Physician Satisfaction Questionnaire

Aetna Specialty Pharmacy®

www.aetna.com
Physician Name: __________________________________________
Phone: ____________________________________________________

4 = Excellent    3 = Good    2 = Average    1 = Below Average

Please rate the following:

1. Your initial contact with our Customer Service representative:
   4 3 2 1

2. The written information you received about our program and services:
   4 3 2 1

3. The availability of our staff to take referral information and get a patient started on service:
   4 3 2 1

4. Your contact with our pharmacists and clinical staff:
   4 3 2 1

5. Your contact, if any, with our business staff (for example, billing reimbursement specialist):
   4 3 2 1

6. The service that we have provided for your patients as compared to other specialty pharmacy providers you may have used:
   4 3 2 1

7. To the best of your knowledge, please rate your patients’ experience with us:
   4 3 2 1

8. Would you like additional information on our company’s services?
   ❑ Yes ❑ No

9. Please add any comments or suggestions:
   ______________________________________________________
   ______________________________________________________
   ______________________________________________________
   ______________________________________________________

Thank you for completing this questionnaire. Your feedback aids in our ongoing quality improvement. Please mail or fax the completed survey to:

Aetna Specialty Pharmacy
503 Sunport Lane, Orlando, FL 32809
Telephone: 1-866-782-ASRX (1-866-782-2779)
Fax: 1-866-FAX-ASRX (1-866-329-2779)
www.AetnaSpecialtyPharmacy.com

Aetna Specialty Pharmacy always strives to improve the quality of the services that we provide to you and your patients.

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