SAMBA
FEDERAL EMPLOYEE BENEFIT ASSOCIATION

HEALTH INSURANCE CLAIM FORM

Instructions are shown on reverse side.

Mail SAMBA Claims To:
CIGNA
P. O. Box 188007
Chattanooga, TN 37422
(301) 984-1440 • (800) 638-6589

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☒ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? PLACE (State) ☐ YES ☐ NO

b. EMPLOYER'S NAME

c. EMPLOYER'S NAME

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes,* return to and complete item 9 a-d

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim.

Signed _____ Date _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

Signed _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First Symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI#

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☐ NO $CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1,2,3 or 4 to Item 24E by Line)

1. _____ 3. _____

2. _____ 4. _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. Place of Service	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID.#
									NPI #	
									NPI #	
									NPI #	
									NPI #	
									NPI #	
									NPI #	

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFORMATION & PHONE #

a. NPI b.

PLEASE PRINT OR TYPE

HEALTH INSURANCE CLAIM FORM INSTRUCTIONS

TO THE INSURED:

1. Complete items (1) through (13).

2. Attach itemized bills to the Claim Form. You do not need to have the provider of service complete the claim form if you attach fully itemized bills and/or receipts. Bills and receipts must show:

   - Name of patient and relationship to member
   - Plan identification number of the member
   - Name and address of physician or supplier providing the service or supply
   - Date service or supply was furnished
   - Type of service or supply and the charge
   - Diagnosis

   In addition:

   - A copy of the Explanation of Benefits from any primary payer (such as Medicare) must be sent with your claim.
   - Claims for rental or purchase of durable medical equipment, private duty nursing and physical, occupation and speech therapy require a written statement from the doctor specifying the medical necessity for the service or supply and the length of time needed.
   - Claims for overseas (foreign) services should include an English translation. Charges should be converted to U.S. dollars using the exchange rate applicable at the time the expense was incurred.

   Cancelled checks, cash register receipts or balance due statements are not acceptable.

TO THE PHYSICIAN OR SUPPLIER:

1. The physician or supplier must complete items (14) through (33).

(Partial List)

PLACE OF SERVICE CODES:

11 - Office	41 - Ambulance-Land
12 - Home	42 - Ambulance-Air, Water
21 - Inpatient Hospital	51 - Inpatient Psychiatric Facility
22 - Outpatient Hospital	52 - Psychiatric Partial Hospitalization
23 - Emergency Room Hospital	55 - Substance Abuse Treatment Center
24 - Ambulatory Surgery Center	56 - Psychiatric Treatment Center
31 - Skilled Nursing Home	61 - Inpatient Rehabilitation Facility
32 - Nursing Facility	62 - Outpatient Rehabilitation Facility
33 - Custodial Care Facility	81 - Independent Lab
34 - Hospice	99 - Other

TYPE OF SERVICE CODES:

1 - Medical Care
2 - Surgery
3 - Consultation
4 - Diagnostic X-Ray
5 - Diagnostic Lab
6 - Radiation/Chemotherapy
7 - Anesthesia
8 - Assistant Surgery
F - ASC Facility Charge
T - Psychological Therapy