

ORDER FORM

PLEASE READ

- Completely fill out the requested information on the front and back pages, so your order will not be delayed. Remember you need to complete the Allergy and Health Conditions grid for each patient submitting a prescription for the first time.
- Please use a black or blue pen to complete this form.
- Please include a phone number so we can contact you if we have any questions about your order.
- Payment **MUST** accompany all orders. Failure to include payment will delay the processing of your order.

- **FOR HELP PLACING YOUR ORDER, PLEASE CALL 1.800.TEL.DRUG (835.3784).**
- If your order requires special instruction, please note in this space provided.

EMPLOYEE/RETIREE INFORMATION

Employee/Retiree Name		Employee/Retiree Member ID #		Shipping address IF DIFFERENT from Employee/Retiree Address	
Permanent Address				Name	
City	State	ZIP		Address	
E-Mail Address		Home Phone ()		City	
Employer Name		Work Phone ()		State	ZIP

TO ORDER REFILLS (OF AN EXISTING PRESCRIPTION ON FILE WITH CIGNA TEL-DRUG)

- Go online to www.teldrug.com or call the Interactive Voice Response (IVR) system at 1.800.835.3784 and choose option 1; or
- Include your refill slip that accompanied the Patient Advisory Leaflet enclosed with your previous order or complete this REFILL section and complete the PAYMENT INFORMATION section below.

Patient Name		Patient Name	
Rx Name	Rx #	Rx Name	Rx #
Rx Name	Rx #	Rx Name	Rx #
Rx Name	Rx #	Rx Name	Rx #

TO FILL NEW OR RENEWAL PRESCRIPTIONS

Patient Name	Date of Birth	Relationship			(Check One)		Brand Only*	Medication Name	Prescribing Doctor Name and Phone #
		Self	Spouse	Other	Fill Now	Place on File			
							<input type="checkbox"/>		
							<input type="checkbox"/>		
							<input type="checkbox"/>		

*I understand that generic drugs will be dispensed in all cases where legally permissible and medically appropriate, unless the above box is checked. By checking that box, a higher copayment amount may apply.

PAYMENT INFORMATION

For reasons of confidentiality, credit card information is no longer placed on file. The payment information section will need to be completed each time you place an order. Please provide payment information below.

# Prescriptions Enclosed	Amount Enclosed \$	<input type="checkbox"/> I have enclosed my check or money order made payable to CIGNA Tel-Drug <input type="checkbox"/> Please bill my credit card: <input type="checkbox"/> American Express <input type="checkbox"/> Discover <input type="checkbox"/> MasterCard <input type="checkbox"/> Visa	
Credit Card Number	Expiration Date /	Credit Cardholder Signature X	

PATIENT PROFILE

ALLERGY AND HEALTH CONDITIONS GRID

Complete This Grid With Your First Order, Or As Information Changes

Please complete this grid for each patient submitting a new prescription for the first time. There is no need to complete this grid with subsequent orders unless the information has changed. This information will be used to check for potential drug and allergy interactions. Just fill in or check the appropriate boxes for each patient. Any other allergies and health conditions should be noted for each patient in the space provided below.

Check here if information has changed.

PRINT OR TYPE

Include last names if not the same as Employee/Retiree

	ALLERGIES							HEALTH CONDITIONS							
	Date of Birth	Gender (M/F)	None	Aspirin	Penicillin	Codeine	Sulfa	Thyroid	Diabetes	Glaucoma	Heart Condition	High Blood Pressure	Lung Condition	Liver	Kidney
Patient Name															

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

Other Allergies (& for whom) _____

Other Health Conditions (& for whom) _____

PLEASE SIGN HERE

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

Signature _____ Date _____

Thank you for using CIGNA Tel-Drug.

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