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

		Mail this form to:		
Member ID # (if not shown Prescription Plan Sponsor		AETNA RX HO PO BOX 4170		
Please use blue or black	ink, capital letters, and fil	l in <b>both sides</b> of this f	orm.	
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 Name	MI Suffix (JR, SR)	
Street Address		Apt./Suite	# Use this address for this order only.	
City		State	ZIP Code	
Daytime Phone #: Evening Phone #:				
<b>B</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.



1st person with a refill or new prescription.	○ Spanish forms and label
Last Name First Name	Suffix (JR,SR)
Nickname  Gender: M F MM-DD-Y	sirth:
E-Mail Address:	Date new prescription written:
Doctor's Last Name Doctor's First Name	Doctor's Phone #
Tell us about <b>new</b> health information for 1st person if never <b>Allergies:</b> None Aspirin Cephalosporin Codeil Sulfa	provided or if changed. ne
Medical Conditions: Arthritis Asthma Diabetes Acompletes High Blood Pressure High Cholesterol Migraine Other:	Osteoporosis O Prostate Issues O Thyroid
2nd person with a refill or new prescription.	) Spanish forms and label
Last Name First Name	Suffix (JR,SR)
Nickname  Gender: M F Date of B MM-DD-Y	irth:
	Date new prescription written:
B-7-1-1-131	Doctor's Phone #
Doctor's Last Name Doctor's First Name  Tell us about <b>new</b> health information for 2nd person if never	
Sulfa Other:  Medical Conditions: Arthritis Asthma Diabetes A High Blood Pressure High Cholesterol Migraine Other:	cid Reflux
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Medical Conditions: Arthritis Asthma Diabetes Acount High Blood Pressure High Cholesterol Migraine Other:  Special Instructions:  How would you like to pay for this order? Fill in the oval to complete Electronic Check. Pay from your bank account. First time of Use my PayPal Credit account. Works like a credit card. First Credit or Debit Card. (VISA®, MasterCard®, Discover®, Americal Fill in this oval to use your card on file.  Fill in this oval to use a new card or to update your card end MMYY  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.	cid Reflux
Medical Conditions: Arthritis Asthma Diabetes Accomplete And High Blood Pressure High Cholesterol Migraine Other:  Special Instructions:  How would you like to pay for this order? Fill in the oval to complete Electronic Check. Pay from your bank account. First time of Use my PayPal Credit account. Works like a credit card. First Credit or Debit Card. (VISA®, MasterCard®, Discover®, Americal Fill in this oval to use your card on file.  Fill in this oval to use a new card or to update your card end Exp.Date MMYY  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.	Cid Reflux  Glaucoma  Heart Problem  Choose a payment.  Users register online or call Customer Care.  St time users register online or call Customer Care  an Express®, including FSA/HRA/HSA debit cards)  Expiration date.  Credit Card Holder Signature/Date  Regular delivery is free and will take 10 to 1 days from the day you send this form.  If you want faster delivery, choose:  2nd Business Day (\$17)  Next Business Day (\$23)  Paster delivery charges may change.  Faster delivery can only be sent to a street address.
Medical Conditions: Arthritis Asthma Diabetes Acount High Blood Pressure High Cholesterol Migraine Other:  Special Instructions:  How would you like to pay for this order? Fill in the oval to complete Electronic Check. Pay from your bank account. First time of Use my PayPal Credit account. Works like a credit card. First Time of Fill in this oval to use your card on file.  Fill in this oval to use a new card or to update your card end Exp.Date MMYY  Check or Money Order. Amount:  Make check or money order out to Aetna Rx Home Delivery Mrite 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, PayPal Credit, or a credit or debit card, we will also use it to pay for any balance that you owe and for	Cid Reflux Glaucoma Heart Problem Choose a payment.  Credit Card Holder Signature/Date  Credit Card Holder Signature/Date  Regular delivery is free and will take 10 to 1 days from the day you send this form.  If you want faster delivery, choose:  2nd Business Day (\$17)  Next Business Day (\$23)  Faster delivery is for shipping time, not processing time.