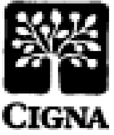


International

INTER-AMERICAN DEVELOPMENT BANK

DENTAL CLAIM FORM

(800) 441-2668 (Inside USA)
(302) 797-3100 (Outside USA)
(302) 797-3150 (FAX)

Please mail completed Claim Form with itemized bills and receipts to:

For Mail Delivery:
CIGNA International
P. O. Box 15050
Wilmington, DE 19850-5050
USA

OR

For Courier Mail Delivery:
CIGNA International
590 Naamans Road
Claymont, DE 19703
USA

10/23/01

You must complete Sections A and B. In addition, you must complete Section C if the claim is for a dependent and/or other coverage is in effect. Employee must sign Claim Form. You must complete a separate Claim Form for each patient. You may include multiple services for the same patient on the same Claim Form.

SECTION A. EMPLOYEE/PATIENT INFORMATION

Employeer **INTER-AMERICAN DEVELOPMENT BANK** Patient's Name ____________

Employee's Name ____________ Policy # on CIGNA ID Card **00390A999**

Employee/Retiree Number, if applicable ____________

Home Address ____________

Please provide telephone and facsimile numbers, with country and city codes, and indicate where you wish to be called:

☐ Home # ____________ ☐ Work # ____________ ☐ Fax # ____________

SECTION B. PAYMENT. ***Please select Option # 1 or Option # 2. Payment will be in United States Dollars.***

☐ ***OPTION # 1 (You wish payment to be made payable to you, the Employee).***
Please indicate where you wish the payment to be sent. You must be an owner of the bank account to which funds are to be sent.

☐ Your home address as listed above

☐ Your bank account for direct deposit

Name on Account ____________ Bank Name ____________

Bank Account # ____________ Bank Address ____________

☐ ***OPTION # 2 (You wish payment to be made payable to the PROVIDER).***
Please complete Provider's name and address in Section D on the reverse side of this Claim Form.

WARNING *Any person who files a statement of claim containing any false, incomplete or misleading information, who knowingly and with intent to injure, defraud, or deceive any insurer, is guilty of a crime.*

Payment Authorization: *I authorize payment directly to me or to the dentist in Section D of this Claim Form.*

EMPLOYEE'S SIGNATURE: ____________ **DATE (M/D/Y):** ____________

Patient's Signature Release (Parent or Guardian, if claim is for a minor): I certify, to the best of my knowledge, that this Claim Form does not contain any false, misleading or incomplete information. I authorize the release of all dental records or other information which may be necessary to determine benefits payable.

PATIENT'S SIGNATURE: ____________ **DATE (M/D/Y):** ____________

SECTION C. OTHER COVERAGE INFORMATION. If the claim is for a dependent and/or other coverage is in effect.

Do you have any other insurance? ☐ Yes ☐ No If yes, please provide source of insurance.

Please indicate source ______________________________

Spouse's name ______________________________

Spouse's insurance company ______________________________

Spouse's employer and telephone # ______________________________

Dependent's date of birth (M/D/Y) ______________ Is your dependent a full-time student? ☐ Yes ☐ No

If yes, please provide documentation of current academic registration.

SECCION D. DENTIST. Please complete this section.

Name, address, and telephone # of dentist of service ______________________________

____

Patient's account # ______________ Place of Service ______________________________

Examination and Treatment Plan - List in order from tooth No. 1 through tooth No. 32. Please use chart system shown.

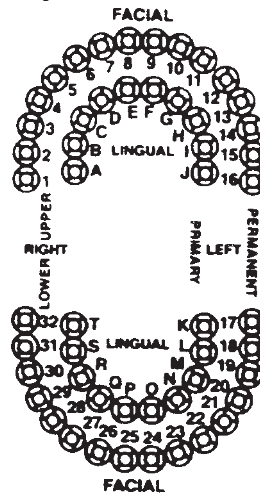
Please check one and specify date

☐ Predetermination of Benefits

☐ Statement of Actual Services

Date:

Please indicate missing teeth with an "x"



Tooth # or Letter	Surface	Description of Procedure	Date of Service	Total Charges	Fee Paid	Fee Due

I certify that the foregoing information is true and correct and that the charges are the actual charges to the patient.

DENTIST'S SIGNATURE: ______________________________ **DATE (M/D/Y)** ______________