Prescription Drug Claim Form

Connecticut General Life Insurance Company
CIGNA Health and Life Insurance Company

CIGNA

REASON FOR REIMBURSEMENT

This claim form can be used to request reimbursement of covered expenses. Please check which reason applies *(at least one must be checked)*:

- ☐ Emergency
- ☐ Non-Participating Pharmacy
- ☐ Primary coverage is with another insurance carrier. Please provide explanation of benefits (EOB) or denial letter from the primary insurance carrier.
- ☐ Eligibility *(Please explain)* _____
- ☐ Other *(Please explain)* _____

PARTICIPANT/PATIENT INFORMATION

PARTICIPANT NAME: _____ ***EMPLOYER:*** _____

CIGNA ID NUMBER OR ***PARTICIPANT*** SOCIAL SECURITY NUMBER *(on the front of your CIGNA ID card)*: _____

PATIENT NAME: _____ ***PATIENT*** BIRTHDATE: ____ /____ /____
-USE A SEPARATE FORM FOR EACH FAMILY MEMBER- MO DAY YEAR

PATIENT RELATIONSHIP TO PARTICIPANT: ☐ SELF (PARTICIPANT) ☐ SPOUSE ☐ DEPENDENT

PATIENT SEX: ☐ MALE ☐ FEMALE ACCOUNT NUMBER *(on the front of your CIGNA ID card):* _____

I represent that the patient information entered on this form is correct, that the patient named is eligible for the benefits and that the patient has received the medication described. I also represent that the medication received is not for treatment of an on-the-job injury. I also authorize release of all information pertaining to this claim to the plan administrator or its designees.

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 York, Oregon, Pennsylvania, Tennessee, Texas and Virginia.

PARTICIPANT SIGNATURE: _____ DATE: _____

DAYTIME PHONE NUMBER: _____

PRESCRIPTION INFORMATION

For Health Care Reform related Over-the-Counter reimbursement requests, include your Doctor's prescription.

1)
_____ / _____ / _____ _____ _____ _____
DATE FILLED RX NUMBER QTY DAY SUPPLY

_____ _ _ _ _ _ _ _ _ _ _ $_____
DRUG NAME & STRENGTH NDC AMT. PAID

_____ _ _ _ _ _ _ _
PHARMACY NAME PHARMACY NABP

_____
PHARMACY ADDRESS

2)
_____ / _____ / _____ _____ _____ _____
DATE FILLED RX NUMBER QTY DAY SUPPLY

_____ _ _ _ _ _ _ _ _ _ _ $_____
DRUG NAME & STRENGTH NDC AMT. PAID

_____ _ _ _ _ _ _ _
PHARMACY NAME PHARMACY NABP

_____
PHARMACY ADDRESS

3)
_____ / _____ / _____ _____ _____ _____
DATE FILLED RX NUMBER QTY DAY SUPPLY

_____ _ _ _ _ _ _ _ _ _ _ $_____
DRUG NAME & STRENGTH NDC AMT. PAID

_____ _ _ _ _ _ _ _
PHARMACY NAME PHARMACY NABP

_____
PHARMACY ADDRESS

4)
_____ / _____ / _____ _____ _____ _____
DATE FILLED RX NUMBER QTY DAY SUPPLY

_____ _ _ _ _ _ _ _ _ _ _ $_____
DRUG NAME & STRENGTH NDC AMT. PAID

_____ _ _ _ _ _ _ _
PHARMACY NAME PHARMACY NABP

_____
PHARMACY ADDRESS

INSTRUCTIONS

PARTICIPANT/PATIENT INFORMATION *(To be completed by the Participant)*

1. Complete ALL information on the front side. Claims missing information may be denied, delayed or returned.

2. Sign and date the Certification Statement in the area provided.

3. Complete the RETURN ADDRESS section below.

4. Submit a separate form for each family member.

5. The Prescription Information section must be completed for each prescription for which you are seeking reimbursement. If you need help completing this form, contact your pharmacist. For Health Care Reform related Over-the-Counter reimbursement requests, include your Doctor's prescription. Please retain a copy of the prescription for your records.

6. **Keep a copy for your records.**

7. Mail the claim form within 12 months of the prescription fill date, along with original receipts (cash register receipts are not acceptable), to:

   CIGNA Pharmacy Service Center
   P.O. Box 3598
   Scranton, PA 18505-0598

8. Questions? Please call the CIGNA number located on your ID card.

Fold *Fold*

RETURN ADDRESS

IMPORTANT: PLEASE PRINT. THIS WILL APPEAR IN A WINDOW ENVELOPE FOR RETURNS.
PLEASE PROVIDE CURRENT ADDRESS INFORMATION BELOW:

_____ **PARTICIPANT NAME**

_____ **PARTICIPANT STREET ADDRESS**

_____ **PARTICIPANT CITY, STATE, ZIP**

Caution: 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.

IMPORTANT CLAIM NOTICE

Alaska Residents: A person who knowingly and with intent to injure, defraud or deceive an insurance company or files a claim containing false, incomplete or misleading information may be prosecuted under state law.

Arizona Residents: For your protection, Arizona law requires the following statement to appear on/with this form. Any person who knowingly presents a false or fraudulent claim for payment of loss is subject to criminal and civil penalties.

California Residents: For your protection, California law requires the following to appear on/with this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado Residents: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

District of Columbia Residents: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Kentucky Residents: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

Maryland Residents: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Minnesota Residents: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Jersey Residents: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New York Residents: 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 shall also be subject to a civil penalty not to exceed $5000 and the stated value of the claim for each such violation.

Oregon Residents: 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, may have committed a fraudulent insurance act.

Pennsylvania Residents: 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 subjects such person to criminal and civil penalties.

Tennessee Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Texas Residents: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Virginia Residents: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

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