



# 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

<input type="text"/>	<input type="text"/>	<input type="text"/>
Cardholder ID	Phone Number	Alternate Phone Number
<input type="text"/>	<input type="text"/>	<input type="text"/>
Last Name	First Name	MI
<input type="text"/>	e-mail <input type="text"/>	
<input type="text"/>	<input type="checkbox"/> This is a one time address	
<input type="text"/>	<input type="text"/>	<input type="text"/>
Address	State	Zip Code
<input type="text"/>	<input type="text"/>	<input type="text"/>
Address		
<input type="text"/>	<input type="text"/>	<input type="text"/>
City	State	Zip Code

### Step 2: 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.

<input type="checkbox"/> Standard Shipping	Standard Delivery	\$0.00	<input type="checkbox"/> FedEx	Overnight	\$17.95
<input type="checkbox"/> USPS Priority Mail	2 - 3 Days	\$5.25	<input type="checkbox"/> UPS Overnight	Overnight (by noon)	\$17.95
<input type="checkbox"/> USPS Express Mail	Overnight	\$17.95	<input type="checkbox"/> UPS Saver	Overnight (by 7:00 pm)	\$16.95

### Step 3: Method of Payment

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

Total payment enclosed (excluding credit card payment):

<input type="checkbox"/> VISA	<input type="checkbox"/> Discover	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> MasterCard	<input type="checkbox"/> American Express	Credit Card #	Expiration Date

Use Credit Card on File

I authorize CIGNA Tel-Drug to bill my credit card. 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 4: Allergies & Health Conditions Complete this section every time**

If no allergies are selected, for new customers this indicates no known allergies and for existing customers this indicates no change from information provided to CIGNA Tel-Drug previously.

<input type="text"/>	<input type="text"/>
Cardholder s First Name	Date of Birth
<input type="text"/>	<input type="text"/>
Dependent s First Name	Date of Birth
<input type="text"/>	<input type="text"/>
Other Dependent s First Name	Date of Birth
<input type="text"/>	<input type="text"/>
Other Dependent s First Name	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)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

**Step 5: Refill Prescriptions**

Affix Label Here  
OR  
Print Prescription Number Here

Drug Name \_\_\_\_\_

Affix Label Here  
OR  
Print Prescription Number Here

Drug Name \_\_\_\_\_

Affix Label Here  
OR  
Print Prescription Number Here

Drug Name \_\_\_\_\_

Affix Label Here  
OR  
Print Prescription Number Here

Drug Name \_\_\_\_\_

**Step 6: Special Instructions Optional**

**PHARMACY LAW PERMITS PHARMACISTS TO SUBSTITUTE A LESS EXPENSIVE GENERICALLY EQUIVALENT MEDICATION FOR A BRAND NAME MEDICATION UNLESS YOU OR YOUR PRESCRIBER INDICATES OTHERWISE.**

Special Instructions \_\_\_\_\_  
\_\_\_\_\_

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.

CIGNA and CIGNA HealthCare refer to various operating subsidiaries of CIGNA Corporation. Products and services are provided by these operating subsidiaries and not by CIGNA Corporation. These operating subsidiaries include Connecticut General Life Insurance Company, Tel-Drug, Inc. and its affiliates, CIGNA Behavioral Health, Inc., Intracorp, and HMO or service company subsidiaries of CIGNA Health Corporation and CIGNA Dental Health, Inc. In Arizona, HMO plans are offered by CIGNA HealthCare of Arizona, Inc. In California, HMO plans are offered by CIGNA HealthCare of California, Inc. In Connecticut, HMO plans are offered by CIGNA HealthCare of Connecticut, Inc. In Virginia, HMO plans are offered by CIGNA HealthCare Mid-Atlantic, Inc. In North Carolina, HMO plans are offered by CIGNA HealthCare of North Carolina, Inc. All other medical plans in these states are insured or administered by Connecticut General Life Insurance Company. CIGNA Tel-Drug refers to Tel-Drug, Inc. and Tel-Drug of Pennsylvania, L.L.C.