



Prescription Drug Claim Form

Aetna
 Pharmacy Management
 Attn: Claim Processing
 P.O. Box 398106
 Minneapolis, MN 55439-8106

Social Security Number/Member Number (claim cannot be processed without number)										Group Number														
Employee Name (First, Middle, Last)															Employee Birthdate (MM/DD/YYYY)									
Employee Address (Street, City, State, Zip Code)																								
Company Name & Address (Street, City, State, Zip Code)																								
Employee Signature															Telephone Number ()					Date				

Prescription(s) were for:

Last Name, First, Middle Initial										Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Employee <input type="checkbox"/>		Spouse <input type="checkbox"/>		Dependent <input type="checkbox"/>		Patient Birthdate (MM/DD/YYYY)						
Indicate reason for manually filing these claims:																								
<input type="checkbox"/> Coordination of Benefits					<input type="checkbox"/> I had not received my Aetna ID card					<input type="checkbox"/> Travel Supply					<input type="checkbox"/> Pharmacy not participating in network					<input type="checkbox"/> Pharmacy unable to process claim electronically				

Pharmacy Information *Please attach prescription receipts or ask your pharmacist to complete the remaining information. We cannot process your claim without this information.*

1) Date Filed (MM/DD/YYYY)		Rx Number		RX (Check one) <input type="checkbox"/> New <input type="checkbox"/> Refill		Quantity		Days Supply		National Drug Code (11 digit)									
Medication Name, Strength & Dosage Form						Doctor Name & DEA Number Name: _____ DEA #: _____				DAW (Check one) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5			RX Price (including tax)						
2) Date Filed (MM/DD/YYYY)		Rx Number		RX (Check one) <input type="checkbox"/> New <input type="checkbox"/> Refill		Quantity		Days Supply		National Drug Code (11 digit)									
Medication Name, Strength & Dosage Form						Doctor Name & DEA Number Name: _____ DEA #: _____				DAW (Check one) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5			RX Price (including tax)						
3) Date Filed (MM/DD/YYYY)		Rx Number		RX (Check one) <input type="checkbox"/> New <input type="checkbox"/> Refill		Quantity		Days Supply		National Drug Code (11 digit)									
Medication Name, Strength & Dosage Form						Doctor Name & DEA Number Name: _____ DEA #: _____				DAW (Check one) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5			RX Price (including tax)						
4) Date Filed (MM/DD/YYYY)		Rx Number		RX (Check one) <input type="checkbox"/> New <input type="checkbox"/> Refill		Quantity		Days Supply		National Drug Code (11 digit)									
Medication Name, Strength & Dosage Form						Doctor Name & DEA Number Name: _____ DEA #: _____				DAW (Check one) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5			RX Price (including tax)						

Place Pharmacy Label here or enter:

Pharmacy Name										Pharmacist Signature					Date				
Street Address										NABP Number									
City					State					Zip Code					Pharmacy Telephone Number ()				

Member

- Please read carefully before completing this form. **Claim forms without the required information cannot be processed. Incomplete forms will be returned to you.**
- Take this claim form to the pharmacy when you obtain prescription drugs.
- If you use more than one pharmacy, use a separate form for each pharmacy.
- Use a separate claim form for each patient.
- Claims must be submitted within two years of date of purchase.
- Complete all employee and patient information on the top portion of the form and be sure to sign it.
- Give the claim form to your pharmacist to complete the bottom portion.
 - **Mail the Prescription Drug Claim Form to:** **Aetna
Pharmacy Management
Attn: Claim Processing
P.O. Box 398106
Minneapolis, MN 55439-8106**

Pharmacist

- Complete bottom portion of form in full.
- Please include complete name and address of the pharmacy, NABP number, and authorized signature. Your signature attests that all information, including total charge, is correct. Incomplete claim forms will be returned.

Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to claim was provided by the applicant. California Residents: For your protection, California law requires notice of the following: Any person who knowingly and with intent to defraud or deceive any insurance company files a statement of claim containing any materially false, incomplete or misleading information is guilty of a crime and may be subject to fines, confinement in a state prison and substantial civil penalties.

Colorado Residents: An insurer or agent who knowingly provides false or misleading information to defraud a claimant regarding insurance proceeds must be reported to the Insurance Division.

Pennsylvania Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.