Direct Member Reimbursement (DMR)
Medical Claim Form

One form per customer. For all other claims, including COVID-19 over-the-counter (OTC) services, please visit: https:/ www.cigna.com/memberrightsandresponsibilities/member-forms/ to download the appropriate form.

Section 1: Over-the-Counter Item Description

Select the response that best describes the type of item for which you are seeking reimbursement:

Purchase Date:	Number of Boxes:	Units Per Box:	Reimbursement Amount:	Select the type of condom purchased:	
				External (Male) Condoms	Internal (Female) Condoms
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐

Section 2: Required Documentation

When submitting your OTC reimbursement form, please include the required documentation listed below.

- Purchase receipt clearly showing the following:
  - Date(s) of Purchase
  - Item(s) Purchased

NOTE: incomplete submissions may not be considered for reimbursement.

PRIMARY CUSTOMER INFORMATION: ***Primary Customer complete this section***

First name:	**Last name:**	**MI:**	**Date of Birth:**	**Gender:** ☐ M ☐ F

Street address *(street, PO Box)*:

City:	**State:**	**Zip code:**	**Phone number:** ( )

Is this a change of address? (**Note**: *address must also be changed with Employer, if applicable)*: ☐ Yes ☐ No	**Cigna ID Number or Primary Customer Social Security Number** *(on the front of your Cigna ID card)*:	**Account No.** *(on the front of your Cigna ID card)*:

Employer's name:	**Primary Customer status:** ☐ Employed ☐ Retired ☐ COBRA ☐ Disabled	**Effective date:**

PATIENT INFORMATION: ***Complete this section only if the patient is not the primary customer***

First name:	**Last name:**	**MI:**	**Date of Birth:**	**Gender:** ☐ M ☐ F

Street address (**if different than primary customer's address**) *(street, PO Box)*:

City:	**State:**	**Zip code:**	**Phone number:** ( )

Relationship to Primary Customer: ☐ Spouse ☐ Child ☐ Other	**At the time medical service was provided was the patient:** ☐ Employed full-time ☐ Student full-time ☐ N/A

FAMILY/OTHER COVERAGE INFORMATION:
Complete only if claim is for a dependent and/or other coverage is in effect

First name:	**Last name:**	**MI:**	**Date of Birth:**	**Gender:** ☐ M ☐ F

Street address *(street, PO Box)*:

City:	**State:**	**Zip code:**	**Phone number:** ( )

Spouse employed? ☐ Yes ☐ No If No, has spouse been employed? ☐ Yes ☐ No	Is the patient covered under Medicare?* ☐ Yes ☐ No

Is the patient covered under another health insurance plan?* ☐ Yes ☐ No	If yes, please provide: name of health insurance company:

Effective date (of coverage):	**Policy number:**	**Type of plan:**

***If you answered Yes and another insurance company or Medicare is primary, then please send us this form and a copy of the Explanation of Benefits (EOB)**

CUSTOMER ATTESTATION

Please check either "Yes" or "No" to the following questions:

Item has been (or will be) reimbursed by another source?	☐ YES	☐ NO
Item has been (or will be) placed for resale?	☐ YES	☐ NO

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 Jersey, New Mexico, New York, Oregon, Pennsylvania, Rhode Island, Tennessee, Texas, Virginia.

I certify that the information supplied is true and correct.

PRIMARY CUSTOMER'S SIGNATURE	DATE		
	MM	DD	YYYY
X			

NOTE: Cigna may disclose the information on this form to other persons and entities, including your employer (if your coverage is through your employer). We may need to do this to process the claim or administer the health plan.

Submission Instructions:

1. Claim forms may be mailed to the address on the back of your ID card.
2. Claim forms may be faxed to: 859.410.2422

Mailing Instructions:

- If you are sending one claim, please do not staple or paper clip the bills or receipts to the claim form.
- If you are sending more than one claim in the same envelope, then please use a paper clip to keep the claim form and the receipt together.
- Send your completed claim form and receipt to the Cigna address listed on your ID card. If you have additional questions, please contact Customer Service using the toll-free number on your ID card.

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 a 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 andconfinement 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 concerningany fact material thereto commits a fraudulent insurance act, which is a crime.

Maryland Residents: Any person who knowingly OR willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly OR willfully presents false information in an application for insurance is guilty of a crime and may be subject tofines 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 ofacrime.

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 andcriminal 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 purposeof 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 subjectssuch person tocriminal 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 andconfinement 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