Member Claim Form

Not to be used for Pharmacy or Dental claims

Insured and/or Administered by
Connecticut General Life Insurance Company
CIGNA Behavioral Health, Inc.

CIGNA HealthCare

This form can be used for all medical plans.
This form only needs to be completed if the provider is not submitting the claim on your behalf.
Out-of-network claims can be submitted by the provider if the provider is able and willing to file on your behalf.

Please refer to reverse side for instructions.

EMPLOYEE INFORMATION: *Employee complete this section*

A. EMPLOYEE'S NAME *(Last Name, First Name, Middle Initial)*

B. DATE OF BIRTH MM | DD | YYYY

C. EMPLOYEE'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)* ☐ YES ☐ NO

D. CIGNA ID NUMBER OR EMPLOYEE SOCIAL SECURITY NUMBER *(on the front of your CIGNA ID card)*

E. ACCOUNT NO. *(on the front of your CIGNA ID card)* **3330877**

F. EMPLOYER NAME **State Health Benefit Plan RETIREES**

G. EMPLOYEE STATUS ☐ EMPLOYED ☐ RETIRED* ☐ COBRA* ☐ DISABLED*

*EFFECTIVE DATE MM | DD | YYYY

PATIENT INFORMATION: *Complete only if patient is other than employee*

A. PATIENT'S NAME *(Last Name, First Name, Middle Initial)*

B. RELATIONSHIP TO EMPLOYEE ☐ Spouse ☐ Child ☐ Other

C. DATE OF BIRTH MM | DD | YYYY

D. SEX ☐ M ☐ F

E. PATIENT'S ADDRESS - IF DIFFERENT THAN EMPLOYEE ADDRESS *(No., Street)* | *(City)* | *(State)* | *(Zip Code)*

F. AT THE TIME MEDICAL SERVICE WAS PROVIDED WAS THE PATIENT: ☐ EMPLOYED FULL-TIME ☐ STUDENT FULL-TIME ☐ N/A

ACCIDENT/OCCUPATIONAL CLAIM INFORMATION:
Complete only if claim is a result of an accident or occupational (work related) illness/injury

A. ACCIDENT OR ILLNESS DUE TO EMPLOYMENT? ☐ YES ☐ NO

B. INJURY DUE TO AUTO ACCIDENT? ☐ YES ☐ 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? ☐ YES ☐ NO If yes, Name of Third Party: _____

FAMILY/OTHER COVERAGE INFORMATION:
Complete only if claim is for a dependent and/or other coverage is in effect

A. SPOUSE EMPLOYED? ☐ YES ☐ NO

IF NO, HAS SPOUSE BEEN EMPLOYED DURING LAST 12 MONTHS? ☐ YES ☐ NO

B. NAME OF SPOUSE *(Last Name, First Name, Middle Initial)*

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 EMPLOYER GROUP HEALTH INSURANCE PLAN? ☐ YES ☐ NO If yes, provide:

NAME OF HEALTH INSURANCE COMPANY | EFFECTIVE DATE OF COVERAGE MM | DD | YYYY | POLICY NUMBER | TYPE OF PLAN (HMO OR PPO) IF KNOWN

D2. IS THE PATIENT COVERED UNDER MEDICARE? ☐ YES ☐ NO

IF YES TO D1. OR D2. AND THE OTHER INSURANCE IS PRIMARY, ENCLOSE A COPY OF THE EXPLANATION OF BENEFITS (EOB) WITH THIS FORM AND THE ITEMIZED BILL(S).

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 York, Oregon, Pennsylvania, Tennessee, Texas and Virginia.

I certify that the information supplied is true and correct.

EMPLOYEE'S SIGNATURE
X

DATE MM | DD | YYYY

PAYMENT INSTRUCTIONS

I authorize payment to be made directly to the healthcare provider(s) indicated on the enclosed bill(s)

EMPLOYEE'S SIGNATURE
X

DATE MM | DD | YYYY

Please be aware that if the provider of service holds a contract with CIGNA, payment will always be made to the provider even if this section is not signed. If the provider is contracted with CIGNA, the provider will be paid by CIGNA at the contracted rate. If you have already paid for services, you should seek reimbursement directly from the provider.

NOTE: The information provided on this form may be disclosed to other persons or entities, including my Plan Sponsor, for the purpose of processing this claim and performing health plan administration.

INSTRUCTIONS FOR FILING A CLAIM

IMPORTANT

1. **This form can be used for all medical plans.** This form only needs to be completed if the provider is not submitting the claim on your behalf. Out-of-network claims can be submitted by the provider if the provider is able and willing to file on your behalf.
2. If you received this claim form electronically, you can fill in the fields by clicking to the right of the first field (Employee's Name) and typing in the information. Remember to click on the Clear Fields button on the top of page 1 after printing out the completed claim form.
3. If you are completing this form by hand, use a new printed form rather than a photocopy to ensure the form can be scanned into our system. Also, be sure to print clearly and use black ink when you complete the form.
4. Claim must be postmarked within one year of your date of service for claims to be considered payable.
5. Use a separate claim form for each provider and each member of the family. A new form can be obtained from www.cigna.com under HealthCare, Important Forms or by calling Member Services using the toll-free number on your CIGNA ID card.
6. Your claim cannot be processed without your ID Number (Employee Section, Block D). Please reference the front of your CIGNA ID card to find this number. Your ID may be the employee's Social Security Number.
7. You must submit an itemized bill for your claim to be processed. Receipts, balance due statements and cancelled checks are not acceptable replacements for the itemized bill.
8. ITEMIZED BILLS MUST INCLUDE:

Employee Name	Provider Name	Date of Service
Patient Name	Provider Address	Diagnosis
Type of Service	Provider Tax ID Number	Charge for Service

9. We suggest you make a copy of your bill(s) and your completed claim form for your records. If you are submitting one claim, please do not paper clip or staple your claim form and bill(s). If you are submitting multiple claims in one envelope, please paper clip the appropriate claim form and itemized bill(s) together.
10. Please be aware that payment will be sent to the provider, unless the provider is non-contracted with CIGNA and you submit a receipt that shows you paid in full (a zero balance) with your itemized bill and this claim form. CIGNA reserves the right to request additional documentation, such as medical records prior to processing your claim.
11. If the patient has coverage through another health insurance carrier which is considered primary (CIGNA as secondary), you must submit the Explanation of Benefits (EOB) from the insurance carrier for this service along with this completed form and itemized bill.

EXPLANATION OF BENEFITS

You will receive an Explanation of Benefits (EOB) after your claim is processed explaining the charges applied to your deductible and any charges you owe to the provider. Please keep your EOBs for later reference.

MAILING INSTRUCTIONS

If you are submitting one claim, please do not paper clip or staple your claim form and bill(s). If you are submitting multiple claims in one envelope, please paper clip the appropriate claim form and itemized bill(s) together.

If you are enrolled in an HMO, POS, or Open Access plan (excluding Open Access Plus), please mail in-network and out-of-network Mental Health or Substance Abuse claims to:

CIGNA Behavioral Health, Inc.
Attn: Claims Service Dept.
P.O. Box 46270
Eden Prairie, MN 55344-6270

Send your ***completed claim form*** and itemized bill(s) to:

Chattanooga
P.O. Box 188050
Chattanooga, TN 37422-8050

If you have additional questions, please contact Member Services at: 1-800-942-6724

Caution: 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.

IMPORTANT CLAIM NOTICE

Alaska Residents: A person who knowingly and with intent to injure, defraud or deceive an insurance company or files a claim containing false, incomplete or misleading information may be prosecuted under state law.

Arizona Residents: For your protection, Arizona law requires the following statement to appear on/with this form. Any person who knowingly presents a false or fraudulent claim for payment of loss is subject to criminal and civil penalties.

California Residents: For your protection, California law requires the following to appear on/with this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado Residents: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

District of Columbia Residents: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Kentucky Residents: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maryland Residents: Any person who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Minnesota Residents: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Jersey Residents: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New York Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed $5000 and the stated value of the claim for each such violation.

Oregon Residents: 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, may have committed a fraudulent insurance act.

Pennsylvania Residents: Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Tennessee Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Texas Residents: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Virginia Residents: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.