

PLEASE DO NOT STAPLE IN THIS AREA



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

CARRIER

HEALTH INSURANCE CLAIM FORM

1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
3. PATIENT'S BIRTH DATE SEX
4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)
6. PATIENT'S RELATIONSHIP TO INSURED
7. INSURED'S ADDRESS (No., Street)
8. PATIENT STATUS
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE
17a. I.D. NUMBER OF REFERRING PHYSICIAN
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
19. RESERVED FOR LOCAL USE
20. OUTSIDE LAB?
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3, OR 4 TO ITEM 24E BY LINE)
22. MEDICAID RESUBMISSION
23. PRIOR AUTHORIZATION NUMBER

Table with 11 columns: A (DATE(S) OF SERVICE), B (Place of Service), C (Type of Service), D (PROCEDURES, SERVICES, OR SUPPLIES), E (DIAGNOSIS CODE), F (\$ CHARGES), G (DAYS OR UNITS), H (EPSDT Family Plan), I (EMG), J (COB), K (RESERVED FOR LOCAL USE)

PHYSICIAN OR SUPPLIER INFORMATION

24. FEDERAL TAX I.D. NUMBER SSN EIN
25. PATIENT'S ACCOUNT NO.
26. ACCEPT ASSIGNMENT?
27. TOTAL CHARGE
28. AMOUNT PAID
29. BALANCE DUE
30. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS
31. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
32. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #