



Cigna Home Delivery Pharmacy Prescription Order Form



10350001

501

- 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.

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

CIGNA ID _____ email _____
 PHO-NE#-____ Person completing _____
 ALT-PHO-NE# _____
 LAST NAME _____ FIRST NAME _____ M
 ADDRESS LINE 1 _____
 ADDRESS LINE 2 _____ CITY _____
 ST ZIP _____
 Order updates, reminders and other educational information may be sent to the email address above for the following individuals: _____
 Address above is a one time address

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

New customers must complete this section.
 If left blank will mean no known drug allergies or no change from information provided previously to Cigna Home Delivery Pharmacy.

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
FIRST NAME _____ LAST NAME _____	MM/DD/YY _____	<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"/>
FIRST NAME _____ LAST NAME _____	MM/DD/YY _____	<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"/>
FIRST NAME _____ LAST NAME _____	MM/DD/YY _____	<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"/>
FIRST NAME _____ LAST NAME _____	MM/DD/YY _____	<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 individual's name and list their other allergies and other health conditions referenced above:

"Cigna" is a registered service mark, and the "Tree of Life" logo and "Cigna Home Delivery Pharmacy" are service marks, of Cigna Intellectual Property, Inc., licensed for use by Cigna Corporation and its operating subsidiaries. All products and services are provided by or through such operating subsidiaries and not by Cigna Corporation. Such operating subsidiaries include Connecticut General Life Insurance Company, Cigna Health and Life Insurance Company, Tel-Drug, Inc., Tel-Drug of Pennsylvania, L.L.C., and HMO subsidiaries of Cigna Health Corporation.
 "Cigna Home Delivery Pharmacy" refers to Tel-Drug, Inc. and Tel-Drug of Pennsylvania, L.L.C.



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 Home Delivery Pharmacy**

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

- VISA Discover /
- MasterCard American Express Credit / Debit Card # /

- Use Credit / Debit Card on File Last 4 digits of Credit / Debit Card Expiration Date /

I allow Cigna Home Delivery Pharmacy to bill my credit / debit card for this and all future orders. I understand that my credit / debit 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, plus any special shipping costs.

Step 5: Refill Prescriptions Attach label OR complete requested information

Print Prescription Number Here

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

Print Prescription Number Here

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

Print Prescription Number Here

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

Print Prescription Number Here

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

Step 6: New Prescriptions Include original written prescription from your doctor

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

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

Pharmacy law allows pharmacists to substitute a less expensive generically equivalent medication for a brand name medication unless you or your doctor request the brand. By checking (✓) "Brand Only", you may incur be responsible for a higher cost.

Remember to include the original prescription(s) from your doctor(s). You can call us at 1.800.835.3784 or visit the website on your ID card. You can also write to us or mail this order form to Cigna Home Delivery Pharmacy, PO Box 1019, Horsham PA 19044.