Member Claim Form

Not to be used for Medical, Pharmacy or Dental claims

Insured and/or Administered by
Cigna Behavioral Health, Inc.

This form can be used for all behavioral plans.
This form only needs to be completed if the provider is not submitting the claim on your behalf.
Out-of-network claims can be submitted by the provider if the provider is able and willing to file on your behalf.

Please refer to instructions attached.

EMPLOYEE INFORMATION: *Employee complete this section*

A1. EMPLOYEE'S NAME *(Last Name)*	*(First Name)*	*(M.I.)*	A2. GENDER ☐ M ☐ F	B. DATE OF BIRTH MM DD YYYY
C. EMPLOYEE'S MAILING ADDRESS *(No., Street)*	*(City)*	*(State)*	*(Zip Code)*	DAYTIME TELEPHONE # ( )

IS THIS A CHANGE OF ADDRESS? *(Note: address must also be changed with Employer)* ☐ YES ☐ NO	D. CIGNA ID NUMBER OR EMPLOYEE SOCIAL SECURITY NUMBER *(on the front of your Cigna ID card)*	E. ACCOUNT NO. *(on the front of your Cigna ID card)*

F. EMPLOYER NAME	G. EMPLOYEE STATUS ☐ EMPLOYED ☐ RETIRED* ☐ COBRA* ☐ DISABLED*	*EFFECTIVE DATE MM DD YYYY

PATIENT INFORMATION: *Complete only if patient is other than employee*

A. PATIENT'S NAME *(Last Name)*	*(First Name)*	*(M.I.)*	B. RELATIONSHIP TO EMPLOYEE ☐ Spouse ☐ Child ☐ Other	C. DATE OF BIRTH MM DD YYYY	D. GENDER ☐ M ☐ F

E. PATIENT'S ADDRESS - IF DIFFERENT THAN EMPLOYEE ADDRESS *(No., Street)*	*(City)*	*(State)*	*(Zip Code)*

F. AT THE TIME SERVICE WAS PROVIDED WAS THE PATIENT: ☐ EMPLOYED FULL-TIME ☐ STUDENT FULL-TIME ☐ N/A

ACCIDENT/OCCUPATIONAL CLAIM INFORMATION:

Complete only if claim is a result of an accident or occupational (work related) illness/injury

A. ACCIDENT OR ILLNESS DUE TO EMPLOYMENT? ☐ YES ☐ NO	B. INJURY DUE TO AUTO ACCIDENT? ☐ YES ☐ NO	C. DESCRIPTION OF HOW ACCIDENT OR WORK RELATED ILLNESS/INJURY OCCURRED

D. DATE OF ACCIDENT OR BEGINNING OF ILLNESS MM DD YYYY	E. ARE YOU OR YOUR DEPENDENTS FILING A CLAIM OR LAWSUIT AGAINST A THIRD PARTY INCLUDING AN INSURANCE COMPANY IN ORDER TO RECOVER THE COST OF EXPENSES INCURRED AS A RESULT OF THIS ACCIDENT OR ILLNESS? ☐ YES ☐ NO If yes, Name of Third Party:

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 *(Last Name)*	*(First Name)*	*(M.I.)*	SPOUSE'S DATE OF BIRTH MM DD YYYY

C. NAME OF SPOUSE'S EMPLOYER	ADDRESS OF SPOUSE'S EMPLOYER *(No., Street)*	*(City)*	*(State)*	*(Zip Code)*	TELEPHONE # ( )

D1. IS THE PATIENT COVERED UNDER ANOTHER EMPLOYER GROUP HEALTH INSURANCE PLAN? ☐ YES ☐ NO If yes, provide: NAME OF HEALTH INSURANCE COMPANY	EFFECTIVE DATE OF COVERAGE MM DD YYYY	POLICY NUMBER	TYPE OF PLAN (HMO OR PPO) IF KNOWN

D2. IS THE PATIENT COVERED UNDER MEDICARE? ☐ YES ☐ NO

IF YES TO D1. OR D2. AND THE OTHER INSURANCE IS PRIMARY, ENCLOSE A COPY OF THE EXPLANATION OF BENEFITS (EOB) WITH THIS FORM AND THE ITEMIZED BILL(S).

CERTIFICATION

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 which is a crime. For residents in the following states, please see the last page of this form: Alaska, Arizona, California, Colorado, District of Columbia, Florida, Kentucky, Maryland, Minnesota, New Hampshire, New Jersey, New Mexico, New York, Oregon, Pennsylvania, Rhode Island, Tennessee, Texas and Virginia.

I certify that the information supplied is true and correct.

EMPLOYEE'S SIGNATURE X	DATE MM DD YYYY

PAYMENT INSTRUCTIONS

I authorize payment to be made directly to the healthcare provider(s) indicated on the enclosed bill(s)

EMPLOYEE'S SIGNATURE X	DATE MM DD YYYY

Please be aware that if the provider of service holds a contract with Cigna, and its affiliates, payment will always be made to the provider at the contracted rate even if this section is not signed. If the provider is contracted with Cigna, the provider will be paid by Cigna at the contracted rate. If you have already paid for services, you should seek reimbursement directly from the provider.

NOTE: The information provided on this form may be disclosed to other persons or entities, including my Plan Sponsor, for the purpose of processing this claim and performing health plan administration.

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INSTRUCTIONS FOR FILING A CLAIM

IMPORTANT

1. **This form can be used for all behavioral plans.** This form only needs to be completed if the provider is not submitting the claim on your behalf. Out-of-network claims can be submitted by the provider if the provider is able and willing to file on your behalf.
2. If you are completing this form by hand, use a new printed form rather than a photocopy to ensure the form can be scanned into our system. Also, be sure to print clearly and use blue or black ink when you complete the form.
3. To consider your claim for payment, Cigna must receive it within 180 days of the date you received the service, unless your plan or state law allows more time.
4. Use a separate claim form for each provider and each member of the family. A new form can be obtained from www.cignabehavioral.com. The form is found under: Are you a Member?, Visit Our Education & Resource Center, Forms, Out-of-Network Claim Form.
5. Your claim cannot be processed without your ID Number (Employee Section, Block D). Please reference the front of your Cigna ID card to find this number. Your ID may be the employee's Social Security Number.
6. You must submit an itemized bill for your claim to be processed. Receipts, balance due statements and cancelled checks are not acceptable replacements for the itemized bill.
7. ITEMIZED BILLS MUST INCLUDE:

Employee Name	Provider Name/Credentials	Date of Service (mm/dd/yyyy)
Patient Name	Provider Address	Diagnosis Code (ICD-10 format)
Type of Service/Procedure Code	Provider Tax ID Number	Charge for Service

8. We suggest you make a copy of your bill(s) and your completed claim form for your records.
9. Cigna reserves the right to request additional documentation, such as medical records prior to processing your claim.
10. If the patient has coverage through another health insurance carrier which is considered primary (Cigna as secondary), you must submit the Explanation of Benefits (EOB) from the primary insurance carrier for this service along with this completed form and itemized bill.

EXPLANATION OF BENEFITS

You will receive an Explanation of Benefits (EOB) after your claim is processed explaining the charges applied to your deductible and any charges you owe to the provider, if applicable. Please keep your EOBs for later reference.

MAILING INSTRUCTIONS FOR CIGNA BEHAVIORAL HEALTH CLAIMS

If you are submitting one claim, please do not paper clip or staple your claim form and bill(s). If you are submitting multiple claims in one envelope, please paper clip the appropriate claim form and itemized bill(s) together.

If you are enrolled in an HMO or POS plan, as indicated on your card, please mail in-network and out-of-network Mental Health or Substance Abuse claims to:

Cigna Behavioral Health, Inc.
Attn: Claims Service Dept.
P.O. Box 188022
Chattanooga, TN 37422

If you are enrolled in Open Access Plus, send completed claim form and itemized bill(s) to the Cigna address listed on your identification card.

If you have additional questions, please contact Customer Service using the toll-free number on your ID card.

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 a false or fraudulent claim for payment of a loss or benefit or 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 Hampshire Residents: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

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 Mexico Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal 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.

Rhode Island Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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.