

ORDER FORM

Please tear at perforation and place in envelope

TO SEND ORDERS:

- Fill out the requested information below completely. Please include a phone number so we can contact you if we have any questions about your order.
- Make sure you use the participant's member ID number.
- Be sure to include your doctor's name and phone number for each prescription on the order form.
- Place your prescription(s) or the CIGNA Tel-Drug refill request inside the envelope. If this is your first order, you should also fill out your Patient Profile (on the other side of the form).

A pharmacist is available Monday through Friday from 7 am to 10 pm (Central Time) and Saturday from 8 am to 5 pm (Central Time) to answer questions concerning your prescriptions and pharmaceutical care. Call **800.835.3784**. If you are having a medical emergency, please contact your physician or caregiver.

**FOR HELP WITH PLACING YOUR ORDER,
CALL: 1.800.TEL.DRUG (835.3784) OR ONLINE GO TO
PHARMACY CUSTOMER SERVICE ON WWW.CIGNA.COM**

PARTICIPANT INFORMATION

Participant's Name		Participant's Member ID #	
Mail to Address			
City	State	Zip	
E-Mail Address			
Work Phone ()	Home Phone ()		
Company Name			

PAYMENT INFORMATION

<input type="checkbox"/> I have enclosed my check or money order, made payable to Tel-Drug of Pennsylvania, L.L.C.	
<input type="checkbox"/> Please bill my credit card.	<input type="checkbox"/> Amex <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> Discover Card
Card Number	Expiration Date /
Cardholder's Signature	
Number of Prescriptions	Total Amount Enclosed
Participant's Signature	Date / /

(Check one)

PRESCRIPTION INFORMATION

FILL IMMEDIATELY PLACE ON FILE FOR FUTURE FILL

PATIENT'S NAME	BIRTHDATE	SEX	PATIENT IS:			DOCTOR'S NAME & PHONE NO.
			SELF	SPOUSE	OTHER	

I represent that the information on this form is correct. I understand that generic drugs will be dispensed in all cases where legally permissible and medically appropriate, unless this box is checked . If this box is checked, a higher copayment amount may apply.

"CIGNA Tel-Drug" refers to Tel-Drug, Inc. and Tel-Drug of Pennsylvania, L.L.C., operating subsidiaries of CIGNA Corporation. Products and services are provided by these subsidiaries and not by CIGNA Corporation.

Check here if information has changed.

PATIENT PROFILE

Please Complete With Your First Order, Or As Information Changes

Please complete this form for ALL eligible family members participating with CIGNA Tel-Drug and send it in with your first order. There is no need to complete this form with subsequent orders unless the information changes. This information will be used to check for potential drug interactions. Just check the appropriate boxes for each covered family member. Any other allergies should be described.

PRINT OR TYPE

Include last names if not the same as participant's

	ALLERGIES							HEALTH CONDITIONS							
	Date of Birth	Sex	None	Aspirin	Penicillin	Codeine	Sulfa	Thyroid	Diabetes	Glaucoma	Heart Condition	High Blood Pressure	Lung Condition	Liver	Kidney
Participant's Name															
Eligible Spouse's Name															
Other Eligible Dependent's Name															
Other Eligible Dependent's Name															
Other Eligible Dependent's Name															

Over-the-Counter Medications (& for whom) _____

Other Allergies (& for whom) _____

Other Health Conditions (& for whom) _____

I represent that the information on this form is correct, and authorize release of all information regarding my or my family's medical and prescription drug history and treatment to the Plan Sponsor and to Tel-Drug, Inc.

Signature _____ Date _____