Claim Form

Insured and/or Administered by:
Connecticut General Life Insurance Company
Cigna Health and Life Insurance Company

Mailing Address: P.O. Box 15050 | Wilmington, DE 19850, USA

Phone: 1.800.441.2668 (Toll-free)
001.302.797.3100 (Collect calls accepted)

Fax: 1.800.243.6998 (Toll-free)
001.302.797.3150

Website: www.CignaEnvoy.com For faster service, submit your claims online via our website.

Please submit this completed claim form with itemized bills and receipts as soon as possible to the address, fax number, or website above. Tape small receipts on 8.5 x 11 inch or ISO A4 paper. Do not staple receipts to the claim form. Complete a separate claim form for each patient. In order for your claim to be considered for reimbursement, you must complete and sign this claim form.

Required information: Missing or incomplete information on this form will delay payment.

SECTION A: Customer Information

CUSTOMER NAME (Last Name, First Name, Middle Initial)		
CUSTOMER DATE OF BIRTH (DD/MM/YY)	ID NUMBER ☐☐☐☐☐☐☐☐☐-☐☐	
PRIMARY MAILING ADDRESS (Where check/correspondence should be sent)		
CITY/STATE	COUNTRY/POSTAL CODE	EMAIL ADDRESS
HOME PHONE NUMBER	WORK PHONE NUMBER	FACSIMILE NUMBER
EMPLOYER		

SECTION B: Patient Information

PATIENT NAME (If multiple, use separate claim forms for each)	
PATIENT DATE OF BIRTH (DD/MM/YY)	COUNTRY WHERE SERVICES WERE RENDERED
DIAGNOSIS / REASON FOR TREATMENT / SYMPTOMS	

NOTE: Please include a prescription from your general practitioner (GP) or medical specialist for prescribed drugs.

SECTION C: Health Care Professional Information

Complete this section if the bill does not include complete health care professional contact information

NAME	ADDRESS	PHONE NUMBER	DATE OF SERVICE	AMOUNT

SECTION D: Payment Information

Incomplete or incorrect information may result in a check payment made in US dollars and mailed to your primary mailing address

☐ PAY CUSTOMER ☐ PAY HEALTH CARE PROFESSIONAL

Please be advised that if the health care professional is a provider in the US and holds a contract with Cigna, payment will be made to the health care professional at the contracted rate even if this section indicates otherwise. If you have already paid for services, you should seek reimbursement directly from the health care professional.

If payment is being made to CUSTOMER – complete payment details below.

PAYMENT TYPE

CLAIM PAYMENT OPTIONS

☐ US DOLLAR
☐ OTHER CURRENCY (PLEASE SPECIFY) _____

Note: Some currencies may not be available for reimbursement. Cigna reserves the right to default the payment currency to US dollars in order to facilitate payment.

☐ CHECK

FOR OTHER AVAILABLE PAYMENT OPTIONS SEE PAGE 3
MORE INFORMATION IS ALSO AVAILABLE ON OUR WEBSITE
www.CignaEnvoy.com

☐ ELECTRONIC PAYMENT

Payments issued in US dollars or international currency via wire transfer to an international bank may be assessed fees by your bank for receipt of the wire transfer.
FILL OUT THE BANK DETAILS SECTION

BANK DETAILS (THIS SECTION FOR ELECTRONIC PAYMENTS ONLY)	BANK ACCOUNT BENEFICIARY NAME	ACCOUNT NUMBER (INTERNATIONAL BANK ACCOUNT NUMBER – IBAN)
	BANK ACCOUNT TYPE	
	BANK NAME	BANK ADDRESS
	BANK ROUTING NUMBER	BANK CITY/STATE
	ABA / Routing / SWIFT / BIC / BSB / Sort codes	
	ACCOUNT CURRENCY	BANK COUNTRY/POSTAL CODE

Verify all account information, bank routing number requirements, and currency requirements for your banking country to ensure the successful transmission of your payment. Incurred currency or US dollar check may be issued as a default payment. Cigna reserves the right to make electronic payments in the method and format deemed to be the most cost effective and expedient way to reach the payee.

SECTION E: Injury / Occupational Claim Information

Complete this section only if you are filing the claim because of an accident or occupational (work-related) injury or illness.

INJURY OR ILLNESS OCCURRED WHILE ON THE JOB?	☐ YES	☐ NO
DESCRIPTION OF HOW INJURY OR ILLNESS OCCURRED		
DATE OF INJURY OR BEGINNING OF ILLNESS (DD/MM/YY)		
ARE YOU OR YOUR DEPENDENT(S) 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 INJURY OR ILLNESS?	☐ YES	☐ NO
IF YES, PLEASE PROVIDE NAME OF THIRD PARTY		

SECTION F: Other Coverage

Complete this section if other coverage is in effect

IS THE PATIENT COVERED UNDER ANOTHER HEALTH INSURANCE PLAN? ☐ YES ☐ NO	
IF YES, PROVIDE NAME OF HEALTH INSURANCE COMPANY:	
EFFECTIVE DATE OF COVERAGE (DD/MM/YY):	POLICY NUMBER:
IS THE PATIENT COVERED UNDER MEDICARE? ☐ YES ☐ NO	
IF YOU ANSWERED YES TO EITHER QUESTION ABOVE AND THE OTHER INSURANCE COMPANY IS PRIMARY, PLEASE SEND US THIS FORM AND (1) A COPY OF THE EXPLANATION OF BENEFITS (EOB) AND (2) THE ITEMIZED BILL(S) FOR THIS CLAIM.	

SECTION G: Certification and Payment Authorization

FRAUD NOTICE: 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.

CERTIFICATION: By signing this form, I certify that this claim form does not contain any false or misleading information. I understand that Cigna and/or its subsidiaries may investigate my claims by collecting additional relevant personal information from me and from third parties, if necessary.

PAYMENT AUTHORIZATION: I authorize payment as indicated in Section D of this claim form.

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 and for such purposes as stated on the privacy notices, available upon request or at http://www.cigna.com/privacyinformation/privacy-notices-and-forms/.

I authorize the release of any medical information necessary to process this claim and for the purposes stated in the privacy notices. I certify that the information supplied is true and correct. I authorize payment as indicated in Section B of this claim form.

PATIENT SIGNATURE / PARENT OR LEGAL GUARDIAN IF PATIENT IS A MINOR _____ DATE (DD/MM/YY): _____

Cigna Global Health Benefits®

IMPORTANT CUSTOMER INFORMATION

Itemized bills must include:

Primary customer name	Type of Service	Health care professional name/credentials
Date of Service (DD/MM/YY)	Charge for the service	Health care professional address
Patient name	Diagnosis code/reason for service	

Payment Information:

Electronic Funds Transfer (EFT) – Referred to in the US as ACH (Automated Clearing House)

EFT is only available for electronic payments made in US dollars to US bank accounts. An EFT authorization form must be completed prior to claim submission. The form can be found on our website at: www.CignaEnvoy.com, under My Account. Banking details will be updated within 10 business days after receiving the EFT authorization form. Within 24 hours of banking details being updated, Cigna can begin making electronic payments to the account. Claim payments made in the interim of receiving the authorization will be made by check in US dollars.

ePayment Plus℠ (Int'l ACH)

International ACH payments are only available for electronic payments in the *United Kingdom, Canada, Hong Kong, Singapore, Australia, Denmark, Sweden or New Zealand* in the local currency of that country. Enrollment must be completed prior to claim submission. To enroll, please access the ePayment *Plus* online enrollment section found on our website at: www.CignaEnvoy.com, under My Account. Once enrolled, your claim reimbursements will be deposited electronically into the bank account you specify. To cancel electronic deposits to your account you must terminate your ePayment *Plus* account information through this website. Lifting fees and additional bank charges may apply, please contact your bank for details.

Wire Payments

Wire payments are only available for payments made to banks outside of the United States. For payment to banks located in the United States, you must use the EFT (ACH) option. Enrollment must be completed prior to claim submission. To enroll, please access the wire transfer online enrollment section found on our website at: www.CignaEnvoy.com, under My Account. To cancel electronic deposits to your account, you must terminate your banking information through our website at: www.CignaEnvoy.com. Your bank may charge a fee for incoming wire payments, please contact your bank for details.

Default Payment Process

- If an electronic payment is rejected due to incorrect bank account information, a local currency or US dollar check may be issued until you correct your electronic payment information through our website at: www.CignaEnvoy.com.
- If your electronic bank information is incomplete or incorrect, your claims reimbursement will be issued as a check and mailed to the primary mailing address stated in the form. You will receive reimbursement through the method of choice, once the correct bank information is received.
- All currencies are not available for some countries. If a currency or payment method is not available, the default payment is a US dollar check.
- If payment currency is in Euros and being remitted to one of the following countries, it may be sent as a SEPA payment: *Aland Island, France, Italy, Norway, Austria, French Guiana, Latvia, Poland, Belgium, Germany, Liechtenstein, Portugal, Bulgaria, Gibraltar, Lithuania, Reunion, Cyprus, Guadeloupe, Luxembourg, Romania, Czech Republic, Greece, Malta, Slovakia, Denmark, Hungary, Martinique, Spain, Estonia, Iceland, Monaco, Switzerland, Finland, Ireland, Netherlands* or *United Kingdom*.
- Cigna reserves the right to make electronic payments in the method and format deemed to be most cost effective and expedient to reach the payee.