Coverage for Medicare Recipients Questionnaire Form

CIGNA HealthCare

If you, your spouse or another dependent family member receive Medicare benefits in addition to your CIGNA HealthCare coverage, please complete this form.

We work with your other health care carrier to coordinate your benefits and make sure you receive prompt, fair and accurate processing of your claims. It's also required by law that you disclose the information we've requested.

Please return this completed questionnaire form to the CIGNA HealthCare Claims Center listed on your CIGNA HealthCare ID card. If you have any questions or need assistance in completing this form, simply call the Claims Center and a representative will be happy to help you.

Please fill out form completely. **Please note: This form cannot be submitted online.** After filling in all of the fields, please print this form by clicking the button at the end of this form or by using your web browser's print function and mail it to the CIGNA HealthCare claims center listed on the back of your CIGNA HealthCare ID Card.

EMPLOYEE ENROLLED IN A CIGNA HEALTHCARE PLAN:

EMPLOYEE ADDRESS: *(Street)* *(Apt. #)* *(City)* *(State)* *(Zip Code)*

RELATIONSHIP: ☐ Self ☐ Spouse	CIGNA HEALTHCARE GROUP NUMBER:	CIGNA HEALTHCARE MEMBER ID NUMBER:

ARE YOU OR ANY OF YOUR DEPENDENTS COVERED BY MEDICARE?
☐ Yes ☐ No

IF YES, WHO?

Name:	Social Security Number:
Name:	Social Security Number:
Name:	Social Security Number:

WHO IS COVERED UNDER MEDICARE PART A? ☐ Self ☐ Spouse ☐ Other	WHO IS COVERED UNDER MEDICARE PART B? ☐ Self ☐ Spouse ☐ Other
IS MEDICARE COVERAGE DUE TO DISABILITY? ☐ Yes ☐ No	IF YES, WHEN DID DISABILITY OCCUR?

ARE YOU OR ANY OF YOUR DEPENDENTS COVERED BY MEDICARE DUE TO KIDNEY FAILURE?
☐ Yes ☐ No

IF YES, WHO? ☐ Self ☐ Spouse ☐ Other	WHEN DID KIDNEY DIALYSIS BEGIN?
SIGNATURE:	DATE SIGNED:

Thank you for your cooperation in providing this information

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803264 07/2006