



# Mail Service Order Form

Mail this form to:

Aetna Rx Home Delivery  
P.O. Box 829518  
Pembroke Pines, FL 33082-9518

Enter ID number

Prescription Plan Sponsor or Company Name

Please use **blue or black ink, capital letters**, and fill in **both sides** of this form.

**New Prescriptions** - Mail your new prescriptions with this form.

Number of **New** prescriptions:

**Refills** - Order by Web, phone, or write in Rx number(s) below.

Number of **Refill** prescriptions:

**For Fastest Service, order refills at [www.aetnavigators.com](http://www.aetnavigators.com) or call toll-free 1-800-227-5720 or TDD (for hearing impaired) at 1-800-823-6373. Your doctor may fax your prescription(s) to 1-866-681-5166. Only a doctor may fax a prescription.**

## A Shipping Address.

Last Name

First Name

MI

Suffix (JR, SR)

Street Name

Apt./Suite #

Use this address for this order only.

City

State

ZIP Code

Daytime Phone #:

Evening Phone #:

## 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.

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.



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**C Tell us about the people getting prescriptions.** If there are more than two people, please complete another form.

**1st person** with a refill or new prescription. This person needs:  Spanish forms and labels

LAST NAME   
 FIRST NAME   
 M Suffix (JR,SR)   
 NICKNAME   
 Gender:  M  F      Date of Birth: MM-DD-YYYY

Your E-Mail: \_\_\_\_\_ Date new prescription written: \_\_\_\_\_

\_\_\_\_\_  
 Doctor's Last Name                      Doctor's First Name                      Doctor's Phone #

Tell us about **new** allergies or health information for this person. Only tell us about **new** information.

**Allergies:**  None  Aspirin  Cephalosporin  Codeine  Erythromycin  Peanuts  Penicillin  
 Sulfa  Other: \_\_\_\_\_

**Health Information:**  Arthritis  Asthma  Diabetes  Acid Reflux  Glaucoma  Heart Problem  
 High Blood Pressure  High Cholesterol  Migraine  Osteoporosis  Prostate Issues  Thyroid  
 Other: \_\_\_\_\_

**2nd person** with a refill or new prescription. This person needs:  Spanish forms and labels

LAST NAME   
 FIRST NAME   
 M Suffix (JR,SR)   
 NICKNAME   
 Gender:  M  F      Date of Birth: MM-DD-YYYY

Your E-Mail: \_\_\_\_\_ Date new prescription written: \_\_\_\_\_

\_\_\_\_\_  
 Doctor's Last Name                      Doctor's First Name                      Doctor's Phone #

Tell us about **new** allergies or health information for this person. Only tell us about **new** information.

**Allergies:**  None  Aspirin  Cephalosporin  Codeine  Erythromycin  Peanuts  Penicillin  
 Sulfa  Other: \_\_\_\_\_

**Health Information:**  Arthritis  Asthma  Diabetes  Acid Reflux  Glaucoma  Heart Problem  
 High Blood Pressure  High Cholesterol  Migraine  Osteoporosis  Prostate Issues  Thyroid  
 Other: \_\_\_\_\_

**D Special Instructions:** \_\_\_\_\_

**E How would you like to pay for this order?** Fill in the oval to choose a payment.

- Electronic Check.** Pay from your bank account. First time users register online or call Customer Care.
- Bill Me Later®.** Works like a credit card. First time users register online or call Customer Care.
- Credit or Debit Card.** (VISA®, MasterCard®, Discover®, American Express®, including FSA/HRA/HSA debit cards)
  - Fill in this oval to use your card on file.
  - Fill in this oval to use a new card or to update your card expiration date.

CARD NUMBER   
 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.
- If your check is returned, we will charge you up to \$40.

**Payment for balance due and future orders:** If you chose electronic check, Bill Me Later®, or a credit or debit card, we will also use it to pay for any balance that you owe and for future orders unless you provide another form of payment.

Fill in this oval if you **DO NOT** want to use this payment method for future orders.

**Credit Card Disclaimer:** 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.

**Regular delivery is free and will take 10 to 14 days from the day you send this form.**  
**If you want faster delivery, choose:**

- 2nd Business Day (\$17)** Business days are only Monday-Friday
- Next Business Day (\$23)** Monday-Friday

- Faster delivery charges may change.
- Faster delivery is for shipping time, not processing time.
- Faster delivery can only be sent to a street address, not a PO box.



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