

# Enrollee Member Request for Reimbursement Claim Form



## REASON FOR REIMBURSEMENT

This claim form can be used to request reimbursement of covered expenses. You may select one of the reasons below to tell us more about your request. Note that the use of a claim form, such as this Enrollee Member Request for Reimbursement Claim Form, is not required to receive a reimbursement.

<input type="checkbox"/> I did not use my medical ID card <input type="checkbox"/> Non-participating provider <i>(Please explain)</i> <hr style="width: 100%;"/> <input type="checkbox"/> Vision <input type="checkbox"/> Hearing Aids <input type="checkbox"/> Primary coverage is with another insurance carrier. Please provide explanation of benefits (EOB) or denial letter from the primary insurance carrier	<input type="checkbox"/> I was waiting for a medical referral or approval <input type="checkbox"/> Traveling out of the country <input type="checkbox"/> Other  Explanation: _____ _____ _____ _____
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## ENROLLEE INFORMATION

ID number (On the front of your Medicare Advantage ID card): \_\_\_\_\_

Enrollee name: \_\_\_\_\_ Enrollee sex:  Male     Female

Enrollee birth date: Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_ Daytime phone: \_\_\_\_\_

Are you the:  Enrollee or  Beneficiary Representatives

If you are the Beneficiary Representatives, please include the required Appointment of Representation (AOR), Power of Attorney or Executor of Estate form. The AOR form can be found at:  
[www.cms.gov/medicare/cms-Forms/downloads/cms1696.pdf](http://www.cms.gov/medicare/cms-Forms/downloads/cms1696.pdf)

## ENROLLEE CERTIFICATION

I represent that the enrollee information entered on this form is correct, that the enrollee named is eligible for the benefits and that the enrollee has received the service described. I also represent that the treatment 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: (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.

Enrollee signature: \_\_\_\_\_ Date: \_\_\_\_\_

Beneficiary Representatives: (If applicable) \_\_\_\_\_ Date \_\_\_\_\_

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**MEDICAL CLAIM INFORMATION**

Date of Service:	Description of Service:
Providers Name	Amount Paid: \$
Provider's Name	Provider's Phone #:
Provider's Address:	
Date of Service:	Description of Service:
Providers Name	Amount Paid: \$
Provider's Name	Provider's Phone #:
Provider's Address:	

**INSTRUCTIONS**

1. Fully complete all sections of this form. Submit a separate form for each request.
2. Sign and date the Enrollee Certification statement in the area provided.
3. If you do not have a detailed receipt for each service related to your request, you can ask your doctor or provider for a replacement receipt or a patient printout. The receipt must show proof of payment.
4. If you are submitting this request for someone other than yourself, please include the required Appointment of Representation (AOR), Power of Attorney or Executor of Estate form. The AOR form can be found at: [www.cms.gov/medicare/cms-Forms/downloads/cms1696.pdf](http://www.cms.gov/medicare/cms-Forms/downloads/cms1696.pdf)
5. Claims missing information may be denied. Remember to send detailed receipts, or invoice printout. Please note that cash register receipts alone are not acceptable.
6. If you need help completing this form, contact customer service.
7. Include any prescription you have pertaining to this request. Make a copy of your prescription receipts. Keep a copy for your records.
8. You should mail your request to: Cigna-HealthSpring Attn: Claims P.O. Box 20002 Nashville, TN 37202-9640.
9. Questions? Please call the customer service number located on your ID card.
10. Feel free to include any additional information here to help us better review your request:

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