Hospital Reimbursement/Alternate Plan

Insured and/or Administered by
Connecticut General Life Insurance Company

CIGNA HealthCare

MAIL THIS COMPLETED FORM AND ITEMIZED BILLS TO:
Personal & Confidential
Kim Stovall
CIGNA HealthCare
P.O. Box 9071
Denison, TX 75020

Please refer to reverse side for instructions.

EMPLOYEE INFORMATION: *Employee complete this section*

A. EMPLOYEE'S NAME *(Last Name, First Name, Middle Initial)*

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)* **3151744**

F. EMPLOYER NAME **Plano Independent School District**

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, Middle Initial)*

B. RELATIONSHIP TO EMPLOYEE ☐ Spouse ☐ Child ☐ Other

C. DATE OF BIRTH MM | DD | YYYY

D. SEX ☐ M ☐ F

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

F. AT THE TIME MEDICAL 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, Middle Initial)*

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.

I certify that the information supplied is true and correct.

EMPLOYEE'S SIGNATURE
X

DATE MM | DD | YYYY

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.

INSTRUCTIONS FOR FILING A CLAIM

IMPORTANT

1. 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.
2. 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.
3. ITEMIZED BILLS MUST INCLUDE:

Employee Name	Provider Name	Date of Service
Patient Name	Provider Address	Diagnosis
Type of Service	Provider Tax ID Number	Charge for Service

4. We suggest you make a copy of your bill(s) and your completed claim form for your records. 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.

EXPLANATION OF BENEFITS

You will receive an Explanation of Benefits (EOB) after your claim is processed. Please keep your EOBs for later reference.

MAILING INSTRUCTIONS

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 have additional questions, please contact Member Services using the toll-free number on your ID card.