Member Claim Form

Not to be used for Pharmacy or Dental claims

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

A1. EMPLOYEE'S NAME *(Last Name)*	*(First Name)*	*(M.I.)*	A2. GENDER ☐ M ☐ F	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)*	
F. EMPLOYER NAME	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)*	*(M.I.)*	B. RELATIONSHIP TO EMPLOYEE ☐ Spouse ☐ Child ☐ Other	C. DATE OF BIRTH MM DD YYYY	D. GENDER ☐ 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)*	*(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 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 Mexico, New York, Oregon, Pennsylvania, Rhode Island, 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.

* "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.