Aetna Rx Home Delivery®

Medication Order Form

Mail this form to:
AETNA RX HOME DELIVERY
PO BOX 417019
KANSAS CITY MO 64179-7019

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.aetnanavigator.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
First Name
MI
Suffix (JR, SR)
Street Name
Apt./Suite #
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.

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.
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 ___________________________

Nickname: ___________________________ Gender: ☐ M ☐ F Date of Birth: MM-DD-YYYY

Your E-Mail: __________________________ Date new prescription written: ____________

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 ___________________________

Nickname: ___________________________ Gender: ☐ M ☐ F Date of Birth: MM-DD-YYYY

Your E-Mail: __________________________ Date new prescription written: ____________

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: ___________________________

Special Instructions:

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)
- 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.

I authorize Aetna Rx Home Delivery to bill my credit card for any out-of-pocket costs or special shipping costs in effect at the time my order is filled.