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aetna Medication Order Form Aetna Rx Home Delivery®

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Please use blue or I	olack ink, capital let	ters, and fill in both side	s 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.				
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B Refills. To order r	mail service refills, en	ter your prescription num	ber(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. Last Name First Name	Spanish forms and labe
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Medical Conditions: Arthritis Asthma Diabetes Aci High Blood Pressure High Cholesterol Migraine Other: Special Instructions: How would you like to pay for this order? Fill in the oval to che Electronic Check. Pay from your bank account. First time us Use my PayPal Credit account. Works like a credit card. First Credit or Debit Card. (VISA®, MasterCard®, Discover®, America Fill in this oval to use your card on file. Fill in this oval to use a new card or to update your card ex 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.	Osteoporosis O Prostate Issues O Thyroic noose a payment. sers register online or call Customer Care. time users register online or call Customer Car n Express®, including FSA/HRA/HSA debit cards) piration date. Credit Card Holder Signature/Date Regular delivery is free and will take 10 to days from the day you send this form. If you want faster delivery, choose:
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