Important Forms: **Pharmacy Forms**

[RxPRIME®] Tel-Drug Rx® Refill

Benefits & Services
Education Center
Calculators & Tools
Important Forms
Your Health
Medical Claim Form
Dental Claim Form
Expatriate Claim Form
Pharmacy Forms
Reimbursement Request
Update Your Plan Coverage
Your Money
Open an IRA Account
Open a Brokerage Account
Automatic Savings Program
Your Security
Disability Disclosure Authorization

CIGNA International
Customer Service

The RxPRIME® pharmacy program is designed for your convenience. You just present your RxPRIME® card and pay your copay. No claims forms to fill out.

However, on occasions due to travel and emergencies, you may have to use a non-network pharmacy and need to file a paper claim. Or you mistakenly paid full price for an in-network prescription.

Instructions

1. Go to the claim form.
2. If you wish, you may fill in the claim form online.
3. Print **two copies** of the claim form.
4. If you did not fill in the form online, fill in by hand.
5. **Sign** and date the certification statement in the area provided.
6. Mail one copy, along with **original receipts**, to:
   Connecticut General Life Insurance Company
   RxPRIME® Customer Service
   P.O. Box 780
   Hartford, CT 06142–0780
7. Keep the other copy for your records.

Note:

- Submit a separate form for each family member.
- For more than 2 prescriptions, use additional forms as necessary.
- Forms must be submitted within 180 days of the prescription fill date.
- The lower section must be completed in full for each prescription dispensed. If you have questions regarding the information needed to complete the form, contact your pharmacist.

Questions?

Call RxPRIME® Customer Service at 1.800.6.CALL.RX (1.800.622.5579) or Contact Us by e-mail.

Participant

Name:

Employer:

Social Security Number: - -

Mailing Address:

City, State, Zip:

Name:

Birth Date: / /
(mm/dd/yyyy)

Relationship to Participant: Self Spouse Dependent

Sex: Male Female

I represent that the patient information entered on this form is correct, that the patient named is eligible for the benefits and that the patient has received the medication described. I also represent that the medication received is not for treatment of an on-the-job injury. I also authorize release of all information pertaining to this claim to the plan administrator or its designees.

Signature: _____

Date: _____

Prescription #1

/ /
Date Filled (mm/dd/yyyy)

Rx Number

Quantity

Days Supply

National Drug Code (11 digits)

$ Amount Member Paid

Pharmacy NABP Number (7 digits):

Select
Reason for Reimbursement Request

Prescription #2

/ / Date Filled (mm/dd/yyyy)

Rx Number

Quantity

Days Supply

National Drug Code (11 digits)

$ Amount Member Paid

Pharmacy NABP Number (7 digits):

Select
Reason for Reimbursement Request