

STEP 4 – Method of Payment

Fill in the appropriate oval for your method of payment. If you are paying by check or money order, please write your Health Net ID number on the check. If you are paying by credit card, be sure to include your signature. Payment by credit card is the preferred method of payment. We accept VISA®, MasterCard®, Discover® or American Express®. **DO NOT SEND CASH.**

STEP 5 – Enclose Your Prescription

Make sure you enclose the original prescription(s) you receive from your doctor (not photocopies).

PAYMENT INFORMATION: Select one payment method below.

Electronic Check Processing (Please pre-register at www.healthnet.com)

Bill Me Later® (Subject to credit approval. Please pre-register at www.healthnet.com)

Credit/Debit Card (VISA, MasterCard, Discover or American Express)

Charge most recently used credit card

Charge new/updated credit/debit card (provide info below)

CREDIT CARD# Exp. Date

Check/Money Order: Amount \$ Credit Card #

Make check or money order payable to CVS Caremark and write your ID# on the check/money order. Returned checks will be subject to a fee of up to \$40, depending on state law.

The selected payment method (unless paying by check) will be charged for future orders, unless a different form of payment is provided. It will also be charged for any outstanding balance due.

Fill in oval if you DO NOT want the selected payment method to be automatically charged for future orders.

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That's It!

Now, simply mail your order form along with your prescription(s) and payment in the envelope provided, or use your own envelope and mail the form and payment to the Caremark Mail Order Pharmacy address printed on the form. Please be sure to fold the mail order form

along the fold lines so the Caremark Mail Order Pharmacy address shows through the window of the envelope.

3 Ways to Refill

Online. You can request your mail order refills at www.healthnet.com. Register online to receive refill reminders, informative newsletters and other important alerts. Have your Health Net ID number handy to register.

By Phone. Call the toll-free Caremark Customer Service phone number at 1-888-624-1139 (TTY 1-866-236-1069) for a fully automated refill service. Have your Health Net ID number ready.

By Mail. You will receive an order form with every prescription order. Simply fill in the ovals for the prescriptions you want to refill. If you need to refill a medication that is not listed, write in the prescription number(s) in the space provided. Send the order form to Caremark and enclose your payment, if your plan requires a payment.

Questions?

If you have any questions about mail order, please call Caremark Customer Care toll-free at 1-888-624-1139, TTY 1-866-236-1069. If you have any questions about your Health Net benefits, please call the phone number on your Health Net ID card.



Getting Started With Health Net's Mail Order Pharmacy

For First Time Users

**CVS
CAREMARK**



Health Net®
A BETTER DECISION

Your Mail Order Pharmacy

The benefits of using mail order

How would you like the convenience of having your prescription medications delivered directly to your home or office, saving you time and trips to a participating retail pharmacy. Using your mail order pharmacy benefit may even save you money! With mail order, you may be able to receive up to a 3-month supply of your medication at significantly less than you would pay at a participating retail pharmacy.

By using the mail order pharmacy you can:

- Receive an extended supply of your prescription medications
- Enjoy the convenience of having your medications delivered to a location of your choice – home, office, vacation spot
- Speak to a registered pharmacist 24 hours a day, seven days a week
- Order medications and get health information online at www.healthnet.com

Getting Started

If you need your prescription filled right away, ask your doctor to write two prescriptions for your medication:

- The first for a short-term supply (e.g., 30-days) to be filled right away at a retail pharmacy

- The second for the maximum days supply allowed (up to a 3-month supply) with as many as three refills (if appropriate) to be mailed to the Caremark Mail Order Pharmacy

If you're not in a hurry, just mail your prescription for a 3-month supply (with any appropriate refills) to Caremark.

Filling Out the Mail Service Order Form

Follow these five easy steps to fill out your mail service order form:

STEP 1 – Health Net ID Number

Fill in your ID number from your Health Net ID card. (On your next order, your ID number will be pre-printed on your order form.)

STEP 2 – Address

Fill in your complete address. Be sure to fill in the oval if the address listed is a one-time only address.

STEP 3 – Prescription Information

You may use one mail service order form to order medications for more than

one person in your household if both share the same Health Net ID number. (If both do not share the same Health Net ID number, separate mail service order forms are needed.) Provide the requested information for the first person for whom a prescription(s) is being submitted.

- Indicate if you would like your order to include Easy-Open Caps. All orders are normally shipped with safety caps or dual-purpose caps (which can be converted from child-safe to easy-open).
- Be sure to completely fill out your Doctor's Name and Telephone Number.
- Fill in the ovals under "Allergies" if you are allergic to any drugs or foods. If you do not see the allergy listed, fill in the "Other" oval and write in the allergy.
- Fill in the ovals if you have any health "Conditions." If you do not see your health condition listed, fill in the "Other" oval and write in the health condition.

Enter ID# if not shown or different from above

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Prescription Plan Sponsor or Company Name

DIRECTIONS: Print in **BLUE** or **BLACK** ink, using CAPITAL letters, both sides of form.

To order new prescriptions: Mail your prescription(s) with this form.

To order refills: Order by Web, phone, or write in Rx number(s).

FOR FASTEST SERVICE, order refills at www.healthnet.com or by phone at 1-800-441-1111.

SHIPPING ADDRESS IF NOT SHOWN OR DIFFERENT FROM ABOVE

Last Name 2 First Name

Street Address

City

FILL IN FOR UP TO TWO PEOPLE WHO WILL RECEIVE PRESCRIPTION(S)

1st PERSON ORDERING A PRESCRIPTION Easy Open Caps

LAST NAME 3 FIRST NAME

NICKNAME Gender: M F Date of Birth: MM/DD/YYYY

Your E-mail: _____ Date new prescription: _____

Doctor's Last Name _____ Doctor's First Name _____

ALLERGY/HEALTH INFORMATION: COMPLETE ONLY IF CHANGING

Allergies: None Aspirin Cephalosporin Codeine Ergot
 Sulfa Other: _____

Conditions: Arthritis Asthma Diabetes Acid Reflux
 High Blood Pressure High Cholesterol Migraine Osteoporosis
 Other: _____

2nd PERSON ORDERING A PRESCRIPTION Easy Open Caps

LAST NAME FIRST NAME

NICKNAME Gender: M F Date of Birth: MM/DD/YYYY