CIGNA Vision Claim Form

CIGNA HealthCare

IMPORTANT: This claim form is intended for subscribers and covered dependents who receive services from providers outside the CIGNA Vision network. If your plan permits a non-participating provider to accept assignment, the provider must submit a completed CMS-1500 form (also known as a HCFA-1500 form) to CIGNA Vision at the address below. If you receive services from a participating provider, no claim form is necessary. Read the following instructions carefully as incorrect, incomplete or illegible claims may result in claim payment being delayed or denied.

1. Enter all requested information in the Patient Information and Subscriber Information sections. Claims may be delayed if information is missing.
2. If you have other insurance, submit the Explanation of Benefits, if any, received from your other insurance provider.
3. Enter the Name, Address and Telephone Number of the provider of services in the Provider Information Section.
4. **Attach the original itemized receipts which include a breakdown of the services and/or materials you received including lens type - i.e. single vision, bifocal, or trifocal - if applicable.**
5. Sign and Date the claim form. *Submission of this claim form does not guarantee payment for services.*

Mail the completed claim form to: CIGNA Vision
P.O. Box 997561
Sacramento, CA 95899-7561

If you are a subscriber or a dependent of a subscriber and you have any questions, please call 1-877-478-7557.
If you are a provider and you have any questions, please call 1-877-478-7557.

PATIENT INFORMATION *(Required)*

LAST NAME	FIRST NAME	M.I.	IDENTIFICATION NUMBER OR SSN

STREET ADDRESS	CITY	STATE	POSTAL CODE	TELEPHONE #
				( )

BIRTH DATE	SEX	RELATIONSHIP TO THE SUBSCRIBER	PATIENT STATUS
	☐ M ☐ F	☐ Self ☐ Spouse ☐ Child ☐ Other	☐ Employed ☐ Full-Time Student

IS PATIENT'S CONDITION RELATED TO:	IS THERE ANOTHER HEALTH BENEFIT PLAN
☐ Employment ☐ Auto Accident ☐ Other Accident	☐ Yes ☐ No *If yes, complete other insurance information.*

SUBSCRIBER INFORMATION *(Required)*

LAST NAME	FIRST NAME	M.I.	IDENTIFICATION NUMBER OR SSN

STREET ADDRESS	CITY	STATE	POSTAL CODE	TELEPHONE NO.
				( )

BIRTH DATE	SEX	EMPLOYER NAME
	☐ M ☐ F	

INSURANCE PLAN NAME	SUBSCRIBER'S GROUP NUMBER

REQUEST FOR REIMBURSEMENT - Please enter amount charged. *REMEMBER TO INCLUDE PAID RECEIPT.*

EXAM	FRAME	LENSES	CONTACTS
$_____	$_____	$_____	$_____

IF LENSES WERE PURCHASED, PLEASE CHECK TYPE:	DATE OF SERVICE:
☐ Single ☐ Bifocal ☐ Trifocal ☐ Progressive	_____ / _____ / _____

PROVIDER INFORMATION *(Required)*

PROVIDER NAME	TELEPHONE NO.
	( )

STREET ADDRESS	CITY	STATE	POSTAL CODE

FRAUD WARNING: Any person who knowingly files a statement of claim containing any misrepresentations or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

Patient's or Authorized Person's Signature: I authorize the release of any medical or other information necessary to process this claim. By signing below, I acknowledge that I have read the applicable Fraud Warning Statements on the back of this form.

Signed _____ Date _____

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 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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