



AETNA PUBLIC EMPLOYEES PLAN Prescription Drug Claim Form

Please submit claim forms to:

Washington State Rx Services

Attn: Pharmacy

P.O. Box 40168

Portland, OR 97240-0168

888-361-1612

www.aetnahca.com

Subscriber ID Number **W** [] [] [] [] [] [] [] [] [] []

Subscriber Name (Please Print) _____
First Middle Last
Street City State ZIP Code

Prescriptions were dispensed to:

Patient Name _____
First Middle Last

Patient Birth Date _____ Male Female Relationship to Subscriber Self Spouse Child
(check one)

Is this medication for an on-the-job injury? Yes No

Does this patient have prescription coverage under any other group insurance plan? Yes No

If yes, provide the name of the insurance company and other employer. _____
Name of Insurance Company

Street City State ZIP Code

Note: Use a separate claim form for each covered patient of the family. I certify that the information on this claim form is true and correct to the best of my knowledge. I authorize the release of any medical information necessary to process this claim.

Signature of Patient (or Parent if a Minor) _____

Please attach a receipt that includes the following information, or have your pharmacist complete and sign the sections below.
Important: If this claim is for a compounded medication, please have your pharmacist complete both pages of this form.

Rx Number	Date Filled	Check One <input type="checkbox"/> New <input type="checkbox"/> Refill	Quantity	Rx Directions	Days Supply
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Medication Name, Dosage, Form & Strength	Physician's name and DEA/NPI #
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NDC Number (11-digit)	Rx Price Including Tax	Amount Paid \$	Compounded Medication <input type="checkbox"/> Yes, see page 2 <input type="checkbox"/> No
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NDC Number (11-digit)	Rx Price Including Tax	Amount Paid \$	Compounded Medication <input type="checkbox"/> Yes, see page 2 <input type="checkbox"/> No
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Rx Number	Date Filled	Check One <input type="checkbox"/> New <input type="checkbox"/> Refill	Quantity	Rx Directions	Days Supply
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Medication Name, Dosage, Form & Strength	Physician's name and DEA/NPI #
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NDC Number (11-digit)	Rx Price Including Tax	Amount Paid \$	Compounded Medication <input type="checkbox"/> Yes, see page 2 <input type="checkbox"/> No
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PHARMACY INFORMATION

Pharmacy Name _____

Street Address _____

City State ZIP Code _____

Ten-digit NPI Number Required [] [] [] [] [] [] [] [] [] []

Note: Benefits are payable directly to the covered individual and any assignment of these benefits is void.

Pharmacist's Signature _____ Date _____

Pharmacy telephone number _____ fax number _____



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Prescription Drug Claim Form *(continued)* for Compounded Prescriptions Only

If your prescription is for a compounded drug, ask your pharmacist to fill out this form. Mail this form along with Prescription Drug Claim Form (page 1) and a receipt.

For Pharmacy use only

- › Enter the NDC number of the most expensive ingredient of the legend drug use.
- › Indicate the drug ingredient(s) and quantity.
- › Indicate the metric quantity dispensed in number of tablets, grams or mls for liquids, creams, ointments, and injectables.
- › Indicate the amount paid for the prescriptions by the patient.

Compounded Prescription Chart			
NDC#	Drug Ingredient	Quantity	Charge
Note: If purchased in a foreign country, the currency must be converted into US dollars.		TOTAL	\$

IMPORTANT: The original Pharmacy prescription label/receipt (including the required drug information) must accompany this claim form. Pharmacy receipts will not be returned, it is recommended that you make copies for your own records.