# Cigna Home Delivery Pharmacy Prescription Order Form

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**To ensure proper processing and delivery, all orders must include:**

- **Shipping address (Section 1)**
- **Allergies and health conditions (Section 2)**
- **Method of payment (Section 4)**
- **New prescriptions (Section 6)**

## Section 1: Insurance Cardholder Information — Complete if above has changed or appears blank

CIGNA ID

email _____

Person completing _____

PHO-NE#-

○ Order updates, reminders and other educational information may be sent to the email address above for the following individuals: _____

ALT-PHO-NE#

LAST NAME FIRST NAME M

ADDRESS LINE 1

ADDRESS LINE 2 CITY

ST ZIP -

○ Address above is a one time address

## Section 2: Allergies & Health Conditions

**New customers must complete this section.**
Please select "none" if you have no known allergies or health conditions.

| 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 | Other (list below) |
| FIRST NAME<br>LAST NAME | MM/DD/YY | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| FIRST NAME<br>LAST NAME | MM/DD/YY | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| FIRST NAME<br>LAST NAME | MM/DD/YY | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| FIRST NAME<br>LAST NAME | MM/DD/YY | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |

If "Other" was selected above, please write the individual's name and list their other allergies and other health conditions:

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## Section 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

## Section 4: Method of Payment Payment must be received before order can be shipped

○ 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 # Expiration Date /

○ 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.

## Section 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** _____

## Section 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.

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

**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 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.