# 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**

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|---|---|---|---|
| **Employer Information** | Name<br>COX ENTERPRISES, INC. | | Policy/Group Number<br>779409 |
| **Employee Information** | Aetna ID or Social Security Number | Name | Birth Date (MM/DD/YYYY) |
| | Date of Retirement<br>☐ Active ☐ Retired | Address (include zip code) ☐ Address is new | Daytime Telephone Number |
| **Patient Information** | Aetna ID or Social Security Number | Name | Birth Date (MM/DD/YYYY) |
| | Relationship to Employee<br>☐ Self ☐ Spouse ☐ Child ☐ Other | Address (if different from employee) | |
| | Sex<br>☐ Male ☐ Female<br>Is patient employed?<br>☐ No ☐ 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? ☐ No ☐ 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?<br>☐ No ☐ Yes If yes, date __________ time ________ ☐ am ☐ pm | | Is claim related to employment?<br>☐ No ☐ Yes |
| | Description of Accident | | |
| **Prescription Drug Receipts** | Attach Pharmacy Receipts or Prescription Drug Record Provided by your Pharmacist<br><br>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). | | |
| **Release** | 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. | | |
| | 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. | | |
| **Employee Certification** | Patient's or Authorized Person's Signature | | Date |

SMITH's Pharmacy
PATIENT: Ben E. Fits
Date RX# Qty/Unit Product Name
01/05/07 6296373 100ML AMOXICILLIN 400
03/31/07 6308145 23ML PREDNISOLO SOD
05/25/07 6925759 200ML CZPHALEXIN SUS

SMITH's Pharmacy
RX# 6296373
AMOXICILLIN 400MG/5ml
NDC 63304-0970-04
Dr. LEE, Ben E. Fits

FX-6047-COXRX-1007