Group Medical Direct Claim Form

Insured and/or Administered by
Connecticut General Life Insurance Company

CIGNA HealthCare

CIGNA

WESLEYAN UNIVERSITY

MAIL THIS FORM TO: THE ADDRESS SHOWN ON YOUR ID CARD.

TELEPHONE: 1-800-244-6224 TOLL FREE

Provider Section and Instructions on Reverse Side

EMPLOYEE INFORMATION: Employee Complete This Section

A. **EMPLOYEE'S NAME** *(First, M.I., Last)*

B. DATE OF BIRTH

C. SEX ☐ M ☐ F

D. EMPLOYEE'S MAILING ADDRESS *(Street, City, State, Zip)* and DAYTIME PHONE #

IS THIS A CHANGE OF ADDRESS? ☐ YES ☐ NO

E. **EMPLOYEE'S SOC. SEC. / ID NO.**

F. MARITAL STATUS

G. **POLICY/ACCOUNT NO.** 3188492

H. DIVISION/BRANCH OR CLASS/LOCATION

I. EMPLOYER: **WESLEYAN UNIVERSITY**

J. EMPLOYEE STATUS ☐ ACTIVE ☐ HOURLY ☐ RETIRED ☐ COBRA ☐ SALARIED ☐ DISABLED

DATE

PATIENT INFORMATION: Complete Only if Patient is Other Than Employee

A. **PATIENT'S NAME** *(First, M.I., Last)*

B. **RELATIONSHIP TO EMPLOYEE**

C. DATE OF BIRTH

D. SEX ☐ M ☐ F

E. COMPLETE THIS INFORMATION IF PATIENT IS AN UNMARRIED DEPENDENT CHILD

DEPENDENT CHILD IS: ☐ EMPLOYED FULL-TIME ☐ STUDENT FULL-TIME

NAME, ADDRESS AND PHONE # OF CHILD'S SCHOOL/EMPLOYER

ACCIDENT/OCCUPATIONAL CLAIM INFORMATION: Complete Only if Claim is a Result of an Accident or Occupational Illness/Injury

A. DESCRIPTION OF ☐ ACCIDENT OR ☐ ILLNESS (How, When, Where)

B. ACCIDENT OR ILLNESS DUE TO EMPLOYMENT ☐ YES ☐ NO

C. DATE OF ACCIDENT OR BEGINNING OF ILLNESS

D. INJURY DUE TO AUTO ACCIDENT ☐ YES ☐ NO

E. HAVE YOU OR YOUR DEPENDENT, OR WILL YOU OR YOUR DEPENDENT FILE CLAIM FOR WORKERS' COMPENSATION BENEFITS? ☐ YES ☐ NO

F. ARE YOU OR YOUR DEPENDENTS FILING A CLAIM OR LAWSUIT AGAINST A THIRD PARTY IN ORDER TO RECOVER THE COST OF EXPENSES INCURRED AS A RESULT OF THIS ACCIDENT OR ILLNESS? ☐ YES ☐ NO

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

SPOUSE'S DATE OF BIRTH

C. **SPOUSE'S SOC. SEC. / ID NO.**

D. NAME, ADDRESS AND PHONE # OF SPOUSE'S EMPLOYER

E. IS THE PATIENT COVERED UNDER ANOTHER GROUP INSURANCE OR GOVERNMENT PLAN SUCH AS MEDICARE, AN HMO PLAN OR AUTOMOBILE MANDATORY NO-FAULT COVERAGE WHICH WILL ALSO COVER ANY OF THE MEDICAL EXPENSES OR DISABILITY LOSSES OF THIS CLAIM? ☐ YES ☐ NO
IF YES, GIVE NAME AND ADDRESS OF INSURANCE COMPANY, ORGANIZATION, OR HMO PROVIDING BENEFITS.

NAME & ADDRESS

POLICY NUMBER

EMPLOYEE'S/PATIENT'S SIGNATURE AND RELEASE: Employee Must Sign all Claims

A. **AUTHORIZATION TO RELEASE INFORMATION- I authorize any Health Care Provider, Insurance Company, Employer, Person or Organization to release any information regarding the medical, dental, mental, alcohol or drug abuse history, treatment, or benefits payable, including disability or employment related information, to any CIGNA company, the Plan Administrator, or their authorized agents for the purpose of validating and determining benefits payable. I will receive a copy of this authorization upon request. This authorization or a copy shall be valid for one year from the date of signature.**

PATIENT'S SIGNATURE (Parent or Guardian if Claim is on a Minor) — **DATE**

NOTE: If you wish your benefits paid directly to the physician or provider of service, sign in box B, below. Benefits will be paid directly to the hospital for a hospital confinement.

B. **PAYMENT AUTHORIZATION - I authorize payment directly to those Health Care Providers described below, and/or as indicated on the enclosed bills, of Medical Benefits otherwise payable to me, for services rendered by them.**

IF YES, EMPLOYEE'S SIGNATURE — **DATE**

C. **CERTIFICATION**
I certify that this information is true and correct.

EMPLOYEE'S SIGNATURE — **DATE**

PHYSICIAN or PROVIDER: Complete This Section

Diagnosis or Nature of Illness or Injury - Relate diagnosis to procedure in Column D by reference to numbers 1, 2, 3, etc. or ICD-9 Code. 1. 2. 3. 4.	DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)	DATE FIRST CONSULTED FOR THIS CONDITION	HOSPITAL CONFINEMENT DATES FROM TO
	DATE ABLE TO RETURN TO WORK	TOTAL DISABILITY DATES FROM TO	PARTIAL DISABILITY DATES FROM TO
	NAME AND ADDRESS OF REFERRING PHYSICIAN OR OTHER SOURCE		

A. DATE OF SERVICE	B. PLACE OF SERVICE *	C. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN PROCEDURE CODE (CPT-4:) (Explain unusual services or circumstances)	D. ICD-9 DIAGNOSIS CODE	E. CHARGES

YOUR PATIENT'S ACCOUNT NO.	**PHYSICIAN'S OR PROVIDER'S TAX IDENTIFICATION NUMBER OR SOCIAL SECURITY NUMBER TO BE USED FOR TAX REPORTING.** **TAX I.D. #** **SOC. SEC. #**	PHYSICIAN OR PROVIDER'S NAME AND ADDRESS **PHYSICIAN'S OR PROVIDER'S TELEPHONE NUMBER** ( )	TOTAL CHARGE AMOUNT PAID BALANCE DUE
I certify that the foregoing information is true and correct and that the charges are the actual charges to the insured.		**PHYSICIAN'S OR PROVIDER'S SIGNATURE**	DATE

* 1. **(IH)** - Inpatient Hospital; 2. **(OH)** - Outpatient Hospital; 3. **(O)** - Doctor's Office; 4. **(H)** - Patient's Home; 5. **(PSY)** - Day Care Facility; 6. **(PSY)** - Night Care Facility; 7. **(NH)** - Nursing Home; 8. **(SNF)** - Skilled Nursing Facility; 9. Ambulance; O. **(OL)** - Other Locations; A. **(IL)** - Independent Laboratory; B. Other Medical Facility

INSTRUCTIONS FOR FILING A CLAIM

Any person who knowingly and with intent to defraud any insurance company or other person files a statement containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act which is a crime.

YOU SHOULD SUBMIT YOUR CLAIMS MONTHLY OR WHEN YOU HAVE BILLS TOTALING MORE THAN $200.00; BUT YOU MUST USE A SEPARATE CLAIM FORM FOR EACH MEMBER OF THE FAMILY.

1. IMPORTANT

- A completed claim form must be included with each submission for each member of the family for each separate accident or illness.
- Your claim cannot be processed without your Social Security Number (Employee Section, Block E).
- You must sign and date your claim form (Employee's / Patient's Signature and Release Section).

2. ATTENDING PHYSICIAN OR PROVIDER INFORMATION SECTION SHOULD BE COMPLETED FOR . . .

Surgery Doctor's Visits Mental Illness Expenses Hospital Confinement

Be certain to include procedure code and ICD-9 Diagnosis Code (Physician or Provider Section, blocks C and D).

3. IF ENCLOSING ITEMIZED BILLS, THEY MUST INCLUDE:

ALL BILLS		DRUG BILLS *(Please tape to an 8 1/2" x 11" piece of paper)*	
Employee Name	Date of Service	Patient Name	Prescription Date
Patient Name	Diagnosis	Physician Name	Drug Name
Type of Service	Charge for Service	Prescription Number	Charge

- Be certain to include Physician or Tax Identification number.
- Bills will not be returned to you - make copies for your records.
- Receipts, balance due statements and cancelled checks are not acceptable.

4. ADDITIONAL INFORMATION

Save your Explanation of Benefits - duplicate vouchers are not available.
Second Opinion Surgical Program - Call your benefits counselor for details.

5. MAILING INSTRUCTIONS

Send your ***completed claim form*** and itemized bills to the address indicated on the front of this form.