Inside Pocket

Patient Registration Form

PTR103001

Fill out the following section if this is your first order with Aetna Rx Home Delivery or if this information has changed.

Please complete the following for EACH family member covered under your Aetna pharmacy benefit. Select "None" for family members with no allergies or health conditions. For your convenience, this information will be included as part of your family's profile with Aetna Rx Home Delivery. We will use this information to check for potential drug interactions and allergies to medications.

For the fields below, mark with an (X) unless otherwise noted.

Member Information					Allergies				Health Conditions						
FAMILY MEMBER NAME	Spanish preferred*	Date Of Birth (MM/DD/YYYY)	Gender (M/F)	Relationship to Subscriber (S)pouse, (C)hild, (O)ther	None	Penicillin	Sulfa	Aspirin	Thyroid	Diabetes	Glaucoma	Heart Conditions	High Blood Pressure	Ulcer	Epilepsy

FAMILY MEMBER NAME	Other allergies or health conditions not listed above (please specify)

If you or a family member has diabetes, indicate the type of supplies being used below:

Name	Monitor	Lancets	Test Strips	Number of tests per day

If you have secondary insurance through another carrier, **check here** ❑

Please note: By submitting this form, you authorize the release of all the foregoing information to Aetna Rx Home Delivery, LLC, and its affiliates.

Aetna Rx Home Delivery now offers our customers the ability to make payments over the phone for balances due. If you would like to use this payment option, let our Customer Service Associate know and your bank account will be electronically debited for the balance due. The first time you use this service, our Associate will ask you to verify your name, address and some additional information to help us uniquely identify you and secure your transaction. You will then be asked to select a User ID and authorization number, which will be required for future "check by phone" transactions.

When you provide a check as payment, you authorize us to use information from your check either to make a one-time electronic fund transfer from your account or to process the payment as a check transaction. When we use information from your check to make an electronic fund transfer, funds may be withdrawn from your account as soon as the same day [you make] [we receive] your payment[, and you will not receive your check back from your financial institution].

*For your convenience, Aetna Rx Home Delivery maintains a staff of Spanish-speaking customer service representatives.

05.09.301.1-KC B (07/07)

We want you to know®
Aetna®

Please fold and tear off stub at perforation before inserting order form into envelope.

DID YOU REMEMBER TO:

- Complete the Order Form?
- Update the Patient Registration Form (if necessary)?
- Include new prescriptions?
- Print your name, address, date of birth and member ID on each prescription?
- Include required payment?

Go to www.AetnaRxHomeDelivery.com to check order status and to place future refills.

AETNA RX HOME DELIVERY
PO BOX 417019
KANSAS CITY MO 64179-9892

POSTAGE WILL BE PAID BY ADDRESSEE

BUSINESS REPLY MAIL
FIRST-CLASS MAIL PERMIT NO. 165 HARTFORD CT

NO POSTAGE NECESSARY IF MAILED IN THE UNITED STATES

[ ] CHECK BOX IF ADDRESS CHANGE IS ENCLOSED

FROM _____

05.09.301.1-KC B (07/07)

We want you to know®

Aetna®

ORD103001

Order Form

Simply follow these easy steps to start using Aetna Rx Home Delivery®:

First Time Customers *New Prescriptions*

1. Complete Sections A, B and C of the Order Form.
2. Complete the Patient Registration Form.
3. Mail the Order Form and Patient Registration Form with your prescription(s) and method of payment to us. Please print your name, address, date of birth and member ID on each prescription.

Please mail all orders to:
Aetna Rx Home Delivery
P.O. Box 417019
Kansas City, MO 64179-9892

Returning Customers *New Prescriptions or Refills of existing prescriptions*

1. Complete Sections A, B and C of the Order Form.
2. Complete the Patient Registration Form ONLY if your member information has changed.
3. Mail the Order Form and Patient Registration Form with your prescription(s) and method of payment to us. Please print your name, address, date of birth and member ID on each prescription.

Refill orders can also be placed by visiting www.AetnaRxHomeDelivery.com or by calling 1-866-612-3862 (TDD: 1-800-201-9457).

Method of Delivery: ❑ Standard ❑ Rush (additional charges apply)

SECTION A

Your Name | Your Aetna ID | Medicare Part B# (if you have one)

Subscriber's Name | Subscriber's Employer | Subscriber's Aetna ID

Home Address | City | State | ZIP

Check here if home address is new ❑

Day Phone | Evening Phone | Cell Phone | E-mail

Shipping Address (If different than home address) **Please note:** Address information entered here will only be used for this order.

Name | Address | City | State | ZIP

SECTION B

Name	Aetna Member ID	Medication Name and Strength	Prescribing Physician Name and Phone Number	Brand Only (X)	If Ordering a Refill: Enter Refill Numbers Below

We will automatically substitute FDA-approved generic medications for brand-name medications when (1) a generic equivalent medication is available and (2) your doctor's prescription instructions allow. If you do not want us to substitute a generic, you must check "Brand Only" above for the medication(s) you want dispensed as brand only. If a member chooses a brand-name drug when a generic alternative is available (regardless of the reason), they may be subject to a higher copay.

In most instances, we are unable to provide refunds for returned medications. If you have questions about your order or our return policy, please call Customer Service at 1-866-612-3862.

SECTION C

To estimate the cost of your medications, visit **www.aetna.com** and log in to AetnaNavigator™. Look for the "Take Action on Your Health" tab, then select "Cost of Care." The cost of your medication can be found on the "Prescription Drugs" link. You may also call the toll-free number on your Aetna member ID card for medication cost information.

Method of Payment: Make a check or money order payable to Aetna Rx Home Delivery or use your personal credit or debit card. Please do not send cash. Important Information:

- If you do not include a method of payment with your order and a previous order was paid for by credit or debit card, we will use that credit or debit card as the method of payment on this order.
- If you have an unpaid balance with our pharmacy this order may not be processed until payment is received.
- If you have a Flexible Spending Account (FSA) auto-debit feature, or are enrolled in an Aetna HealthFund® or Vital Savings on Health℠ plan, please provide a personal credit or debit card to cover any expenses that may exceed your account balance.
- If you are enrolled in an FSA, Health Savings Account (HSA) or Vital Savings on Health program and have a FSA/HSA/Vital Savings on Health debit card, you can use your card for payment (please also provide a personal credit or debit card to cover any expenses in excess of your account balance).
- Providing a credit or debit card will help prevent delays in order processing that result from insufficient payment.

MC/VISA/AmEx/Discover or debit card number | Expiration Date

FSA/HSA debit card number | Expiration Date

Cardholder Name | Signature

The credit and/or debit cards used in processing this order will be billed for medication order costs, rush shipping costs (if applicable) and any outstanding balances. They will also be billed for all future orders unless you provide a different form of payment.

Total amount enclosed (if paying by check or money order) _____

05.09.301.1-KC B (07/07)

Please fold and tear off stub at perforation before inserting order form into envelope.