

CIGNA Home Delivery Pharmacy Prescription Order Form



51

 Please complete this form for NEW and REFILL prescription medication. You can also order refills online at the website on your ID card.

 Print all information clearly as shown in the sample below using BLUE or BLACK ink.

1234 ABCD

• Fill in the applicable ovals completely ().

Step 1: Insurance Cardholder Information Complete if above has changed or appears blank															
MEMBER ID	mailerson completing														
					and other educational information may be sent to the email										
ALT-PHO-NE#	ALT-PHO-NE#														
LASTNAME				R	S	Т		N /	A M	E					M
ADDRESSILINE															П
ADDRESSILLINE				7	ī	1									_
	1 O A	ddres	ss al	hove	o ic	a or	ne tii	me :	addr	288					
Step 2: Allergies & Health Conditions					7 10	u 01	10 (11		uddi	000					
		Allergies					Health Conditions								
New customers must complete this so If left blank will indicate no known drug no change from information provided processed to CIGNA Home Delivery Pharmacy.	allergies or reviously to	None	Penicillin	Sulfa	Codeine/Morphine	Aspirin	Erythromycin	NSAIDS	Other (list below))iabetes	High Blood Pressure	Asthma	3I/GERD	High Cholesterol	Other (list below)
Name (start with cardholder)	Date of Birth	_		0)		_	ш	_							
LAST NAME	<u> </u>														
FIRST NAME															
LAST NAME															
FIRST NAME	MM/DD/YY														
LASTNAME															
FIRSTNAME															

The "Tree of Life" logo is a registered service mark, and "CIGNA Home Delivery Pharmacy" is a service mark, of CIGNA Intellectual Property, Inc., licensed for use by CIGNA Corporation and its operating subsidiaries. All products and services are provided exclusively by such operating subsidiaries, including Tel-Drug, Inc. and Tel-Drug of Pennsylvania, L.L.C., and not by CIGNA Corporation. "CIGNA Home Delivery Pharmacy" refers to Tel-Drug, Inc. and Tel-Drug of Pennsylvania, L.L.C.

Please write the individual's name and list their other allergies and other health conditions referenced above:





Step 3: Shipping Method											
	e only. Order proces	ssing is not	st. You are responsible for the affected by SPECIAL SHIPPIN pending on weight and zone.								
O Standard Shipping \$0.0	00 USPS I	Priority Mail	2 - 3 Days \$9.25	Overniç	ght Delivery	\$17.95					
Step 4: Method of Paymen	t										
Check Mono	-		neck or money order payable to	o CIGNA I	Home Delive	ry Pharmacy					
O VISA O Disce	over					/ 🗌 🗎					
MasterCard Ame	rican Express	Credit / I	Debit Card #		Expir	ation Date					
O Use Credit / Debit Card or	n File Last 4 digit	s of Credit /	Debit Card	Expiratio	n Date	/					
credit / debit card will be bill	ed the following am	ounts in effe	lit / debit card for this and all fuect at the time my order is filled edications not covered under me	d: any app	olicable copa	yment(s),					
Step 5: Refill Prescriptions	Affix label OR co	omplete red	quested information								
Print Prescrip	tion Number Here		Print Prescr	iption Nu	mber Here						
Individual's Name Date of Birth Drug Name			Date of Birth	Individual's Name Date of Birth Drug Name							
Print Prescrip	tion Number Here		Print Prescr	Print Prescription Number Here							
Individual's Name Date of Birth Drug Name			Individual's Name Date of Birth Drug Name								
Step 6: New Prescriptions Please write the date of birth			n prescription from your d ok of each prescription.	loctor							
	Chec	ck (√) One		Check							
Individual's Full Name	Fill Date of Birth No	Do Not I Fill	Medication Name & Strength	(√) if Brand Only	Doctor's F	ull Name					

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

