

HOME DELIVERY ORDER FORM



EXPRESS SCRIPTS® from Cigna
Pharmacy



Home Delivery Order Options

Ask your doctor to write your prescription for up to a 90-day supply or the maximum days allowed by your plan with refills up to one year, if appropriate.

ePrescribe: For fastest service ask your doctor to submit prescriptions electronically to Express Scripts PharmacySM.

Online/Mobile App: Log in to myCigna.com or the myCigna® mobile app to refill your medications. You'll be automatically directed to Express Scripts Pharmacy website where you can choose the medication you want delivered, add it to your cart, then check out.

Fax: Have your doctor call 888.327.9791 for faxing instructions. (Faxes can only be accepted from a doctor's office.)

Phone: Call 800.835.3784 for assistance in switching to home delivery.

Mail: Complete the order form and send to Express Scripts Pharmacy along with prescriptions and payment.

Please use ALL CAPITAL LETTERS with black or blue ink. Fill in the ovals as shown. (●)

1 Member Information			
Member ID Number		Group #	
Member Last Name		Member First Name	
☐ Please send email notices regarding this order's status		Email address	
To go paperless, go to Pharmacy section of myCigna.com and update your Communication Preference under Account.			
2 Shipping Address			
☐ Permanent ☐ Temporary		If temporary address, please provide effective dates From ___/___/___ To ___/___/___	
Shipping Address Line 1 (Street address is preferred over PO Box)			Apt#
Shipping Address Line 2			
City		State	Zip
Primary Phone Number ()		Circle One M H W	Secondary Phone Number () Circle One M H W
Shipping Method (Expedited shipping will not rush prescription processing)			
☐ Standard	Free	Arrives within 5-10 days after order is shipped	
☐ Two Day	\$12.00	Arrives 2 business days after order is shipped	
☐ One Day	\$21.00	Arrives 1 business day after order is shipped	
3 Patient Information			
Please only include prescriptions for patients covered under the above Member ID			
Patient #1			
Patient Last Name		Patient First Name	
Patient DOB		Gender ☐ Male ☐ Female	
Physician Name		Physician Phone ()	
Patient #2			
Patient Last Name		Patient First Name	
Patient DOB		Gender ☐ Male ☐ Female	
Physician Name		Physician Phone ()	

4	Payment Method	Do not send cash				
You authorize us to retain on file your payment card details that you used to make this purchase and to charge your payment card account to pay for any prescription orders requested by you. Should you also choose to enroll in the auto-pay program, you further consent that we may charge your enrolled payment method for prescription orders made by covered members, including previously ordered prescriptions which are unpaid. - We will notify you of any changes to this authorization by email or mail as applicable. This Card on File Authorization, and if applicable auto-pay enrollment, will remain in effect until you cancel the authorization by logging into your account or calling the toll-free number on your Cigna ID card. The transaction amount is determined by your plan's benefit structure at the time the prescription is shipped. - State law prohibits the return of prescription medications for resale or reuse. If you feel a credit or refund is warranted, please call the number on your prescription label. - See our privacy policy for information regarding our use and disclosure of personally identifiable information. Signature X _____						
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; padding: 5px;"> Credit Card: We accept VISA, MC, Discover, AMEX, Diners </td> <td style="width: 50%; padding: 5px;"> Check or Checking Account </td> </tr> <tr> <td style="width: 50%; padding: 5px; vertical-align: top;"> ☐ Automatic, ongoing payment through credit card Authorize to pay for this order and all future orders with the credit card below. ☐ For this order only. Simply fill in your credit card information below. Credit Card Number _____ Exp Date _____ </td> <td style="width: 50%; padding: 5px; vertical-align: top;"> ☐ Automatic, ongoing payment through checking account I authorize to pay for this order and all future orders with the checking account information below or include a voided check. ☐ For this order only. Enclose a check payable to Express Scripts Pharmacy. Write invoice number on the check. Name of checking account holder _____ Checking Account Number _____ Routing Number (first 9 digits lower-left corner of personal check) _____ </td> </tr> </table>			Credit Card: We accept VISA, MC, Discover, AMEX, Diners	Check or Checking Account	☐ Automatic, ongoing payment through credit card Authorize to pay for this order and all future orders with the credit card below. ☐ For this order only. Simply fill in your credit card information below. Credit Card Number _____ Exp Date _____	☐ Automatic, ongoing payment through checking account I authorize to pay for this order and all future orders with the checking account information below or include a voided check. ☐ For this order only. Enclose a check payable to Express Scripts Pharmacy. Write invoice number on the check. Name of checking account holder _____ Checking Account Number _____ Routing Number (first 9 digits lower-left corner of personal check) _____
Credit Card: We accept VISA, MC, Discover, AMEX, Diners	Check or Checking Account					
☐ Automatic, ongoing payment through credit card Authorize to pay for this order and all future orders with the credit card below. ☐ For this order only. Simply fill in your credit card information below. Credit Card Number _____ Exp Date _____	☐ Automatic, ongoing payment through checking account I authorize to pay for this order and all future orders with the checking account information below or include a voided check. ☐ For this order only. Enclose a check payable to Express Scripts Pharmacy. Write invoice number on the check. Name of checking account holder _____ Checking Account Number _____ Routing Number (first 9 digits lower-left corner of personal check) _____					
Visit myCigna.com to access the Express Scripts Pharmacy website for account balances and to make payments. To change the limit of the amount we can charge your card without a call to you: - Go to the Pharmacy section of myCigna.com. - Select Payment Methods under Account then Edit Information. - Change the payment authorization limit You can manage account preferences on the Express Scripts Pharmacy website, accessed through MyCigna.com or call 800.835.3784.						
5	Health History					
To update your allergies or health conditions: Visit the Express Scripts Pharmacy website by logging into the Pharmacy section of myCigna.com or call 877.438.4417. This information helps us protect you against potentially harmful drug interactions and allergies.						
6	Important reminders and other information					
If you are a Medicare Part B beneficiary AND have private health insurance, check your prescription drug benefit materials to determine the best way to get Medicare Part B drugs and supplies. Or, call Member Services at the toll-free number found on your ID card. To verify Medicare Part B prescription coverage, call Medicare at 1.800.633.4227. For additional information or help, visit us at myCigna.com or call us at the toll-free number found on your ID card. TTY/TDD dial 711 and follow the prompts. Prescriptions may be processed by: Cigna Home Delivery Pharmacy (Tel-Drug, Inc. or Tel-Drug of Pennsylvania, LLC), Express Scripts Pharmacy (ESI Mail Pharmacy Service, Inc., Express Scripts Pharmacy, Inc. or MAH Pharmacy LLC.), Accredo (Accredo Health Group, Inc.) or Freedom Fertility Pharmacy (Lynnfield Drug, Inc.).						
7	Generic Substitution					
State law permits a pharmacist to substitute a less expensive generic equivalent drug for a brand-name drug unless you or your physician directs otherwise. Please note that this applies to new prescriptions and to any future refills of that prescription. Also be aware that you may pay more for a brand-name drug. ☐ I do not wish to receive a less expensive brand or generic medication. If the prescription is being submitted electronically, discuss with your doctor.						

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Place your prescription(s), order form(s)
and your payment in an envelope.
Do not use staples or paper clips.
Do not affix post it notes to form.

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