


K @yahoo.com 302649609 Enter ID number <input style="width:100%; height: 15px;" type="text"/> <input style="width:100%; height: 15px;" type="text"/> <input style="width:100%; height: 15px;" type="text"/> Prescription Plan Sponsor or Company Name	Mail this form to:  AETNA RX HOME DELIVERY P.O. BOX 829518 PEMBROKE PINES, FL 33082-9518
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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 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.

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

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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