CIGNA Tel-Drug Prescription Order Form

By submitting this form you are representing that the information provided is correct.

- **Please print all information clearly with black or blue ink.**
- **Please complete Steps 1, 2, 3 and 4. Then complete Step 5 and/or 6 as needed.**
- **Incomplete information may delay processing.**
- **Please enclose payment method and original prescription(s) only. *Copies of prescription(s) will not be accepted.***
- **Please do not staple any items to this form.**

CIGNA Tel-Drug

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STEP 1: INSURANCE CARDHOLDER INFORMATION

Cardholder ID # *(See insurance card)*	Cardholder's Full Name		**TEMPORARY SHIPPING ADDRESS (FOR THIS ORDER ONLY)**	
Address			In Care of Name	
City	State	Zip Code (+ 4) —	Temp Address	
Home Phone ( ) —	Alternate Phone ( ) —		Temp City	Temp State
Cardholder's Employer	Cardholder's E-mail		Temp Zip Code —	Temp Phone ( ) —

STEP 2: SHIPPING

If this section is left blank, Standard Shipping will be used. Refrigerated shipments will be expedited at no additional cost.

Check (✓) the box for the Shipping Method of your choice. You are responsible for the cost of SPECIAL SHIPPING.

Shipping Method	# of Days	Cost
☐ Standard Shipping	Standard Delivery	$0.00
☐ USPS PRIORITY MAIL	2-3 Days	$5.25
☐ USPS EXPRESS MAIL	Overnight	$17.95
☐ FEDERAL EXPRESS	Overnight	$17.95
☐ UPS OVERNIGHT	Overnight (by 12:00 noon)	$17.95
☐ UPS SAVER	Overnight (by 7 pm)	$16.95

SPECIAL SHIPPING 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.

STEP 3: PAYMENT

Failure to include complete payment information may delay or prevent shipment of order.

Check (✓) the box for the Payment method of your choice.

☐ Enclosed is a check or money order made payable to CIGNA Tel-Drug.

☐ 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.
Complete credit card information is required for each order.
Check (✓) credit card type and enter corresponding credit card information below.

☐ American Express
☐ Discover
☐ MasterCard
☐ VISA

Credit Card #

Expiration Date (MM/YY) /

Name on Credit Card

I would like to pay full price for the medication(s) listed below. Do not bill my insurance.

Medication Name and Strength	Medication Name and Strength

Don't forget to complete the remaining steps on the reverse side.

STEP 4: ALLERGIES & HEALTH CONDITIONS

Please complete this section every time a medication is ordered.

If no allergies are checked (✓), for new customers this indicates no known allergies and for existing customers this indicates no change.

Patient's Full Name Include nickname, Jr./Sr., etc.	Male / Female	Birth Date	None	Aspirin	Cephalosporins	Codeine	Erythromycin	Ibuprofen	Penicillin	Sulfa	Other Allergies	Major Health Conditions
		/ /										
		/ /										
		/ /										
		/ /										

STEP 5: REFILL PRESCRIPTIONS

For your convenience, you can order refills by calling our automated system at 1.800.TEL.DRUG (835.3784) option 1 or by visiting us at *mycigna.com*.
Do not include refills on this form that you plan to order by phone or Internet. Refills from other pharmacies should not be included on this form.

Patient's Full Name	Birth Date	CIGNA Tel-Drug Rx Number	Medication Name and Strength
	/ /	Rx#	
	/ /	Rx#	
	/ /	Rx#	
	/ /	Rx#	

STEP 6: NEW PRESCRIPTIONS

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.

Patient's Full Name	Birth Date	Check (✓) One: Fill Now	Check (✓) One: Do Not Fill Now*	Medication Name & Strength	Check (✓) if Brand Only	Prescriber's/Physician's Full Name	Prescriber's/Physician's Phone Number
	/ /						( ) —
	/ /						( ) —
	/ /						( ) —
	/ /						( ) —

*** By checking this option, you are indicating you do not want the prescription filled at this time. Please contact CIGNA Tel-Drug when the medication is needed.**

Thank you for choosing CIGNA Tel-Drug.

You can call us at 1.800.TEL.DRUG (835.3784) or visit us at *www.teldrug.com.*
You can also write to us or mail this order form to CIGNA Tel-Drug, PO Box 1019, Horsham PA 19044.

At times it may be necessary to switch manufacturers on generic medications. This may cause a change in appearance *(size, shape and/or color)* of the medication.

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