

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

Send your completed claim form and itemized bill(s) to: CIGNA Health Care
P.O. Box 182223
Chattanooga, TN 37422

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) <input type="checkbox"/> YES <input type="checkbox"/> NO		D. CIGNA ID NUMBER (as it appears on the front of your CIGNA ID card)		E. ACCOUNT NO. (on the front of your CIGNA ID card) 3206628	
F. EMPLOYER NAME INTER-AMERICAN DEVELOPMENT BANK			G. EMPLOYEE STATUS <input type="checkbox"/> EMPLOYED <input type="checkbox"/> RETIRED* <input type="checkbox"/> COBRA* <input type="checkbox"/> 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 <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		C. DATE OF BIRTH MM DD YYYY	
D. SEX <input type="checkbox"/> M <input type="checkbox"/> 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: <input type="checkbox"/> EMPLOYED FULL-TIME <input type="checkbox"/> STUDENT FULL-TIME <input type="checkbox"/> 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? <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: Complete only if claim is for a dependent and/or other coverage is in effect					
A. SPOUSE EMPLOYED? 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, 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? <input type="checkbox"/> YES <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> 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: 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.					