Commercial Prescription Drug Claim Form

Aetna Pharmacy Management
Attn: Claim Processing
P.O. Box 14024
Lexington, KY 40512-4024

Aetna 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	Gender	Employee	Spouse	Dependent	Patient Birthdate (MM/DD/YYYY)
	☐ Male ☐ Female	☐	☐	☐	

Indicate reason for manually filing these claims:

- ☐ Coordination of Benefits – Please attach an Explanation of Benefits from the primary carrier along with the detailed receipt.
- ☐ I had not received my Aetna ID card
- ☐ Pharmacy not participating in network
- ☐ Pharmacy unable to process claim electronically
- ☐ Emergency – If Emergency, describe Emergency below, or on a separate sheet

Manual submission of claims does not guarantee reimbursement of claim.

Describe Emergency

_____
_____
_____
_____
_____
_____

Pharmacy Information *Please attach* **detailed 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)	Quantity	Days Supply	National Drug Code (11 digit)
		☐ New ☐ Refill			

Medication Name, Strength & Dosage Form	Doctor Name & DEA Number	DAW (Check one)	RX Price (including tax)
	Name: _____ DEA #: _____	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5	

2) Date Filed (MM/DD/YYYY)	Rx Number	RX (Check one)	Quantity	Days Supply	National Drug Code (11 digit)
		☐ New ☐ Refill			

Medication Name, Strength & Dosage Form	Doctor Name & DEA Number	DAW (Check one)	RX Price (including tax)
	Name: _____ DEA #: _____	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5	

3) Date Filed (MM/DD/YYYY)	Rx Number	RX (Check one)	Quantity	Days Supply	National Drug Code (11 digit)
		☐ New ☐ Refill			

Medication Name, Strength & Dosage Form	Doctor Name & DEA Number	DAW (Check one)	RX Price (including tax)
	Name: _____ DEA #: _____	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5	

Place Pharmacy Label here or enter:

Pharmacy Name		
Street Address		
City	State	Zip Code

Pharmacist Signature Required	Date
NABP Number	National Provider Identifier
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 14024
  Lexington, KY 40512-4024

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.

Attention 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.

Attention 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.

Attention New York 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 shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

Attention 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.