



PHARMACY COORDINATION OF BENEFITS

Primary Insurance Company's Name:	
Primary Insurance Company's Policy/Group Number:	
Primary Member's Identification Number:	
Patient's Name:	
Patient's Date of Birth:	
Balance to be reimbursed under the secondary plan:	\$

Please be sure to attach copies of the receipts

Note: Information regarding your secondary coverage under CIGNA's prescription drug program should be completed on the Prescription Drug Claim Form and must be submitted with this form as well as the receipts from the primary plan.