# 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 | | | |
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| | | **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_____ |