans and health care

providers/agents for health benefits management.