# *Prescription Drug Claim Form*

CIGNA HealthCare

## 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:*** INTER-AMERICAN DEVELOPMENT BANK

***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

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 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.

***PARTICIPANT*** SIGNATURE: _____ DATE: _____

DAYTIME PHONE NUMBER: _____

## PRESCRIPTION INFORMATION

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.

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

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

8. Questions? Please call the CIGNA HealthCare 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**