

Medical Claim Form

This form can be used with all **medical** plans. It's not intended for Dental or Pharmacy claims.**

**Please note:

You only need to fill out this form if your health care professional isn't filing the claim for you.

Even if not part of the Cigna network (out-of-network), your health care professional still can file the claim for you.

We've added instructions on the back of this form to make it easy for you to complete.

You can find Dental and Pharmacy claim forms on mycigna.com. Go to: Review My Coverage>Dental or Pharmacy>Related Links.

Insured and/or Administered by
Connecticut General Life Insurance Company
Cigna Health and Life Insurance Company
Cigna HealthCare*



PRIMARY CUSTOMER INFORMATION: <i>Primary Customer complete this section</i>					
A1. PRIMARY CUSTOMER'S NAME (Last Name)		(First Name)	(M.I.)	A2. GENDER <input type="checkbox"/> M <input type="checkbox"/> F	B. DATE OF BIRTH MM DD YYYY
C. PRIMARY CUSTOMER'S MAILING ADDRESS (No., Street)		(City)	(State)	(ZIP Code)	DAYTIME TELEPHONE # ()
IS THIS A CHANGE OF ADDRESS? (Note: address must also be changed with Employer, if applicable) <input type="checkbox"/> YES <input type="checkbox"/> NO		D. CIGNA ID NUMBER OR PRIMARY CUSTOMER SOCIAL SECURITY NUMBER (on the front of your Cigna ID card)		E. ACCOUNT NO. (on the front of your Cigna ID card)	
F. EMPLOYER NAME			G. PRIMARY CUSTOMER STATUS <input type="checkbox"/> EMPLOYED <input type="checkbox"/> RETIRED*** <input type="checkbox"/> COBRA*** <input type="checkbox"/> DISABLED***		*** EFFECTIVE DATE MM DD YYYY

PATIENT INFORMATION: <i>Complete this section only if the patient is not the primary customer</i>						
A. PATIENT'S NAME (Last Name)		(First Name)	(M.I.)	B. RELATIONSHIP TO PRIMARY CUSTOMER <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	C. DATE OF BIRTH MM DD YYYY	D. GENDER <input type="checkbox"/> M <input type="checkbox"/> F
E. PATIENT'S ADDRESS - IF DIFFERENT THAN PRIMARY CUSTOMER ADDRESS (No., Street)			(City)	(State)	(ZIP Code)	
F. AT THE TIME MEDICAL SERVICE WAS PROVIDED WAS THE PATIENT: <input type="checkbox"/> EMPLOYED FULL-TIME <input type="checkbox"/> STUDENT FULL-TIME <input type="checkbox"/> N/A						

ACCIDENT/OCCUPATIONAL CLAIM INFORMATION: <i>Complete this section only if you are filing the claim because of an accident or occupational (work-related) illness or injury</i>					
A. ACCIDENT OR ILLNESS DUE TO EMPLOYMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	B. INJURY DUE TO AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	C. DESCRIPTION OF HOW ACCIDENT OR WORK-RELATED ILLNESS/INJURY OCCURRED			
D. DATE OF ACCIDENT OR BEGINNING OF ILLNESS MM DD YYYY		E. ARE YOU OR YOUR DEPENDENTS FILING A CLAIM OR LAWSUIT AGAINST A THIRD PARTY INCLUDING AN INSURANCE COMPANY IN ORDER TO RECOVER THE COST OF EXPENSES INCURRED AS A RESULT OF THIS ACCIDENT OR ILLNESS? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, Name of Third Party: _____			

FAMILY/OTHER COVERAGE INFORMATION: <i>Complete only if claim is for a dependent and/or other coverage is in effect</i>							
A. SPOUSE EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF NO, HAS SPOUSE BEEN EMPLOYED DURING LAST 12 MONTHS? <input type="checkbox"/> YES <input type="checkbox"/> NO	B. NAME OF SPOUSE (Last Name)		(First Name)	(M.I.)	SPOUSE'S DATE OF BIRTH MM DD YYYY	
C. NAME OF SPOUSE'S EMPLOYER		ADDRESS OF SPOUSE'S EMPLOYER (No., Street)		(City)	(State)	(ZIP Code)	TELEPHONE # ()
D1. IS THE PATIENT COVERED UNDER ANOTHER HEALTH INSURANCE PLAN? If yes, provide: NAME OF HEALTH INSURANCE COMPANY			<input type="checkbox"/> YES <input type="checkbox"/> NO	EFFECTIVE DATE OF COVERAGE MM DD YYYY	POLICY NUMBER	TYPE OF PLAN (HMO OR PPO) IF KNOWN	
D2. IS THE PATIENT COVERED UNDER MEDICARE? <input type="checkbox"/> YES <input type="checkbox"/> NO							

If you answered Yes to D1 and/or D2 above, and the other insurance company is primary, then please send us this form and (a) a copy of the explanation of benefits (EOB) and (b) the itemized bill(s) for this claim.

CERTIFICATION	
Any person who knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act which is a crime. For residents in the following states, please see the last page of this form: Alaska, Arizona, California, Colorado, District of Columbia, Florida, Kentucky, Maryland, Minnesota, New Jersey, New Mexico, New York, Oregon, Pennsylvania, Rhode Island, Tennessee, Texas and Virginia.	
I certify that the information supplied is true and correct.	

PRIMARY CUSTOMER'S SIGNATURE X	DATE MM DD YYYY
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PAYMENT INSTRUCTIONS	
I authorize Cigna to make payment directly to the health care professional listed on the enclosed bills.	

PRIMARY CUSTOMER'S SIGNATURE X	DATE MM DD YYYY
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IMPORTANT: When the health care professional holds a Cigna contract, Cigna will always pay the health care professional directly, even if this section is left unsigned. We pay the health care professional at the contracted rate. If you already paid the health care professional for the services you received, you should ask your health care professional to pay you back.

NOTE: Cigna may disclose the information on this form to other persons and entities, including your employer (if your coverage is through your employer). We may do this to process the claim or administer the health plan.

**Cigna HealthCare* refers to the various HMO subsidiaries of Cigna Health Corporation. If you are enrolled in a Cigna HMO plan, complete details can be found in your plan documents or Evidence of Coverage.

"Cigna" is a registered service mark, and the "Tree of Life" logo is a service mark, of Cigna Intellectual Property, Inc. licensed for use by Cigna Corporation and its operating subsidiaries. All products and services are provided by or through such operating subsidiaries and not by Cigna Corporation. Such operating subsidiaries include Connecticut General Life Insurance Company, Cigna Health and Life Insurance Company, Cigna Health Management, Inc., and HMO subsidiaries of Cigna Health Corporation.

INSTRUCTIONS FOR FILING A CLAIM

IMPORTANT

- 1. Use this form for all medical plans.** You can find Dental and Pharmacy claim forms on mycigna.com. Go to: Review My Coverage>Dental or Pharmacy>Related Links.
- You only need to fill out this form if your health care professional isn't filing the claim for you. Even if not part of the Cigna network (out-of-network), your health care professional still can file the claim for you.
- If you received this claim form electronically, click to the right of the each field and type in the information. Once done, remember to click on the Clear Fields button on the bottom of page 1 after printing out the completed form.
- If you are filling the form out by hand, use a new printed form instead of a photocopy. That way we can scan your form and process the claim with no delays. Please print clearly in black ink.
- We must get your claim within 180 days from the date you received the service, unless your plan or state laws allow for more time.
- Please use a separate claim form for each health care professional, and for each member of your family. You can get a new blank form by going to www.cigna.com/customer-forms and clicking on the "Medical Claim Form" link under "Medical Forms", or by calling Customer Service at the toll-free number on the back of your ID card.
- To process your claim, we need your ID number (Primary Customer Section, Block D). It's on the front of your Cigna ID card. It might be the same as your Social Security Number.
- We need an itemized bill to process the claim correctly. We can't accept receipts, balance due statements and cancelled checks in place of the itemized bill.
- Itemized bills must include:

Primary customer name	Type of service/Procedure code	Health care professional address
Date of Service (mm/dd/yyyy)	Charge for the service	Health care professional Tax ID number
Patient name	Health care professional name/credentials	Diagnosis code (ICD format)
- We suggest you make a copy of your bill(s) and your completed claim form for your records.
- 11. Important:** We pay covered claims directly to any health care professional with a Cigna contract. We only send the payment to you when:
 - the health care professional doesn't have a contract with Cigna and/or
 - you leave the payment instructions section blank.We reserve the right to request other documents, such as medical records, if we need them before processing your claim.
- If the patient has other health insurance coverage, and that other insurance is primary and Cigna secondary, we need an Explanation of Benefits (EOB) for this service from the other insurance company when you send the completed form and itemized bill.

MAILING INSTRUCTIONS

- If you are sending one claim, please don't staple or paper clip the bills to the claim form.
- If you are sending more than one claim in the same envelope, then please use a paper clip to keep the claim form and itemized bills together.
- Send your **completed** claim form and itemized bills to the **Cigna address** listed on your ID card.

If you have additional questions, please contact Customer Service using the toll-free number on your ID card.

EXPLANATION OF BENEFITS

Once we've processed the claim, you'll receive an Explanation of Benefits (EOB). The EOB will explain the charges applied to your deductible (the amount you pay for covered services before your plan begins to pay) and any charges you owe your health care professional. Please keep your EOB on file in case you need it in the future.