Group Medical Direct Claim Form

Insured and/or Administered by
Connecticut General Life Insurance Company

CIGNA HealthCare

CIGNA

STATE OF ILLINOIS
GROUP INSURANCE PROGRAM

Quality Care Health Plan
Local Care Health Plan
Teachers' Choice Health Plan
College Choice Health Plan

MAIL COMPLETED CLAIM FORM TO THE ADDRESS SHOWN ON YOUR ID CARD.

Provider Section and Instructions on Reverse Side

EMPLOYEE INFORMATION: Employee Complete This Section

A. **EMPLOYEE'S NAME** *(First, M.I., Last)*

B. DATE OF BIRTH

C. SEX ☐ M ☐ F

D. EMPLOYEE'S MAILING ADDRESS *(Street, City, State, Zip)* and DAYTIME PHONE #

IS THIS A CHANGE OF ADDRESS? ☐ YES ☐ NO

E. **EMPLOYEE'S SOC. SEC. / ID NO.**

F. MARITAL STATUS

G. GROUP/ACCOUNT NUMBER

H. PLAN

I. EMPLOYEE STATUS

☐ ACTIVE ☐ COBRA ☐ HOURLY ☐ SALARIED ☐ RETIRED ☐ DISABLED

DATE

PATIENT INFORMATION: Complete Only if Patient is Other Than Employee

A. **PATIENT'S NAME** *(First, M.I., Last)*

B. **RELATIONSHIP TO EMPLOYEE**

C. DATE OF BIRTH

D. SEX ☐ M ☐ F

E. COMPLETE THIS INFORMATION IF PATIENT IS AN UNMARRIED DEPENDENT CHILD

DEPENDENT CHILD IS:
☐ EMPLOYED FULL-TIME
☐ STUDENT FULL-TIME

NAME, ADDRESS AND PHONE # OF CHILD'S SCHOOL/EMPLOYER

ACCIDENT/OCCUPATIONAL CLAIM INFORMATION: Complete Only if Claim is a Result of an Accident or Occupational Illness/Injury

A. DESCRIPTION OF ☐ ACCIDENT OR ☐ ILLNESS (How, When, Where)

B. ACCIDENT OR ILLNESS DUE TO EMPLOYMENT ☐ YES ☐ NO

C. DATE OF ACCIDENT OR BEGINNING OF ILLNESS

D. INJURY DUE TO AUTO ACCIDENT ☐ YES ☐ NO

E. HAVE YOU OR YOUR DEPENDENT, OR WILL YOU OR YOUR DEPENDENT FILE CLAIM FOR WORKERS' COMPENSATION BENEFITS? ☐ YES ☐ NO

F. ARE YOU OR YOUR DEPENDENTS FILING A CLAIM OR LAWSUIT AGAINST A THIRD PARTY IN ORDER TO RECOVER THE COST OF EXPENSES INCURRED AS A RESULT OF THIS ACCIDENT OR ILLNESS? ☐ YES ☐ NO

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

SPOUSE'S DATE OF BIRTH

C. **SPOUSE'S SOC. SEC. / ID NO.**

D. NAME, ADDRESS AND PHONE # OF SPOUSE'S EMPLOYER

E. IS THE PATIENT COVERED UNDER ANOTHER GROUP INSURANCE OR GOVERNMENT PLAN SUCH AS MEDICARE, AN HMO PLAN OR AUTOMOBILE MANDATORY NO-FAULT COVERAGE WHICH WILL ALSO COVER ANY OF THE MEDICAL EXPENSES OR DISABILITY LOSSES OF THIS CLAIM? ☐ YES ☐ NO
IF YES, GIVE NAME AND ADDRESS OF INSURANCE COMPANY, ORGANIZATION, OR HMO PROVIDING BENEFITS.

NAME & ADDRESS

POLICY NUMBER

EMPLOYEE'S/PATIENT'S SIGNATURE AND RELEASE: Employee Must Sign all Claims

A. **I hereby apply for benefits and certify that the above information is complete, true and correct.**

I hereby agree to reimburse State of Illinois for any overpayment by the Plan.

To all physicians and other medical professionals, hospitals and other medical care institutions, and to insurers, medical or hospital service and prepaid health plans, employers and group policyholders, contractholders or benefit plan administrators: You are authorized to provide CIGNA Healthcare and any benefit plan administrators, the State of Illinois, attorneys and independent claim administrators acting on behalf of CIGNA Healthcare or State of Illinois with information concerning medical care, advice, treatment or supplies provided the Patient, and any employment-related information regarding the Patient. This information will be used for the purpose of evaluating and administering claims for benefits. You are also hereby authorized to release to regulatory and law enforcement agencies of the State of Illinois certain claims information necessary for the investigation and prosecution of fraud and abuse. I understand that the duration of the authorization is for the term of coverage of the policy or contract under which a claim for health benefits has been submitted. I understand that I have a right to receive a copy of this authorization upon request. I agree that a photographic copy of this authorization is as valid as the original. Claim cannot be processed without employee's signature.

EMPLOYEE'S SIGNATURE | **DATE** | **DEPENDENT PATIENT'S SIGNATURE - IF NOT A MINOR** | **DATE**

NOTE: If you wish your benefits paid directly to the physician or provider of service, sign in box B, below. Benefits will be paid directly to the hospital for a hospital confinement.

B. **PAYMENT AUTHORIZATION - I authorize payment directly to those Health Care Providers described below, and/or as indicated on the enclosed bills, of Medical Benefits otherwise payable to me, for services rendered by them.**

IF YES, EMPLOYEE'S SIGNATURE | **DATE**

PHYSICIAN or PROVIDER: Complete This Section

Diagnosis or Nature of Illness or Injury - Relate diagnosis to procedure in Column D by reference to numbers 1, 2, 3, etc. or ICD-9 Code.

1.
2.
3.
4.

DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)	DATE FIRST CONSULTED FOR THIS CONDITION	HOSPITAL CONFINEMENT DATES FROM TO
DATE ABLE TO RETURN TO WORK	TOTAL DISABILITY DATES FROM TO	PARTIAL DISABILITY DATES FROM TO
NAME AND ADDRESS OF REFERRING PHYSICIAN OR OTHER SOURCE		

A. DATE OF SERVICE	B. PLACE OF SERVICE *	C. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN PROCEDURE CODE (CPT-4:) (Explain unusual services or circumstances)	D. ICD-9 DIAGNOSIS CODE	E. CHARGES

YOUR PATIENT'S ACCOUNT NO.	**PHYSICIAN'S OR PROVIDER'S TAX IDENTIFICATION NUMBER OR SOCIAL SECURITY NUMBER TO BE USED FOR TAX REPORTING.** **TAX I.D. #** **SOC. SEC. #**	PHYSICIAN OR PROVIDER'S NAME AND ADDRESS **PHYSICIAN'S OR PROVIDER'S TELEPHONE NUMBER** ( )	TOTAL CHARGE AMOUNT PAID BALANCE DUE

I certify that the foregoing information is true and correct and that the charges are the actual charges to the insured. | **PHYSICIAN'S OR PROVIDER'S SIGNATURE** | DATE

* 1. **(IH)** - Inpatient Hospital; 2. **(OH)** - Outpatient Hospital; 3. **(O)** - Doctor's Office; 4. **(H)** - Patient's Home; 5. **(PSY)** - Day Care Facility; 6. **(PSY)** - Night Care Facility; 7. **(NH)** - Nursing Home; 8. **(SNF)** - Skilled Nursing Facility; 9. Ambulance; O. **(OL)** - Other Locations; A. **(IL)** - Independent Laboratory; B. Other Medical Facility

INSTRUCTIONS FOR FILING A CLAIM

Any person who knowingly and with intent to defraud any insurance company or other person files a statement 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.

YOU SHOULD SUBMIT YOUR CLAIMS MONTHLY OR WHEN YOU HAVE BILLS TOTALING MORE THAN $200.00; BUT YOU MUST USE A SEPARATE CLAIM FORM FOR EACH MEMBER OF THE FAMILY.

1. IMPORTANT

- A completed claim form must be included with each submission for each member of the family for each separate accident or illness.
- Your claim cannot be processed without your Social Security Number (Employee Section, Block E).
- You must sign and date your claim form (Employee's / Patient's Signature and Release Section).

2. ATTENDING PHYSICIAN OR PROVIDER INFORMATION SECTION SHOULD BE COMPLETED FOR . . .

Surgery Doctor's Visits Hospital Confinement

Be certain to include procedure code and ICD-9 Diagnosis Code (Physician or Provider Section, blocks C and D).

3. IF ENCLOSING ITEMIZED BILLS, THEY MUST INCLUDE:

ALL BILLS

Employee Name	Date of Service
Patient Name	Diagnosis
Type of Service	Charge for Service

- Be certain to include Physician or Tax Identification number.
- Bills will not be returned to you - make copies for your records.
- Receipts, balance due statements and cancelled checks are not acceptable.

4. ADDITIONAL INFORMATION

Save your Explanation of Benefits - duplicate vouchers are not available.

5. MAILING INSTRUCTIONS

Send your ***completed claim form*** and itemized bills to the address shown on your ID card.