Prescription Drug Claim Form



This claim form can be used to request reimbursement of covered expenses. Please check which reason applies (at least one must be checked): Emergancy Eligibility (Please explain) Non-Participating Pharmacy Eligibility (Please explain) Eligibility (Please explain) Primary coverage is with another insurance carrier. Other (Please explain) Energinance PARTICIPANT patient information of benefits (EOB) or denial letter from the primary insurance carrier. EMPLOYER: EMPLOYER: PARTICIPANT NAME: EMPLOYER: DEVELOPMENT BANK CIGNA ID NUMBER OR PARTICIPANT SOCIAL SECURITY NUMBER (on the font of your CIGNA ID card). PARTICIPANT NAME: USE A SEPARATE FORM FOR EACH FAMILY MEMBER. BINTHDATE: Mo PATIENT RELATIONSHIP TO PARTICIPANT: USE A SEPARATE FORM FOR EACH FAMILY MEMBER. BINTHDATE: Mo DAY YEAR PATIENT RELATIONSHIP TO PARTICIPANT: SELF (PARTICIPANT) SPOUSE DEPENDENT PATIENT RELATIONSHIP TO PARTICIPANT: SELF (PARTICIPANT) SPOUSE DEPENDENT PATIENT SEX: MALE FEMALE Information pertaining to this claim to the plan administrator of ta designees. Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially task information or conceals, four purpose of misleading, information concering any fa	REASON FOR R	EIMBURSEMENT	
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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.

6. Keep a copy for your records.

Fold

7. Mail the claim form within 6 months of the prescription fill date, along with original receipts (cash register receipts are not acceptable), to:

Connecticut General Life Insurance Company Pharmacy Service Center P.O. Box 3598 Scranton, PA 18505-0598

Fold

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

RETURN ADDRESS		
<u>IMPORTANT</u> : 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	