

TOWNSHIP OF WAYNE MEDICAL & RX REIMBURSEMENT CLAIM FORM

THIS MEDICAL/PRESCRIPTION CLAIM FORM IS FOR USE BY A RETIREE ENROLLED THROUGH THE AETNA MEDICAL/RX PROGRAM FOR THE REIMBURSEMENT OF THE DIFFERENCE IN RX /MEDICAL COPAYMENTS FROM THE AETNA PLAN & THE WAYNE PLAN.

PERSONAL INFORMATION				
NAME: LAST	FIRST	MIDDLE	HOME PHONE NUMBER:	
ADDRESS: STREET	APARTMENT #	CITY	STATE	ZIP
SOCIAL SECURITY # _____ / _____ / _____				

Instructions

1. FOR MEDICAL/PRESCRIPTION DRUG COPAYMENT REIMBURSEMENT, PLEASE SUBMIT THE AETNA MEDICAL/PRESCRIPTION DRUG DOCUMENTATION FOR THE PAYMENT OF THE MEDICAL/PRESCRIPTION DRUG COPAYMENT

2. SUBMIT THIS FORM TO: INSURANCE DESIGN ADMINISTRATORS (IDA)
 P.O. Box 690
 OAKLAND, NJ 07436
 CUSTOMER SERVICE TELEPHONE: 1-800-225-1345

EXPENSES			
TOTAL AMOUNT			

EMPLOYEE CERTIFICATION AND SIGNATURE	
I CERTIFY THAT ALL ITEMS REQUESTED TO BE REIMBURSED HAVE NOT AND WILL NOT BE COVERED BY ANY OTHER HEALTH PLAN OR PROGRAM OF ANY EMPLOYER OR OTHER PERSON.	
SIGNATURE _____	DATE _____