CIGNA International Medical & Dental Claim Form

Please mail or fax completed Claim Form with itemized bills and receipts. Please tape small receipts on 8.5 x 11 paper. Please do not staple receipts to Claim Form.

CIGNA International
P O Box 15050
Wilmington, DE 19850-5050

Phone: (800) 441.2668 (outside the U.S.A., via ATT + access)
(302) 479.6617 (outside the U.S.A., collect calls accepted)
Facsimile: (302) 479.6650 (inside the U.S.A.)
(800) 243.6998 (outside the U.S.A., via ATT + access)
E-mail: cieb@cigna.com

Please print or type on this Claim Form. Please complete Sections A and B and Signature lines. Complete Section C if other coverage is in effect or the claim is accident or work related. Complete a Separate Claim Form for each Family Member.

SECTION A. EMPLOYEE AND PATIENT INFORMATION

Type of Claim ❑ Medical/Vision ❑ Dental ❑ Prescription Drugs (Please tape receipts on 8.5 x 11 paper) Date of service, earliest date if multiple ____________ (month) (day) (year)

Country where services were rendered ____________ Diagnosis/Reason for treatment ____________ (Please note diagnosis/reason for each service received)

Employer ____________ CIGNA Employee ID Number |_|_|_|_|_|_|_|_|_|_|

Employee's Name ____________ Patient's Name ____________

Employee's Date of Birth ____________ (month) (day) (year) Patient's Date of Birth ____________ (month) (day) (year)

Mailing Address ____________

City ____________ State/Province ____________ Country ____________

Postal/Zip Code ____________

Please provide telephone and facsimile numbers, with country and city codes.

Home # ____________ Work # ____________ Fax # ____________

E-mail Address ____________

SECTION B. PAYMENT INFORMATION. Please complete either Option #1 or Option #2 and indicate preferred currency for payment. If you wish to receive funds via wire transfer, please contact us for additional instructions (note: your financial institution may assess fees for processing the wire). If you would like to enroll for Electronic Funds Transfer (EFT) please contact us for an application. If already enrolled with EFT, we will automatically send payment via EFT unless noted otherwise below.

Please indicate currency preference ____________
If currency is not specified, payment will be made in U.S. dollars.

❑ ***OPTION #1*** ***Payment to EMPLOYEE. Please indicate where you wish the payment to be sent***	❑ ***OPTION #2*** ***Payment to PROVIDER of Service, e.g. hospital, physician.***
❑ Address as listed above ❑ EFT (requires prior EFT enrollment)	Provider name ____________
❑ Direct mail check deposit to your bank account:	Provider Address ____________
Bank account # ____________	City ____________ State/Province ____________
Bank name ____________	Country ____________
Name on account ____________	Postal/Zip code ____________
Bank Branch Address ____________	Telephone Number ____________
____________	

PAYMENT AUTHORIZATION: I authorize payment as indicated in Section B of this Claim Form.

EMPLOYEE'S SIGNATURE: ____________ DATE: ____________

PATIENT'S SIGNATURE AND 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 records or other information which may be necessary to determine benefits payable.

PATIENT'S SIGNATURE: ____________ ***DATE:*** ____________

SECTION C. OTHER COVERAGE INFORMATION. Complete only if other coverage is in effect or if the claim is accident or work related.

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

1. Please indicate source ____

2. Is this claim accident or work related?

   ❑ Accident related (continue to no. 3)

   ❑ Work related (continue to no. 3)

   ❑ No, not accident or work related (go to signature section)

3. Please provide a brief description of how the accident or work injury occurred.

   ____

   ____

   ____

   ____

   ____

4. If claim is due to an accident, are you seeking reimbursement from another source? ❑ Yes ❑ No.

   If yes, please indicate source ____

Please be sure to sign the Claim Form and attach all itemized bills and receipts.

Please tape small receipts on 8.5 x 11 paper. Please do not staple receipts to Claim Form.

Please include diagnosis or reason for treatment information for each service received.

DISCLOSURE

Information we collect about you will not be given to anyone without your consent, except when it is necessary for conducting our business. The only individuals who have access to the information are CIGNA employees who service your policy or claims, and those who have insurance related, regulatory or legal need for the information. In other situations, we will ask for your written authorization to disclose information about you.

FRAUD NOTICE:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim 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 and subject such person to criminal and civil penalties.