CIGNA Insurance Services Company

# MEDICAL CLAIM FORM

*Please read the instructions on the back of this form carefully.*

CORPORATE OFFICE
PO Box 190024
Charleston, SC 29419-9024
(800) 720-3150

## PATIENT AND INSURED INFORMATION

| 1. Patient's Name (last, first, mi) | 2. Patient's date of birth (mo/day/yr) | 3. Insured's name (last, first, mi) |
|---|---|---|
| 4. Patient's address (street, city, state, zip code) | 5. Patient's sex ☐ male ☐ female | 6. Insured's ID no. |
| | 7. Patient's relationship to insured ☐ self ☐ spouse ☐ child ☐ other | 8. Insured's group no. |

## OTHER COVERAGE INFORMATION

| 9. Name of insured's spouse (last, first, mi) | 10. Spouse's date of birth (mo/day/yr) | 11. Spouse's social security no. |
|---|---|---|
| 12. Is your spouse employed? ☐ Yes ☐ No | 13. If yes, by whom? (name and address of employer) | |
| 14. Is patient insured under any other health plan? ☐ Yes ☐ No | 15. If yes, give name and address of insurance company | |

## MEDICAL CLAIM INFORMATION

**Part A** **To be completed by patient (or parent if minor)**

| 16. IMPORTANT Briefly describe the illness or injury which required treatment | 17. Has patient ever been treated for this injury/illness before? ☐ Yes ☐ No<br>If yes, give date last treated (mo/day/yr) |
|---|---|
| 18. Was condition related to:<br>A. Patient's employment ☐ Yes ☐ No B. Accident ☐ Yes ☐ No | 19. If accident, please list date (mo/day/yr)<br>Place (home, work, highway, etc.) |
| 20. Physician or Provider's name and address | 21. I authorize payment for medical benefits to undersigned physician or supplier for service described below.<br>Signed _____ |

**Part B** **To be completed by attending provider (or attach itemized statement)**

| 22. Diagnosis or nature of illness/injury. Relate to procedure in column D by Ref. no's 1,2,3, etc., or DX code.<br>1.<br>2.<br>3.<br>4. | 23. Name of facility where services rendered (if other than home or office).<br>24. Provider account no. |
|---|---|

| 25. **A.** Date of service From - To | **B.** Place of service | **C.** Fully describe procedures, medical services or supplies furnished for each date given. Explain unusual services or circumstances)<br>Procedure Code: Identity | **D.** Diagnosis Code | **E.** Charges | **F.** Days or Units | **G.** TOS | **H.** Leave Blank |
|---|---|---|---|---|---|---|---|
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| 26. Signature of physician or provider (including degree(s) or credentials). I certify that the above information is correct. | 27. Federal tax ID number | 28. Total charge | 29. Amount paid | 30. Balance due |
|---|---|---|---|---|
| | | | | |

The individuals signing this form are advised that the willful making of a false or fraudulent statement herein renders them liable to prosecution. I agree to reimburse the Plan if this claim for sickness/injury is compensable under the Worker's Compensation Act or similar law or if such claim is payable by any primary insurance. I authorize release of any information necessary to process this claim for benefits.

31. Patient or guardian signature (Signature necessary on all claims)

# Instructions for Filing a Medical Claim

1. A claim form is required when submitting bills for reimbursement of medical services.

2. A claim is required for each bill.

3. Please fill in all requested information for Part A on the front of this form.
   No payment of benefits will be made until all the information is received.

4. Have the attending provider or physician complete Part B or attach an itemized bill signed by the provider.

5. When attaching an itemized bill, please be sure the bill contains the following information:
   - Provider's Name and Address
   - Patient's Name, Address, and Date of Birth
   - Date of Service
   - Procedure Description
   - Charge for Each Procedure
   - Diagnosis
   - Provider's Signature

6. Pharmacy Receipts should be submitted with the Prescription Reimbursement Form.

7. Please submit your claims as soon as the medical expenses are incurred.
   CIGNA will not pay for claims submitted after one year from the date of service.

**All claims should be submitted to CIGNA Insurance Services Company.**
If you need additional forms, please see your employer or contact CIGNA.

If you have any questions or need assistance, please contact the CIGNA Member Services Department at the address and or phone number listed below.


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