

## **Prescription Drug Claim Form**

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

	I Security Numb				ocessed with	out nu	mher)	Group	Νι	umbe	er										
			Clairi cai	Inot be pr	occased With	out nu															
Emplo	yee Name (Firs	st. Middle. L	ast)		<u> </u>				-			-1	-		En	nploye	e Birl	thdate	(MM/	DD/Y	YYY)
	oyee Address (S																				
Comp	any Name & Ac	ldress (Stre	eet, City,	State, Zip	Code)																
Employee Signature							Telephone Number ( )						Date								
Pres	cription(s) w	vere for:																			
Last N	lame, First, Mid	dle Initial			Sex Male	<u>.</u> _	Female	Emplo	ye T	е	Spous	е	Depe Г	nder 1	nt Pa	tient B	Birthd	ate (M	M/DD	/YYY	Y)
Indica	te reason for ma	anually filin	g $\square$	Coordin	ation of Be		i ciliale		<del> </del>	had	not red	ceive	d mv	<u> </u>	na ID	) card		Пт	ravel	Sup	vla
these	claims:				cy not parti		ng in net	work [	_				-								i)
				Emerge	ncy – If Em	ergen	icy, desc	ribe Eı	ner	gen	cy belo	ow, o	r on a	a sep	arat	e she	et				
Desc	ribe Emerge	ency																			
-																					
-																					
Phar	macy Inforn				escription of the cour claim w					arm	acist t	о соі	mplet	e the	rem	naining	g info	ormat	ion.	We	
1) Da	te Filed	Rx Number		RX (Che	Quar		matio	_	Days Supply Na			tional Drug Co			(11 diç	git)					
(MM/DD/YYYY)																					
Medic	ation Name, St	rength & Do			√  Refill									I			I	I	ĺ	I	1
			osage Fo		√  Refill	Doct	or Name	& DEA		mber			DAW	/ (Che	eck o	ne)	F	 RX Prid	e (inc	cludin	g tax)
			osage Fo		v ☐ Refill	Doct Nam		& DEA		mber	•			/ (Che	eck o		2 F	 RX Prid	ce (inc	ludin	g tax)
			osage Fo		v ☐ Refill		ne:	& DEA		mber					eck o 1 4		_	RX Prid	ce (inc	ludin	g tax)
2) Da	te Filed	Rx Numb				Nan	ne: \ #:	& DEA	Nur		Supply	Nati		0	1 4		2 5	 RX Prid	ce (inc	cludin	g tax)
2) Da	te Filed (MM/DD/YYYY)			rm	eck one)	Nam DE <i>A</i>	ne: \ #:	& DEA	Nur			Nati		0	1 4		2 5	 RX Prid	ce (ind	cludin	g tax)
	te Filed (MM/DD/YYYY)	)	er	RX (Che	eck one)	Nam DEA Quar	ne: A #: ntity		Nur	Days	Supply	Nati		0   3   0rug (	1 4 Code	(11 dig	2 5 git)	RX Prid			
	(MM/DD/YYYY)	)	er	RX (Che	eck one)	Nam DEA Quar Doct Nam	ne: A #: ntity or Name ne:		Nur	Days	Supply	Nati	onal C	0   3   0rug (	1 4 Code	(11 dig	2 5 git)				
	(MM/DD/YYYY)	)	er	RX (Che	eck one)	Nam DEA Quar	ne: A #: ntity or Name ne:	& DEA	Nur	Days	Supply	Nati	onal C	0   3   Orug (C	1 4 Code	(11 dig	2 5 git)				
Medic	(MM/DD/YYYY) cation Name, St	rength & Do	er osage Fo	RX (Che	eck one)	Nam DEA Quar Doct Nam	ne: A #: ntity or Name ne: A #:	& DEA	Nur	Days	Supply		onal C	0   3   0rug ( (Che 0   3	1 4 Code   1 eck o	(11 dig	2   5   git)   F 2   5				
Medic	(MM/DD/YYYY)	rength & Do	er osage Fo	RX (Che	eck one)  V	Quan  Doct Nam DEA	ne: A #: ntity or Name ne: A #:	& DEA	Nur	Days	Supply		onal C	0   3   0rug ( (Che 0   3	1 4 Code   1 eck o	(11 dig	2   5   git)   F 2   5				
Medic	(MM/DD/YYYY) cation Name, St	Rx Numb	er osage Fo er	RX (Che	eck one)  V	Nam DEA  Quan  Doct Nam DEA  Quan	ne: ntity  or Name ne: A #: ntity  or Name	& DEA	Nur  Dur  Nur  Nur	Days	Supply		onal C	0   3   0   0   0   0   0   0   0   0	1 deck of 1 deck	(11 dig	2 git) F 2 git)		ce (inc	  cludin	g tax)
Medic	cation Name, Station Name, Sta	Rx Numb	er osage Fo er	RX (Che	eck one)  V	Nam DEA  Quan  Doct Nam DEA  Quan	ne: A #: ntity or Name ne: A #:	& DEA	Nur  Dur  Nur  Nur	Days	Supply		onal C DAW Onal C	0   3   Orug (C   1   Orug (C   C   Orug (C   C   Orug (C   C   Orug (C   C   Orug (C   Or	1 deck of 1 deck	(11 dig	2 git) F	 RX Prio	ce (inc	  cludin	g tax)
Medic	cation Name, Station Name, Sta	Rx Numb	er osage Fo er	RX (Che	eck one)  V	Nam DEA  Quan  Doct Nam DEA  Quan	ne: ntity  or Name ne: ntity  or Name ne: ntity	& DEA	Nur  Dur  Nur  Nur	Days	Supply		DAW Onal C	0   3   Orug (C   1   Orug (C   C   Orug (C   C   Orug (C   C   Orug (C   C   Orug (C   Or	1 d d d d d d d d d d d d d d d d d d d	(11 dig	2   5   F   F   F   F   F   F   F   F   F	 RX Prio	ce (inc	  cludin	g tax)
Medic  3) Da  Medic	cation Name, Station Name, Sta	Rx Numb	er osage Fo er osage Fo	RX (Che	eck one)  V	Quan  Doct Nam  DEA  Quan  Doct Nam  DEA	ne: ntity  or Name ne: ntity  or Name ne: ntity	& DEA	Nur  Dur  Nur  Nur	Days	Supply		DAW Onal C	0   3   3   3   3   3   3   3   3   3	1 1 4 Code	(11 dig	2   5   F   F   F   F   F   F   F   F   F	 RX Prio	ce (inc	  cludin	g tax)
Medic  3) Da  Medic	cation Name, Strate Filed (MM/DD/YYYY) cation Name, Strate	Rx Numb	er osage Fo er osage Fo	RX (Che	eck one)  V	Quan  Doct Nam  DEA  Quan  Doct Nam  DEA	ne: ntity  or Name ne: ntity  or Name ne: ntity	& DEA	Nur	Days  The state of	Supply	Nati	DAW DAW	0   3   3   3   3   3   3   3   3   3	1 1 4 Code	(11 dig	2   git)   F   G   F	 RX Prio	ce (inc	  cludin	g tax)
Medic  3) Da  Medic  Place	cation Name, Station Name, Sta	Rx Numb	er osage Fo er osage Fo	RX (Che	eck one)  V	Quan  Doct Nam  DEA  Quan  Doct Nam  DEA	ne: ntity  or Name ne: ntity  or Name ne: ntity	& DEA	Nur Nur Nur	Days	Supply	Nati	DAW DAW	0   3   3   3   3   3   3   3   3   3	1 1 4 Code 1 1 4 4 Code 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	(11 dig	2   git)   F   G   F	 RX Prio	ce (inc	  cludin	g tax)

## 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.