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

CIGNA

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)* **3211392**

F. EMPLOYER NAME **Legal Services for New York City**

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, 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:

☐ CIGNA HealthCare
P.O. Box 5200
Scranton, PA 18505-5200
AK, CT, DE, GU, HI, IL, IN, IA, ME, MD, MA, MI, MN, MO, NE, NH, NJ, NY, NC, ND, OH, PA, PR, RI, SC, SD, VT, VA, VI, DC, WV, WI

☐ CIGNA HealthCare
P.O. Box 182223
Chattanooga, TN 37422-7223
AL, AZ, AR, CA, CO, FL, GA, ID, KS, KY, LA, MS, MT, NV, NM, OK, OR, TN, TX, UT, WA, WY

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