Group Medical Direct Claim Form

Insured and/or Administered by
Connecticut General Life Insurance Company

CIGNA HealthCare

CIGNA

MAIL COMPLETED CLAIM FORM TO
THE ADDRESS SHOWN ON YOUR
ID CARD.

Provider Section and Instructions on Reverse Side

EMPLOYEE INFORMATION: Employee Complete This Section

A. **EMPLOYEE'S NAME** *(First, M.I., Last)*

B. DATE OF BIRTH

C. SEX ☐ M ☐ F

D. EMPLOYEE'S MAILING ADDRESS *(Street, City, State, Zip)* and DAYTIME PHONE #

IS THIS A CHANGE OF ADDRESS? ☐ YES ☐ NO

E. **EMPLOYEE'S SOC. SEC. / ID NO.**

F. MARITAL STATUS
SINGLE

G. **POLICY/ACCOUNT NO.**

H. DIVISION/BRANCH OR CLASS/LOCATION

I. EMPLOYER

J. EMPLOYEE STATUS
☐ ACTIVE ☐ HOURLY
☐ COBRA ☐ SALARIED

DATE
☐ RETIRED
☐ DISABLED

PATIENT INFORMATION: Complete Only if Patient is Other Than Employee

A. **PATIENT'S NAME** *(First, M.I., Last)*

B. **RELATIONSHIP TO EMPLOYEE**

C. DATE OF BIRTH

D. SEX ☐ M ☐ F

E. COMPLETE THIS INFORMATION IF PATIENT IS AN UNMARRIED DEPENDENT CHILD

DEPENDENT CHILD IS:
☐ EMPLOYED FULL-TIME
☐ STUDENT FULL-TIME

NAME, ADDRESS AND PHONE # OF CHILD'S SCHOOL/EMPLOYER

ACCIDENT/OCCUPATIONAL CLAIM INFORMATION:
Complete Only if Claim is a Result of an Accident or Occupational Illness/Injury

A. DESCRIPTION OF ☐ ACCIDENT OR ☐ ILLNESS (How, When, Where)

B. ACCIDENT OR ILLNESS DUE TO EMPLOYMENT ☐ YES ☐ NO

C. DATE OF ACCIDENT OR BEGINNING OF ILLNESS

D. INJURY DUE TO AUTO ACCIDENT ☐ YES ☐ NO

E. HAVE YOU OR YOUR DEPENDENT, OR WILL YOU OR YOUR DEPENDENT FILE CLAIM FOR WORKERS' COMPENSATION BENEFITS? ☐ YES ☐ NO

F. ARE YOU OR YOUR DEPENDENTS FILING A CLAIM OR LAWSUIT AGAINST A THIRD PARTY IN ORDER TO RECOVER THE COST OF EXPENSES INCURRED AS A RESULT OF THIS ACCIDENT OR ILLNESS? ☐ YES ☐ NO

FAMILY/OTHER COVERAGE INFORMATION:
Complete Only if Claim is for a Dependent and/or Other Coverage is in Effect

A. SPOUSE EMPLOYED ☐ YES ☐ NO

IF NO, HAS SPOUSE BEEN EMPLOYED DURING LAST 12 MONTHS? ☐ YES ☐ NO

B. NAME OF SPOUSE

SPOUSE'S DATE OF BIRTH

C. **SPOUSE'S SOC. SEC. / ID NO.**

D. NAME, ADDRESS AND PHONE # OF SPOUSE'S EMPLOYER

E. IS THE PATIENT COVERED UNDER ANOTHER GROUP INSURANCE OR GOVERNMENT PLAN SUCH AS MEDICARE, AN HMO PLAN OR AUTOMOBILE MANDATORY NO-FAULT COVERAGE WHICH WILL ALSO COVER ANY OF THE MEDICAL EXPENSES OR DISABILITY LOSSES OF THIS CLAIM? ☐ YES ☐ NO
IF YES, GIVE NAME AND ADDRESS OF INSURANCE COMPANY, ORGANIZATION, OR HMO PROVIDING BENEFITS.

NAME & ADDRESS

POLICY NUMBER

EMPLOYEE'S/PATIENT'S SIGNATURE AND RELEASE: Employee Must Sign all Claims

A. **AUTHORIZATION TO RELEASE INFORMATION- I authorize any Health Care Provider, Insurance Company, Employer, Person or Organization to release any information regarding the medical, dental, mental, alcohol or drug abuse history, treatment, or benefits payable, including disability or employment related information, to any CIGNA company, the Plan Administrator, or their authorized agents for the purpose of validating and determining benefits payable. I will receive a copy of this authorization upon request. This authorization or a copy shall be valid for one year from the date of signature.**

PATIENT'S SIGNATURE (Parent or Guardian if Claim is on a Minor)

DATE

NOTE: If you wish your benefits paid directly to the physician or provider of service, sign in box B, below. Benefits will be paid directly to the hospital for a hospital confinement.

B. **PAYMENT AUTHORIZATION - I authorize payment directly to those Health Care Providers described below, and/or as indicated on the enclosed bills, of Medical Benefits otherwise payable to me, for services rendered by them.**

IF YES, EMPLOYEE'S SIGNATURE

DATE

C. **CERTIFICATION**
I certify that this information is true and correct.

EMPLOYEE'S SIGNATURE

DATE