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	Mail this form to:  AETNA RX HOME DELIVERY PO BOX 417019 KANSAS CITY MO 64179-7019
Member ID # (if not shown or if different from above) <input style="width: 100%; height: 1.2em;" type="text"/>	
Prescription Plan Sponsor or Company Name <input style="width: 100%; height: 1.2em;" type="text"/>	

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Instructions:
 Please use **blue or black ink** and **print in capital letters**. 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:

TO RECEIVE YOUR ORDER SOONER request refills or new prescriptions online at www.aetn navigator.com
 or call toll-free **1-888-RX AETNA (1-888-792-3862)**, TTY 711.

A Shipping Address. To ship to an address different from the one printed above, enter the changes here.

Last Name	First Name	MI	Suffix (JR, SR)
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 20px; height: 15px;" type="text"/>	<input style="width: 40px; height: 15px;" type="text"/>
Street Address	Apt./Suite #	<input type="radio"/> Use shipping address for this order only.	
<input style="width: 100%;" type="text"/>	<input style="width: 40px; height: 15px;" type="text"/>		
City	State	ZIP Code	
<input style="width: 100%;" type="text"/>	<input style="width: 20px; height: 15px;" type="text"/>	<input style="width: 60px; height: 15px;" type="text"/> - <input style="width: 30px; height: 15px;" type="text"/>	
Daytime Phone #:	Evening Phone #:		
<input style="width: 40px; height: 15px;" type="text"/> - <input style="width: 40px; height: 15px;" type="text"/> - <input style="width: 60px; height: 15px;" type="text"/>	<input style="width: 40px; height: 15px;" type="text"/> - <input style="width: 40px; height: 15px;" type="text"/> - <input style="width: 60px; height: 15px;" type="text"/>		

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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.

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.



