LEGAL SERVICES NYC

CIGNA OPEN ACCESS PLUS BASIC REIMBURSEMENT REQUEST FORM

ABOUT THIS FORM - WHAT YOU NEED TO DO:

If you are enrolled in the CIGNA Open Access Plus Basic plan you may be entitled to receive reimbursement for certain benefits. Specifically, In-Network Deductible ($150.00 per employee or $300.00 per family); Hospital Co-pays, Out-of- Network Deductible; Out of Pocket maximums and Infertility treatments; Financial assistance for Adoption and Surrogacy.

Please use this form to submit your proof of reimbursement by following these instructions
1. Complete the information on this form.
2. Submit the proof of payment. Examples of proof of payment include
An explanation of benefits [EOB] showing this amount incurred toward your deductible and/or copayment

Fax your proof of payment, along with this completed form to USI Insurance Services at (610) 537-4087. Or Email to: gerard.lannigan@usi.com

YOU ARE NOT OBLIGATED TO FAX OR EMAIL ANY PERSONAL HEALTH INFORMATION. If you prefer, you can mail your completed form to: USI Insurance Services, 261 Madison Avenue, 5th Floor, New York, NY 10016 Attn: Gerard Lannigan. To qualify for reimbursement, you must submit this form an proof of payment with 365 day of your date of service.

If you have any questions, contact Gerard Lannigan at USI Insurance Services: (212) 842-3409

YOUR INFORMATION:

NAME: _____ EMAIL ADDRESS: _____

MAILING ADDRESS: _____

_____

_____

DAYTIME PHONE: _____

REIMBURSEMENT INFORMATION

Indicate Check mark	TOTAL	
		IN NETWORK DEDUCTIBLE
		($150 PER PERSON / $300 PER FAMILY)

Indicate Check mark	TOTAL	
		HOSPITAL CO PAY
		($425 OUT OF $500)

Indicate Check mark	TOTAL	
		OUT OF NETWORK DEDUCTIBLE
		(UP TO $150 AFTER $350 MET PER PERSON)
		(UP TO $250 AFTER $750 MET PER FAMILY)

Indicate Check mark	TOTAL	
		OUT OF POCKET MAXIMUM [Out of Network Only]
		UP TO $300 AFTER $1,050 MET PER PERSON
		UP TO $650 AFTER $2,100 MET PER FAMILY

Indicate Check mark	TOTAL	
		INFERTILITY TREATMENTS - EFFECTIVE 07/01/2013
		ANNUAL MAXIMUM $25,000 PER PERSON
		LIFETIME MAXIMUM REIMBURSEMENT $50,000 PER PERSON

Indicate Check mark	TOTAL	
		OUT OF NETWORK MAXIMUM
		REIMBURSEMENT CHARGE
		250% OF MEDICARE VS. 80% R&C

Indicate Check mark	TOTAL	
		FINANCIAL ASSISTANCE FOR ADOPTION AND SURROGACY
		LSNYC WILL PROVIDE FINANCIAL ASSISTANCE FOR ADOPTION OR SURROGACY UP TO AN ANNUAL MAXIMUM OF $12,500 AND A LIFETIME MAXIMUM OF $25,000 .

PLEASE INDICATE IF YOU ARE A MEMBER OF MANAGEMENT OR UNION:

☐ Union Member ☐ Management Member

TOTAL REQUEST OF REIMBURSEMENT: $

REIMBURSEMENT FOR THE FOLLOWING PARTIES:

NAMES:

☐ SELF _____

☐ SPOUSE _____

☐ CHILD _____

YOUR SIGNATURE:

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I AM RESPONSIBLE TO PAY MY DEDUCTIBLES/ CO PAYMENTS/ OUT OF POCKET MAXIMUMS UNDER THE CIGNA OPEN ACCESS PLUS BASIC PLAN. I UNDERSTAND THIS IF I REQUEST REIMBUSEMENT FRAUDULENTLY, I WILL BE RESPONSIBLE TO PAY LEGAL SERVICES OF NYC BACK FOR THE AMOUNT I WAS REIMBURSED.

YOUR SIGNATURE: _____ DATE: _____