XAetna° Mail Service Order Form

	Mail this form to:
Enter ID number	Influffulufulufulufulufulufulufulufulufu Aetna Rx Home Delivery P.O. Box 829518 Pembroke Pines, FL 33082-9518
Prescription Plan Sponsor or Company Name	
Please use blue or black ink, capital letters, and fil	I in both sides of this form.
New Prescriptions - Mail your new prescriptions with	n 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.aetnanavigator.com or impaired) at 1-800-823-6373. Your doctor may fax your prescription	call toll-free 1-888-RX AETNA (1-888-792-3862) or TDD (for hearing s) to 1-877-270-3317 . Only a doctor may fax a prescription.
A Shipping Address.	
Last Name Street Name	First Name MI Suffix (JR, SR) Apt./Suite # Use this address
City	for this order only.
City	State ZIP Code
Daytime Phone #:	Evening Phone #:
Refills. To order mail service refills, enter your pre	scription number(s) here.
1)2)	3)4)

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.



	O Spanish forms and label
L A S T N A M E F I R S	T NAME M Suffix (JR,SR)
NICKNAME Gender: () M () F Date of Birt	th: MM-DD-YYYY
Your E-Mail: Da	te new prescription written:
Doctor's Last Name Doctor's First Name	Doctor's Phone #
Tell us about new allergies or health information for this personal Allergies: None Aspirin Cephalosporin Codeine Sulfa	
Health Information: Arthritis Asthma Diabetes Acid High Blood Pressure High Cholesterol Migraine Other:	The state of the s
2nd person with a refill or new prescription. This person needs:	○ Spanish forms and label
L A S T N A M E FIRS	T NAME M Suffix (JR,SR)
NICKNAME Gender: () M () F Date of Birt	th: MM-DD-YYYY
Your E-Mail: Da	te new prescription written:
Doctor's Last Name Doctor's First Name	 Doctor's Phone #
Tell us about new allergies or health information for this perso	
Allergies: None Aspirin Cephalosporin Codeine Sulfa Other: Health Information: Arthritis Asthma Diabetes Acid High Blood Pressure High Cholesterol Migraine	I Reflux
Other:	·
Special Instructions:	
How would you like to pay for this order? Fill in the oval to cho	
How would you like to pay for this order? Fill in the oval to cho	pose a payment.
•	oose a payment. ers register online or call Customer Care.
 Electronic Check. Pay from your bank account. First time use Bill Me Later[®]. Works like a credit card. First time users regis Credit or Debit Card. (VISA[®], MasterCard[®], Discover[®], American 	oose a payment. ers register online or call Customer Care. ster online or call Customer Care.
 Electronic Check. Pay from your bank account. First time use Bill Me Later®. Works like a credit card. First time users regis Credit or Debit Card. (VISA®, MasterCard®, Discover®, American Fill in this oval to use your card on file. 	cose a payment. ers register online or call Customer Care. eter online or call Customer Care. Express®, including FSA/HRA/HSA debit cards)
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 Electronic Check. Pay from your bank account. First time use Bill Me Later®. Works like a credit card. First time users regis Credit or Debit Card. (VISA®, MasterCard®, Discover®, American Fill in this oval to use your card on file. Fill in this oval to use a new card or to update your card exp 	ers register online or call Customer Care. Iter online or call Customer Care. Express®, including FSA/HRA/HSA debit cards) Firation date. Credit Card Holder Signature/Date
 Bill Me Later®. Works like a credit card. First time users regis Credit or Debit Card. (VISA®, MasterCard®, Discover®, American Fill in this oval to use your card on file. Fill in this oval to use a new card or to update your card exp Exp. 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 	cose a payment. ers register online or call Customer Care. eter online or call Customer Care. Express®, including FSA/HRA/HSA debit cards) iration 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:
 Electronic Check. Pay from your bank account. First time used Bill Me Later®. Works like a credit card. First time users regis Credit or Debit Card. (VISA®, MasterCard®, Discover®, American Fill in this oval to use your card on file. Fill in this oval to use a new card or to update your card exp CARD NUMBER Exp. 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. 	cose a payment. ers register online or call Customer Care. eter online or call Customer Care. Express®, including FSA/HRA/HSA debit cards) piration 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) Business days are only are only
 ☐ Electronic Check. Pay from your bank account. First time users regis ☐ Bill Me Later®. Works like a credit card. First time users regis ☐ Credit or Debit Card. (VISA®, MasterCard®, Discover®, American ☐ Fill in this oval to use your card on file. ☐ Fill in this oval to use a new card or to update your card exp ☐ ARD NUMBER Exp. MMYY ☐ Check or Money Order. Amount: \$	cose a payment. ers register online or call Customer Care. eter online or call Customer Care. Express®, including FSA/HRA/HSA debit cards) iration 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) Business day, are only Next Business Day (\$23) Monday-Frida
 Electronic Check. Pay from your bank account. First time used Bill Me Later®. Works like a credit card. First time users regis Credit or Debit Card. (VISA®, MasterCard®, Discover®, American Fill in this oval to use your card on file. Fill in this oval to use a new card or to update your card exp CARD NUMBER Exp. 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. 	cose a payment. ers register online or call Customer Care. eter online or call Customer Care. Express®, including FSA/HRA/HSA debit cards) piration 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) Business day are only

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.