


aetna® Medication Order Form

Aetna Rx Home Delivery®

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	Mail this form to:  AETNA RX HOME DELIVERY PO BOX 417019 KANSAS CITY MO 64179-7019
Member ID # (if not shown or if different from above) _____ _____	
Prescription Plan Sponsor or Company Name _____	

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Please use **blue or black ink, capital letters**, and 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:

For Fastest Service, order refills at www.aetnavigators.com or call toll-free **1-888-RX AETNA (1-888-792-3862)**, or TDD (for hearing impaired) at **1-800-823-6373**. Your doctor may fax your prescription(s) to **1-877-270-3317**. Only a doctor may fax a prescription.

A Shipping Address.

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

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

1) _____	2) _____	3) _____	4) _____
5) _____	6) _____	7) _____	8) _____

Aetna wants to provide you with high quality medicines at the best possible price. In order to do this, we will substitute equivalent generic medicines for Brand name medicines whenever possible. If you do not want us to substitute generics, please provide specific instructions including drug names, use the "Special instructions" section of this form.

All claims for prescriptions sent to Aetna Rx Home Delivery 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.

We may package all of these prescriptions together unless you tell us not to.

Please Note: By submitting this form you verify that the information is correct, that the prescriptions enclosed are for use by eligible participants and authorize the release of all information to the Plan Sponsor, administrator, or underwriter. All communications regarding this account will be directed to the member (employee/retiree). If a spouse or other eligible dependent wishes to direct their communications to an alternate address or telephone number, they may make this request by completing the Confidential Communications Request form provided in the Privacy Notice, or as available on our website.



C Tell us about the people getting prescriptions. If there are more than two people, please complete another form.

1st person with a refill or new prescription.

Spanish forms and labels

Last Name

First Name

Nickname

MI Suffix (JR,SR)

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: _____

2nd person with a refill or new prescription.

Spanish forms and labels

Last Name

First Name

Nickname

MI Suffix (JR,SR)

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? Fill in the oval to choose a payment.

- Electronic Check.** Pay from your bank account. First time users register online or call Customer Care.
- Use my BillMeLater[®] account.** Works like a credit card. First time users register online or call Customer Care.
a PayPal service
- Credit or Debit Card.** (VISA[®], MasterCard[®], Discover[®], American Express[®], including FSA/HRA/HSA debit cards)
 - Fill in this oval to use your card on file.
 - Fill in this oval to use a new card or to update your card expiration date.

Exp. Date

Check or Money Order. Amount: \$

- Make check or money order out to Aetna Rx Home Delivery.
- Write your Aetna Member 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 chose electronic check, Bill Me Later[®], or a credit or debit card, we will also use it to pay for any balance that you owe and for future orders unless you provide another form of payment.

Fill in this oval if you **DO NOT** want to use this payment method for future orders.

I authorize Aetna Rx Home Delivery to bill my credit card for any out-of-pocket costs or special shipping costs in effect at the time my order is filled.

Credit Card Holder Signature/Date _____

Regular delivery is free and will take 10 to 14 days 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, not processing time.
- Faster delivery can only be sent to a street address, not a PO box.



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