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

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.aetnanavigator.com** or call toll-free **1-888-RX AETNA (1-888-792-3862)**, TTY 711.

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

Last Name | First Name | MI | Suffix (JR, SR)

Street Address | Apt./Suite #

○ **Use shipping address for this order only.**

City | State | ZIP Code

Daytime Phone #: - - Evening Phone #: - -

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 ordering prescriptions.** If there are more than two people, please complete another form.

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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:

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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.)

Please fold here

◯ **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 MMYY

Credit card holder signature/Date

◯ **Check or money order.** Amount: $.

- Make check or money order payable 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 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.

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.

Regular delivery is free and takes up to 5 days after your order is processed.

If you want faster delivery, choose:

◯ **2nd business day ($17)**

◯ **Next business day ($23)**

Faster delivery can only be sent to a street address, not a PO Box

Expected processing time from receipt of this form:

- Refills: 1-2 days
- New/renewed prescriptions: Within 5 days unless additional information is needed from your doctor

(Charges subject to change)

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