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## **aetna** Medication Order Form Aetna Rx Home Delivery®

		Mail this fo	rm to:	
Enter ID number  Prescription Plan Sponsor or	Company Name	AET PO I		
Please use blue or black inl	k, capital letters, and fill	in both side	es of this form.	
New Prescriptions - Mail your new prescriptions with this form.  Refills - Order by Web, phone, or write in Rx number(s) below.  For Fastest Service, order refills at www.aetnanavigator.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 Nam	ne	MI Suffix (JR, SR)
Ctus at Name			A 1 /O : 1 //	
Street Name			Apt./Suite #	Use this address for this order only.
City				Code
Daytime Phone #:	-	Evening Pl	hone #:	
B Refills. To order mail serv	ice refills, enter your pre	scription num	nber(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.



1st person with a refill or new prescription. This person needs:	: ○ Spanish forms and labe
Last Name First Name	Suffix (JR,SR)
Nickname Date of Bil	rth:
Your E-Mail: D	ate new prescription written:
Doctor's Last Name Doctor's First Name	Doctor's Phone #
Tell us about <b>new</b> allergies or health information for this pers	
Allergies: None Aspirin Cephalosporin Codein Sulfa Other:	e
Health Information: Arthritis Asthma Diabetes Aci High Blood Pressure High Cholesterol Migraine Other:	Osteoporosis O Prostate Issues O Thyroid
2nd person with a refill or new prescription. This person needs:	: Spanish forms and labe
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Nickname  Date of Bir  Gender: M F MM-DD-YY	rth:
	ate new prescription written:
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