CIGNA Tel-Drug Prescription Order Form

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- Please complete this form for NEW and REFILL prescription medication. You can also order refills online at **myCIGNA.com**.
- Print all information clearly as shown in the sample below using BLUE or BLACK ink.

1 2 3 4 A B C D

- Fill in the applicable ovals completely (●).

Step 1: Insurance Cardholder Information Complete if above has changed or appears blank

MEMBER ID | PHONE # | ALT-PHONE #

LAST NAME | FIRST NAME | M

ADDRESS LINE 1

ADDRESS LINE 2 | CITY

ST | ZIP

○ Address above is a one time address

e-mail _____

e-mail owner _____

Step 2: Allergies & Health Conditions Complete this section every time

New customers must complete this section.
If left blank will indicate no known drug allergies, or no change from information provided previously to CIGNA Tel-Drug.

Name (start with cardholder)	Date of Birth	Allergies								Health Conditions						
		None	Penicillin	Sulfa	Codeine/Morphine	Aspirin	Erythromycin	NSAIDS	Other (list below)	Diabetes	High Blood Pressure	Asthma	GI/GERD	High Cholesterol	Other (list below)
FIRST NAME LAST NAME	MM/DD/YY	○	○	○	○	○	○	○	○	○	○	○	○	○	○
FIRST NAME LAST NAME	MM/DD/YY	○	○	○	○	○	○	○	○	○	○	○	○	○	○
FIRST NAME LAST NAME	MM/DD/YY	○	○	○	○	○	○	○	○	○	○	○	○	○	○
FIRST NAME LAST NAME	MM/DD/YY	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Please write the person's name and list their other allergies and/or other conditions referenced above:

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Step 3: Shipping Method

Refrigerated shipments will be expedited at no additional cost. You are responsible for the cost of SPECIAL SHIPPING which expedites carrier delivery time only. Order processing is not affected by SPECIAL SHIPPING. These costs may be subject to change by carrier without prior notification and may vary depending on weight and zone.

○ Standard Shipping $0.00 ○ USPS Priority Mail 2 - 3 Days $9.25 ○ Overnight Delivery $17.95

Step 4: Method of Payment

○ Check ○ Money Order Please make check or money order payable to **CIGNA Tel-Drug**.

Total payment enclosed (excluding credit card payment): $□□,□□□.□□

○ VISA ○ Discover

○ MasterCard ○ American Express

Credit Card # □□□□□□□□□□□□□□□□ Expiration Date □□/□□

○ Use Credit Card on File Last 4 digits of Credit Card □□□□ Expiration Date □□/□□

I authorize CIGNA Tel-Drug to bill my credit card for this and all future orders. I understand that my credit card will be billed the following amounts in effect at the time my order is filled: any applicable copayment(s), coinsurance and/or deductible(s), payments due for any medications not covered under my benefit plan, plus any special shipping costs.

Step 5: Refill Prescriptions Affix label OR complete requested information

Print Prescription Number Here
□□□□□□□□□□

Patient's Name _____
Date of Birth _____
Drug Name _____

Print Prescription Number Here
□□□□□□□□□□

Patient's Name _____
Date of Birth _____
Drug Name _____

Print Prescription Number Here
□□□□□□□□□□

Patient's Name _____
Date of Birth _____
Drug Name _____

Print Prescription Number Here
□□□□□□□□□□

Patient's Name _____
Date of Birth _____
Drug Name _____

Step 6: New Prescriptions Enclose original written prescription from your prescriber

Please write the date of birth and the Member ID on the back of each prescription.

		Check (✓) One			Check	
Patient's Full Name	Date of Birth	Fill Now	Do Not Fill Now	Medication Name & Stength	(✓) if Brand Only	Doctor's Full Name

Pharmacy law permits pharmacists to substitute a less expensive generically equivalent medication for a brand name medication unless you or your prescriber indicate otherwise. By checking (✓) "Brand Only", you may incur a higher cost.

Remember to enclose the original prescription(s) from your prescriber(s).
You can call us at **1.800.Tel-Drug** (835.3784) or visit us at **myCIGNA.com**. You can also write to us or mail this order form to CIGNA Tel-Drug, PO Box 1019, Horsham PA 19044.