

Prescription Drug Claim Form



CIGNA HealthCare

REASON FOR REIMBURSEMENT

This claim form can be used to request reimbursement of covered expenses. Please check which reason applies (at least one must be checked):

- Emergency
 Eligibility (Please explain) _____
 Non-Participating Pharmacy
 Primary coverage is with another insurance carrier. Please provide explanation of benefits (EOB) or denial letter from the primary insurance carrier.
 Other (Please explain) _____

PARTICIPANT/PATIENT INFORMATION

PARTICIPANT NAME: _____ **EMPLOYER:** _____

PARTICIPANT SOCIAL SECURITY NUMBER: _____ - _____ - _____

PATIENT NAME: _____ **PATIENT BIRTHDATE:** ____/____/____
 -USE A SEPARATE FORM FOR EACH FAMILY MEMBER- MO DAY YEAR

PATIENT RELATIONSHIP TO PARTICIPANT:
 SELF (PARTICIPANT)
 SPOUSE
 DEPENDENT

PATIENT SEX:
 MALE
 FEMALE

I represent that the patient information entered on this form is correct, that the patient named is eligible for the benefits and that the patient has received the medication described. I also represent that the medication received is not for treatment of an on-the-job injury. I also 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 files a statement of claim 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.

PARTICIPANT SIGNATURE: _____ **DATE:** _____

DAYTIME PHONE NUMBER: _____

PRESCRIPTION INFORMATION

1)
 ____/____/____ DATE FILLED RX NUMBER QTY DAYS SUPPLY
 _____ \$ _____
 NATIONAL DRUG CODE AMOUNT MEMBER PAID
 PHARMACY NABP # _____

2)
 ____/____/____ DATE FILLED RX NUMBER QTY DAYS SUPPLY
 _____ \$ _____
 NATIONAL DRUG CODE AMOUNT MEMBER PAID
 PHARMACY NABP # _____

3)
 ____/____/____ DATE FILLED RX NUMBER QTY DAYS SUPPLY
 _____ \$ _____
 NATIONAL DRUG CODE AMOUNT MEMBER PAID
 PHARMACY NABP # _____

4)
 ____/____/____ DATE FILLED RX NUMBER QTY DAYS SUPPLY
 _____ \$ _____
 NATIONAL DRUG CODE AMOUNT MEMBER PAID
 PHARMACY NABP # _____

INSTRUCTIONS

PARTICIPANT/PATIENT INFORMATION *(To be completed by the Participant)*

1. Complete ALL information in the top section.
2. Sign and date the Certification Statement in the area provided.
3. Complete the RETURN ADDRESS section below.
4. Submit a separate form for each family member.
5. The lower section must be completed in full for each prescription dispensed. If you have questions regarding the information needed to complete the form, contact your pharmacist.
6. **Keep a copy for your records.**
7. Mail the claim form within one year of the prescription fill date, along with original receipts (not cash register receipts), to:

Connecticut General Life Insurance Company
Pharmacy Service Center
P.O. Box 3598
Scranton, PA 18505-0598
8. Questions? Please call the CIGNA HealthCare number located on your ID card.

Fold

Fold

RETURN ADDRESS

**IMPORTANT: PLEASE PRINT. THIS WILL APPEAR IN A WINDOW ENVELOPE FOR RETURNS.
PLEASE PROVIDE CURRENT ADDRESS INFORMATION BELOW:**

PARTICIPANT NAME

PARTICIPANT STREET ADDRESS

PARTICIPANT CITY, STATE, ZIP