

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.

505

STEP 1: INSURANCE CARDHOLDER INFORMATION

Cardholder ID # <i>(See insurance card)</i>		Cardholder's Full Name		TEMPORARY SHIPPING ADDRESS <i>(FOR THIS ORDER ONLY)</i>	
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
<input type="checkbox"/> Standard Shipping	Standard Delivery	\$0.00
<input type="checkbox"/> USPS PRIORITY MAIL	2-3 Days	\$5.25
<input type="checkbox"/> USPS EXPRESS MAIL	Overnight	\$17.95
<input type="checkbox"/> FEDERAL EXPRESS	Overnight	\$17.95
<input type="checkbox"/> UPS OVERNIGHT	Overnight (by 12:00 noon)	\$17.95
<input type="checkbox"/> 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.

