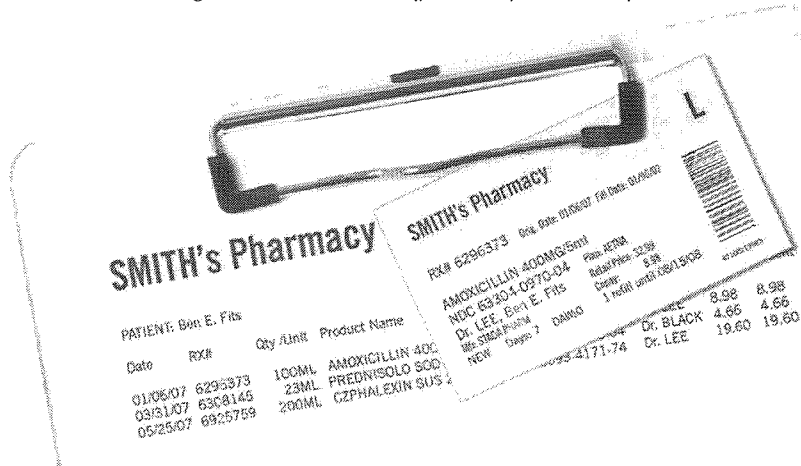




Prescription Drug Claim Form

Send completed form to: AETNA CLAIM OFFICE; P.O. Box 14079; Lexington, KY 40512
 Claim Questions: Call Toll-Free 1-888-553-3449



Employer Information	Name COX ENTERPRISES, INC.		Policy/Group Number 779409
Employee Information	Aetna ID or Social Security Number		Name
	Date of Retirement <input type="checkbox"/> Active <input type="checkbox"/> Retired		Address (include zip code) <input type="checkbox"/> Address is new
Patient Information	Aetna ID or Social Security Number		Birth Date (MM/DD/YYYY)
	Relationship to Employee <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		Address (if different from employee)
	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Is patient employed? <input type="checkbox"/> No <input type="checkbox"/> Yes	Name/Address of Employer
Other Coverage Information	Are any family member's expenses covered by another health plan, group pre-payment plan (Blue Cross/Shield, etc.), Medicare or any federal, state or local government plan? <input type="checkbox"/> No <input type="checkbox"/> Yes		
	If yes, list policy or contract holder, policy or contract number(s) and name/address of insurance company or administrator		
Claim Information	Is claim related to an accident? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, date _____ time _____ <input type="checkbox"/> am <input type="checkbox"/> pm		Is claim related to employment? <input type="checkbox"/> No <input type="checkbox"/> Yes
	Description of Accident		
Prescription Drug Receipts	<p>Attach Pharmacy Receipts or Prescription Drug Record Provided by your Pharmacist</p> <p>Please note: This claim cannot be processed without attached pharmacy receipt or drug record listing the Date, NDC Number, Drug Name, and Cost (per samples below).</p> 		
Release	<p>By submitting this form, you consent to the use and the release of your health information and that of your covered dependents (if you are their guardian or authorized representative) by Aetna Life Insurance Company or one of its affiliated companies ("Aetna"), your health plans and health care providers/agents as permitted by law, including for the purpose of health benefits management.</p> <p>Warning: By returning this form, you certify that the information you have provided is true, correct and complete. The submission of false or misleading information for the purpose of defrauding your health plan or any other person may result in penalties and other actions, including the denial of benefits.</p>		
Employee Certification	Patient's or Authorized Person's Signature _____		Date _____