aetna™ Medicare Prescription Drug Claim Form

Mail completed form with receipts:
Aetna Pharmacy Management
PO Box 52446
Phoenix, AZ 85072-2446

When you submit:

- Do not staple or tape receipts to this form. Keep all attachments separate.
- Include pharmacy receipt, (not the cash receipt). Pharmacy receipts are usually attached to the bag with the prescription, or can be obtained from the pharmacy if you need another copy.

Call the number on your ID card if you need help completing this form.

STEP 1: Patient Information

Please complete all sections.

Identification Number (refer to your Member card) ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Rx Group Number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Name (Last Name) ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

(First Name) ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

(MI) ☐

Address ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Address 2 ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

City ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

State ☐☐ **Zip Code** ☐☐☐☐☐

Date of Birth (MM/DD/YYYY) ☐☐/☐☐/☐☐☐☐

Male ☐ **Female** ☐

Phone Number (☐☐☐)-☐☐☐-☐☐☐☐

Tell us about your prescriptions.

Were any prescriptions:

Covered by a manufacturer patient assistance program? YES ☐ NO ☐

Covered under another plan (e.g., through an employer)? YES ☐ NO ☐

If yes, is this other plan Primary? YES ☐ NO ☐

If Primary, include the explanation of benefits (EOB) with your submission and let us know:

Name of Insurance Company: _____

ID Number: _____

Were any prescriptions:

A compound prescription? YES* ☐ NO ☐

From a hospital? YES ☐ NO ☐

From a long-term care pharmacy? YES ☐ NO ☐

Paid out-of-pocket due to an emergency situation (e.g., you forgot medicine on vacation or had to evacuate due to a natural disaster)? YES ☐ NO ☐

Other reasons can be provided in Step 3, page 2.

*If reimbursement is for a compound drug, complete the additional compound prescription claim form too (located at the end).

IMPORTANT! A signature is REQUIRED

Any person who knowingly and with the intent to defraud, injure, or deceive any insurance company, submits a claim or application containing any materially false, deceptive, incomplete or misleading information pertaining to such claim may be committing a fraudulent insurance act which is a crime and may subject such a person to criminal and/or civil penalties, including fines, denial of benefits, and/or imprisonment.

I certify that (or my eligible dependent) have received the medication(s) received herein. I certify that I have read and understood this form, and that all the information entered on this form is true and correct.

X _____ _____

Signature of Plan Participant **Date**

If completing this form on behalf of a Medicare Part D member, a valid CMS 1696 Appointment of Representative form (or equivalent) is required visit www.cms.gov for a copy of the form.

STEP 2: Submission Requirements

Please provide the:

Pharmacy name and address or pharmacy NABP number (refer to the pharmacy receipt):

_____

_____

Prescribing physician's name: _____

Number of prescriptions you're submitting for reimbursement: _____

1. Prescription (Rx) Number ☐☐☐☐☐☐☐☐☐☐☐☐	Drug Name	
National Drug Code (NDC Number) ☐☐☐☐☐☐☐☐☐☐☐	Date Filled (MM/DD/YY) ☐☐/☐☐/☐☐	Total Charge ☐☐☐☐.☐☐
Prescriber's NPI Number ☐☐☐☐☐☐☐☐☐☐	Quantity ☐☐☐☐	Day's Supply ☐☐☐☐
2. Prescription (Rx) Number ☐☐☐☐☐☐☐☐☐☐☐☐	Drug Name	
National Drug Code (NDC Number) ☐☐☐☐☐☐☐☐☐☐☐	Date Filled (MM/DD/YY) ☐☐/☐☐/☐☐	Total Charge ☐☐☐☐.☐☐
Prescriber's NPI Number ☐☐☐☐☐☐☐☐☐☐	Quantity ☐☐☐☐	Day's Supply ☐☐☐☐
3. Prescription (Rx) Number ☐☐☐☐☐☐☐☐☐☐☐☐	Drug Name	
National Drug Code (NDC Number) ☐☐☐☐☐☐☐☐☐☐☐	Date Filled (MM/DD/YY) ☐☐/☐☐/☐☐	Total Charge ☐☐☐☐.☐☐
Prescriber's NPI Number ☐☐☐☐☐☐☐☐☐☐	Quantity ☐☐☐☐	Day's Supply ☐☐☐☐

Use an additional form if requesting more than 3 prescriptions for reimbursement.

STEP 3: Next steps:

- We'll mail you a response on whether we approve or deny your request. Please allow 30 days for a response and any payment we owe you. Please remember that completing this form is not a guarantee that you'll be reimbursed.
- We recommend you keep a copy of all documents submitted for your records.
- Provide any additional comments or information here:

_____

_____

_____

_____

_____

_____

ONLY COMPLETE THIS SECTION IF YOU'RE SUBMITTING REIMBURSEMENT FOR A COMPOUND DRUG

COMPOUND PRESCRIPTION CLAIM FORM:

Number of compound prescriptions you're submitting for reimbursement: _____

1. Pharmacy Name	Date Filled (MM/DD/YY) ☐☐/☐☐/☐☐	Prescription (Rx) Number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐
DRUG NAME		
National Drug Code (NDC Number) ☐☐☐☐☐-☐☐☐☐-☐☐	Metric Quantity ☐☐☐☐☐☐☐☐	Cost ☐☐☐☐.☐☐
DRUG NAME		
National Drug Code (NDC Number) ☐☐☐☐☐-☐☐☐☐-☐☐	Metric Quantity ☐☐☐☐☐☐☐☐	Cost ☐☐☐☐.☐☐
DRUG NAME		
National Drug Code (NDC Number) ☐☐☐☐☐-☐☐☐☐-☐☐	Metric Quantity ☐☐☐☐☐☐☐☐	Cost ☐☐☐☐.☐☐
	Total Metric Quantity ☐☐☐☐☐☐☐☐	Total Cost ☐☐☐☐.☐☐

2. Pharmacy Name	Date Filled (MM/DD/YY) ☐☐/☐☐/☐☐	Prescription (Rx) Number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐
DRUG NAME		
National Drug Code (NDC Number) ☐☐☐☐☐-☐☐☐☐-☐☐	Metric Quantity ☐☐☐☐☐☐☐☐	Cost ☐☐☐☐.☐☐
DRUG NAME		
National Drug Code (NDC Number) ☐☐☐☐☐-☐☐☐☐-☐☐	Metric Quantity ☐☐☐☐☐☐☐☐	Cost ☐☐☐☐.☐☐
DRUG NAME		
National Drug Code (NDC Number) ☐☐☐☐☐-☐☐☐☐-☐☐	Metric Quantity ☐☐☐☐☐☐☐☐	Cost ☐☐☐☐.☐☐
	Total Metric Quantity ☐☐☐☐☐☐☐☐	Total Cost ☐☐☐☐.☐☐

Use an additional form if requesting more than 2 compound prescriptions for reimbursement.

Your privacy is <u>important</u> to us. Our employees are trained regarding the appropriate way to handle your private health information.

Aetna Medicare is a PDP, HMO, PPO plan with a Medicare contract. Our SNPs also have contracts with State Medicaid programs. Enrollment in our plans depends on contract renewal. See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area.

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