# Medical Claim Form

This form can be used with all **medical** plans. It's not intended for Dental or Pharmacy claims.**

**Please note:
You only need to fill out this form if your health care professional isn't filing the claim for you.
Even if not part of the Cigna network (out-of-network), your health care professional still can file the claim for you.

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

Cigna.

**We've added instructions on the back of this form to make it easy for you to complete.**
**You can find Dental and Pharmacy claim forms on mycigna.com. Go to: Review My Coverage>Dental or Pharmacy>Related Links.**

## PRIMARY CUSTOMER INFORMATION: *Primary Customer complete this section*

| A1. PRIMARY CUSTOMER'S NAME *(Last Name)* | *(First Name)* | *(M.I.)* | A2. GENDER ☐ M ☐ F | B. DATE OF BIRTH MM DD YYYY |
|---|---|---|---|---|
| C. PRIMARY CUSTOMER'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, if applicable)* ☐ YES ☐ NO | D. CIGNA ID NUMBER OR PRIMARY CUSTOMER 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. PRIMARY CUSTOMER STATUS ☐ EMPLOYED ☐ RETIRED*** ☐ COBRA*** ☐ DISABLED*** | *** EFFECTIVE DATE MM DD YYYY |
|---|---|---|

## PATIENT INFORMATION: *Complete this section only if the patient is not the primary customer*

| A. PATIENT'S NAME *(Last Name)* | *(First Name)* | *(M.I.)* | B. RELATIONSHIP TO PRIMARY CUSTOMER ☐ Spouse ☐ Child ☐ Other | C. DATE OF BIRTH MM DD YYYY | D. GENDER ☐ M ☐ F |
|---|---|---|---|---|---|

| E. PATIENT'S ADDRESS - IF DIFFERENT THAN PRIMARY CUSTOMER 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 this section only if you are filing the claim because of an accident or occupational (work-related) illness or 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 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 you answered Yes to D1 and/or D2 above, and the other insurance company is primary, then please send us this form and (a) a copy of the explanation of benefits (EOB) and (b) the itemized bill(s) for this claim.***

## 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.**

| PRIMARY CUSTOMER'S SIGNATURE | DATE MM DD YYYY |
|---|---|
| X | |

## PAYMENT INSTRUCTIONS

**I authorize Cigna to make payment directly to the health care professional listed on the enclosed bills.**

| PRIMARY CUSTOMER'S SIGNATURE | DATE MM DD YYYY |
|---|---|
| X | |

**IMPORTANT: When the health care professional holds a Cigna contract, Cigna will always pay the health care professional directly, even if this section is left unsigned. We pay the health care professional at the contracted rate. If you already paid the health care professional for the services you received, you should ask your health care professional to pay you back.**

**NOTE: Cigna may disclose the information on this form to other persons and entities, including your employer (if your coverage is through your employer). We may do this to process the claim or administer the health plan.**

*"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.



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