aetna®

Medicare Part D: Prescription Claim Form

Mail completed forms with receipts:
P.O. Box 52446
Phoenix, Arizona 85072-2446

Important!

- Your complete claim will be processed within 14 days of receipt of your request. Please allow additional mail time.
- Keep a copy of all documents submitted for your records.
- Do not staple or tape receipts or attachments to this form.

STEP 1 Patient Information

This section must be fully completed to ensure proper reimbursement of your claim.

Patient Information

Identification Number (refer to your prescription card)

Group No./Group Name

Name *(Last Name)* *(First Name)* *(MI)*

Address

Address 2

City State Zip

Date of Birth 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:		
Approved for a drug tier cost change?	YES ☐	NO ☐
A compound prescription?	YES ☐	NO ☐
From an outpatient hospital observation stay?	YES ☐	NO ☐
From a long-term care pharmacy?	YES ☐	NO ☐
Filled as a result of:		
• Illness after travelling outside of the service area?	YES ☐	NO ☐
• No network pharmacy within reasonable driving distance?	YES ☐	NO ☐
• Medication not in stock at my network pharmacy?	YES ☐	NO ☐
• Vaccine received at my doctor's office?	YES ☐	NO ☐
• Federal emergency/natural disaster?	YES ☐	NO ☐

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

For **Compound Prescriptions,** please click here or use the attached form, for **Vaccines:** please click here or use the attached form.

Important! A signature is REQUIRED

Any person who knowingly and with 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 person to criminal or civil penalties, including fines, denial of benefits, and/or imprisonment.

I certify that I (or my eligible dependent) have received the medicine described 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**

Please note: If completing this form on behalf of a Medicare Part D member, please submit a completed CMS 1696 form (Appointment of Representative form). Per CMS regulations, a purported representative may submit a completed a CMS 1696 form or a form that includes the same information as a 1696 form.

(Over)

STEP 2 Submission Requirements:

You MUST include all original "pharmacy" receipts in order for your claim to process. "Cash register" receipts will only be accepted for diabetic supplies. The minimum information that must be included on your pharmacy receipts is listed below:

- Patient Name
- Prescription Number
- Drug's 11 Digit NDC Number
- Date of Fill
- Quantity of Drug
- Total Paid
- Days Supply for your prescription (you need to ask your pharmacist for this "Day Supply" information)

Pharmacy name and address or pharmacy NABP number: _____

Prescribing physician's name: _____

Prescribing physician's address: _____

Prescribing physician's phone number: _____

Number of prescriptions you are submitting for reimbursement: _____

Prescription 1	**Prescription (Rx) Number**	**Drug Name**	
	National Drug Code (NDC Number)	**Date Filled (MM/DD/YY)**	**Total Paid ($ Amount)**
	Prescriber's National Provider Identifier Number	**Quantity of Drug**	**Days Supply**
Prescription 2	**Prescription (Rx) Number**	**Drug Name**	
	National Drug Code (NDC Number)	**Date Filled (MM/DD/YY)**	**Total Paid ($ Amount)**
	Prescriber's National Provider Identifier Number	**Quantity of Drug**	**Days Supply**
Prescription 3	**Prescription (Rx) Number**	**Drug Name**	
	National Drug Code (NDC Number)	**Date Filled (MM/DD/YY)**	**Total Paid ($ Amount)**
	Prescriber's National Provider Identifier Number	**Quantity of Drug**	**Days Supply**

Please utilize Additional Prescription Information page if necessary (more than 3 prescriptions).

STEP 3 Provide any Additional Comments or Information Here:

Please remember that completing this form is not a guarantee that you'll be reimbursed.

IMPORTANT REMINDER–To avoid having to submit a paper claim form:

- Always have your prescription card available at time of purchase.
- Use medication from your formulary list.
- Always use pharmacies within your network.
- If problems are encountered at the pharmacy, call the number on the back of your card.

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

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