



**C Tell us about the people getting prescriptions.** If there are more than two people, please complete another form.

**1st person with a refill or new prescription.** This person needs:

Spanish forms and labels

LAST NAME

FIRST NAME

M

Suffix (JR,SR)

NICKNAME

Gender:  M  F

Date of Birth: MM-DD-YYYY

Your E-Mail: \_\_\_\_\_ Date new prescription written: \_\_\_\_\_

Doctor's Last Name

Doctor's First Name

Doctor's Phone #

Tell us about **new** allergies or health information for this person. Only tell us about **new** information.

Allergies:  None  Aspirin  Cephalosporin  Codeine  Erythromycin  Peanuts  Penicillin  
 Sulfa  Other: \_\_\_\_\_

Health Information:  Arthritis  Asthma  Diabetes  Acid Reflux  Glaucoma  Heart Problem  
 High Blood Pressure  High Cholesterol  Migraine  Osteoporosis  Prostate Issues  Thyroid  
 Other: \_\_\_\_\_

**2nd person with a refill or new prescription.** This person needs:

Spanish forms and labels

LAST NAME

FIRST NAME

M

Suffix (JR,SR)

NICKNAME

Gender:  M  F

Date of Birth: MM-DD-YYYY

Your E-Mail: \_\_\_\_\_ Date new prescription written: \_\_\_\_\_

Doctor's Last Name

Doctor's First Name

Doctor's Phone #

Tell us about **new** allergies or health information for this person. Only tell us about **new** information.

Allergies:  None  Aspirin  Cephalosporin  Codeine  Erythromycin  Peanuts  Penicillin  
 Sulfa  Other: \_\_\_\_\_

Health Information:  Arthritis  Asthma  Diabetes  Acid Reflux  Glaucoma  Heart Problem  
 High Blood Pressure  High Cholesterol  Migraine  Osteoporosis  Prostate Issues  Thyroid  
 Other: \_\_\_\_\_

**D Special Instructions:** \_\_\_\_\_

**E How would you like to pay for this order?** Fill in the oval to choose a payment.

- Electronic Check.** Pay from your bank account. First time users register online or call Customer Care.
- Bill Me Later®.** Works like a credit card. First time users register online or call Customer Care.
- Credit or Debit Card.** (VISA®, MasterCard®, Discover®, American Express®, including FSA/HRA/HSA debit cards)
  - Fill in this oval to use your card on file.
  - Fill in this oval to use a new card or to update your card expiration date.

CARD NUMBER Exp. Date MMY Y

**Check or Money Order.** Amount: \$ \_\_\_\_\_ . \_\_\_\_\_

- Make check or money order out to Aetna Rx Home Delivery.
- Write your Aetna Member ID number on your check or money order.
- If your check is returned, we will charge you up to \$40.

**Payment for balance due and future orders:** If you chose electronic check, Bill Me Later®, or a credit or debit card, we will also use it to pay for any balance that you owe and for future orders unless you provide another form of payment.

Fill in this oval if you **DO NOT** want to use this payment method for future orders.

Credit Card Holder Signature/Date

**Regular delivery is free and will take 10 to 14 days from the day you send this form. If you want faster delivery, choose:**

- 2nd Business Day (\$17)** Business days are only Monday-Friday
- Next Business Day (\$23)** Monday-Friday

- Faster delivery charges may change.
- Faster delivery is for shipping time, not processing time.
- Faster delivery can only be sent to a street address, not a PO box.

**Credit Card Disclaimer:** I authorize Aetna Rx Home Delivery to bill my credit card. I understand that my credit card will be billed the following amounts in effect at the time my order is filled: any applicable copayment(s), coinsurance and/or



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