Call your doctor for medical advice about side effects. You may report side effects to FDA at 1-800-FDA-1088.

Aetna

Prescription Order Form

Questions? Call **1-800-227-5720** to speak to a pharmacist.

SECTION 1 Review the Information

Member ID:
Date of Birth:

1. **Online** Visit **www.aetna.com/aetnarxhomedelivery**
2. **By Phone** Call us at **1-800-227-5720** or TDD (for hearing impaired) at **1-800-823-6373.**
3. **By Mail** Fill out the information and send your refill slips, prescription(s)and this Order form to the below:

Please write in the number of prescription(s) you are submitting with this order:

☐☐ New ☐☐ Refill

Aetna Rx Home Delivery
PO Box 829519
Pembroke Pines, FL 33082

Print all information clearly as shown in the sample using BLUE or BLACK ink: 1 2 3 4 A B C D

SECTION 2 Insurance Cardholder Information

Complete if your shipping address has changed or does not appear in Section 1. ○ **Temporary Shipping Address**

Member ID ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ E-mail _____

Last Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ First Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ MI ☐

Address 1 ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Phone Number ☐☐☐-☐☐☐-☐☐☐☐

Address 2 ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Alternate Phone Number ☐☐☐-☐☐☐-☐☐☐☐

City ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ State ☐☐ Zip Code ☐☐☐☐☐-☐☐☐☐

SECTION 3 Comments Relating to This Order

_____

_____

_____

_____

SECTION 4 Shipping & Method of Payment

○ Shipping - Fill in oval for Expedited Delivery ($20 additional charge)

○ Check or Money Order — Please make check or money order payable to **Aetna Rx Home Delivery**
Total payment enclosed (excluding credit card payment): $☐,☐☐☐.☐☐

DO NOT SEND CASH

○ VISA ○ Discover
○ MasterCard ○ American Express
○ Use Credit Card on File

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Credit Card # ☐☐/☐☐ Exp Date

○ Use for this transaction only

Cardholder Signature _____

I authorize Aetna Rx Home Delivery to bill my credit card. I understand that my credit card will be billed the following amounts in effect at the time my order is filled: any applicable copayment(s), coinsurance and/or deductible(s), payments due for any medications not covered under my benefit plan, plus any special shipping costs. I also understand my credit card will be charged for future orders, unless I provide an alternative form of payment or indicate otherwise by selecting "Use for this transaction only" above.

WE WILL DISPENSE FDA-APPROVED GENERIC-EQUIVALENT MEDICATION WHEN AVAILABLE AND APPROPRIATE AS INDICATED ON YOUR PRESCRIPTION.

SECTION 5 New Prescription Order

Fill out the information below and enclose new prescription(s) and payment with this form

Patient First Name | Self ○ Spouse ○ Dependent ○ | Sex M / F | Date of Birth (MM/DD/YYYY) | Doctor Phone Number (___-___-____)

Doctor Last Name | Drug Name

Patient First Name | Self ○ Spouse ○ Dependent ○ | Sex M / F | Date of Birth (MM/DD/YYYY) | Doctor Phone Number (___-___-____)

Doctor Last Name | Drug Name

Patient First Name | Self ○ Spouse ○ Dependent ○ | Sex M / F | Date of Birth (MM/DD/YYYY) | Doctor Phone Number (___-___-____)

Doctor Last Name | Drug Name

SECTION 6 Refills - Please send in refill slips for medications you would like to order. If you do not have your refill slip please complete the section below.

Print Prescription Number Here (_____-_____)

Drug Name: _____

Print Prescription Number Here (_____-_____)

Drug Name: _____

Print Prescription Number Here (_____-_____)

Drug Name: _____

Print Prescription Number Here (_____-_____)

Drug Name: _____

SECTION 7 Allergies & Health Conditions

Complete this section only if adding a new customer or there are changes to existing customer Allergies or Health Conditions.

If no allergies are selected, for new customers, this indicates no known allergies. For existing customers, this indicates no change from information provided to Aetna Rx Home Delivery previously.

Cardholder's First Name | Date of Birth (MM/DD/YYYY)

Dependent's First Name | Date of Birth (MM/DD/YYYY)

Other Dependent's First Name | Date of Birth (MM/DD/YYYY)

Other Dependent's First Name | Date of Birth (MM/DD/YYYY)

	Allergies								Health Conditions						
	None	Penicillin	Sulfa	Codeine	Aspirin	Erythromycin	NSAIDS	Other (write in below)	Diabetes	High Blood Pressure	Asthma	GI/GERD	High Cholesterol	Other (write in below)
Cardholder's First Name	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Dependent's First Name	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Other Dependent's First Name	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Other Dependent's First Name	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Please write the person's name and list their Other Allergies and/or Health Conditions referenced above:_____

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/retired). 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.