Direct Member Reimbursement Form for Cigna Healthcare AZ

ENROLLEE INFORMATION

ID card number (found on the front of your Cigna Healthcare ID card) _____

Enrollee First and Last Name: _____

Enrollee Birth Date: Month _____Day_____ Year_____ Enrollee sex: ☐ Male ☐Female

Daytime phone: _____

Are you the: ☐ Enrollee or ☐Beneficiary Representative

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

REASON FOR REIMBURSEMENT

This claim form can be used to request reimbursement of covered expenses. You may select the reasons below to tell us more about your request.

☐ I did not use my medical ID card

☐ I was waiting for a Medical referral or Authorization (Organizational Determination)

☐ Traveling out of the Country/Cruise Ship

☐ Non-participating provider/ Out of State

☐ Other

☐ Durable Medical Equipment

☐ Vision Exam, Eye glasses or contacts

☐ Hearing Aids

☐ Accident or Illness due to employment

☐ Injury due to Auto Accident

Date of Accident or Beginning of illness

Month _____Day_____ Year_____

☐ My Primary coverage is with another insurance carrier.

Name of Other Health Insurance Plan:

_____

Policy Number: _____

Effective Date of Coverage

Month _____Day_____ Year_____

Include any additional information or reason for services rendered to help us better review your request:

_____
_____
_____
_____
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_____

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MEDICAL CLAIM INFORMATION

Please submit a copy of the providers bill, your cash receipt, credit card receipt or statement (if paid by credit card) showing proof of payment for your medical services

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

ENROLLEE CERTIFICATION

I represent that the Enrollee information entered on this form is correct, that the Enrollee named has received the service described. I 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 Representative: _____ Date _____

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INSTRUCTIONS CHECKLIST

1. Fully complete all sections of this form.

2. Sign and Date the Enrollee Certification statement

3. A Copy of Proof of payment or receipt including an itemized bill

4. When submitting this request for someone other than yourself, please include the required Appointment of Representation (AOR), Power of Attorney or Executor of Estate form.

5. If you need help completing this form, contact Cigna Healthcare AZ Customer Service at 1.800.627.7534

7. Make copies of your prescription receipts and keep a copy for your records.

8. Mail your request to:
Cigna Healthcare
Attn: DMR
PO Box 38639
Phoenix, AZ 85063-8639.

Once we've processed the request, you'll receive an Explanation of Benefits (EOB). The EOB will explain the charges applied to your covered services and any charges you owe the Health Care Professional. Allow 30 days for claim processing.