CORESOURCE
A Trustmark Company

MAIL TO:
CIGNA
PO Box 188061
Chattanooga, TN 37422-8061

HEALTH CLAIM FORM

INSTRUCTIONS

THIS SIDE OF THE FORM MUST BE COMPLETED IN FULL. Attach this form to itemized bills for all expenses being claimed. The bills must show: Patient's Name, Type of Service, Date(s) of Service(s), and the Total Charge. If you are submitting a surgical bill of if the bills are for a major illness, accident, or hospitalization the reverse side of this form must be completed by the attending physician. **AVOID DELAY - ANSWER ALL QUESTIONS.**

EMPLOYEE INFORMATION

EMPLOYMENT STATUS ☐ ACTIVE ☐ RETIRED ☐ LAID OFF ☐ DISABILITY LEAVE ☐ OTHER

EMPLOYEE NAME: (PLEASE PRINT FIRST NAME, MIDDLE INITIAL, LAST NAME	SOCIAL SECURITY NO.	MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ LEGALLY SEPARATED
STREET ADDRESS: (STREET, CITY, STATE, ZIP CODE)		DATE OF BIRTH: MONTH/DAY/YEAR
EMPLOYER'S NAME		GROUP NO.

DEPENDENT'S INFORMATION: (Complete Only If Patient Is A Dependent)

NAME OF DEPENDENT	RELATIONSHIP ☐ SPOUSE ☐ CHILD ☐ OTHER (EXPLAIN)	MARITAL STATUS (OTHER THAN SPOUSE)
IF CLAIM IS FOR DEPENDENT CHILD 19 OR OLDER, IS CHILD ENROLLED AS A FULL-TIME STUDENT? ☐ YES ☐ NO	NAME OF SCHOOL	DATE OF BIRTH: MONTH/DAY/YEAR

AT TIME CHARGES WERE INCURRED (IF ANSWER TO EITHER IS YES, GIVE EMPLOYER'S NAME AND ADDRESS)

WAS SPOUSE EMPLOYED? ☐ YES ☐ NO IF CLAIM WAS FOR CHILD, WAS CHILD EMPLOYED? ☐ YES ☐ NO

COMPLETE FOR ALL PATIENTS

DIAGNOSIS OR NATURE OF INJURY

WHEN WHERE YOU FIRST TREATED FOR THIS CONDITION? (MONTH, DAY, YEAR)	NAME AND ADDRESS OF PHYSICIAN WHO FIRST TREATED YOU

IS PATIENT ALSO COVERED FOR BENEFITS BY:

a. Other Group Health Insurance of any kind including Blue Cross and Blue Shield? ☐ YES ☐ NO
b. Group prepayment arrangement providing for medical care and treatment ☐ YES ☐ NO
c. Coverage of medical care expenses provided by a school, or by Medicare or other federal, state, provincial or government agency? ☐ YES ☐ NO
d. No fault automobile insurance as a result of injuries sustained in an automobile accident? ☐ YES ☐ NO

If any of the above answered YES please indicate in "Remarks" the policy number, insurance company and the name and address of the school, employer, union or government agency.

WAS ILLNESS OR INJURY DUE IN ANY WAY:

a. To the patient's occupation? ☐ YES ☐ NO
b. To an automobile accident? ☐ YES ☐ NO
c. To any other type of accident? ☐ YES ☐ NO

If any of the above are answered "YES" give details under "Accident".

REMARKS

ACCIDENT

DATE (TIME: ☐ A.M. ☐ P.M.) (PLACE OF ACCIDENT ☐ WORK ☐ OTHER

HOW DID ACCIDENT HAPPEN?	NAME AND ADDRESS WHERE ACCIDENT OCCURRED

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment of Medical Benefits to Physician or supplier for services described within.

SIGNED (PATIENT, OR PARENT IF MINOR) **DATE**

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the release of any medical information necessary to process this claim.

SIGNED (PATIENT, OR PARENT IF MINOR) **DATE**

EMPLOYEE SIGNATURE	PATIENT SIGNATURE (UNLESS MINOR)	DATE

STOP - If attaching an itemized statement, do not complete this side.

Itemized statements must show Physician's name and address, dates and types of services, charges, patient's name and diagnosis.

PATIENT'S NAME 9FIRST, MI/LAST)	PATIENT'S BIRTH DATE (MO/DAY/YR)	EMPLOYEE'S SOCIAL SECURITY NUMBER

VERIFICATION OF SERVICES

In order to process your bill for services as part of your patient's claim for health care expenses reimbursement, we require the following data. **Your cooperation is appreciated.**

PHYSICIAN OR SUPPLIER INFORMATION

DATE OF ⇦	ILLNESS (FIRST SYMPTOM), OR INJURY (ACCIDENT), OR PREGNANCY (LMP)	DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION	HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? ☐ YES ☐ NO

PROVIDER OF CARE (PLEASE CHECK) ☐ ATTENDING ☐ SURGEON ☐ CONSULTING	IF OTHER THAN ATTENDING, GIVE NAME OF REFERRING PHYSICIAN

NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE	FOR SERVICES RELATED TO HOSPITALIZATION, GIVE HOSPITALIZATION DATES ADMITTED DISCHARGED

DIAGNOSIS PLEASE INDICATE ICD9-CM OR DSM III CODES

PRIMARY **SECONDARY**

DATE OF SERVICE	PLACE OF SERVICE	CPT PROCEDURE (IDENTIFY)	Fully Describe procedures, types of therapy, or services furnished for each date given, indicate whether primary or secondary (if mental therapy indicate length of session)	CHARGES	AMT. PAID	BALANCE DUE
SIGNATURE OF PROVIDER DATE SIGNED DEGREE				TOTAL CHARGE	AMOUNT PAID	BALANCE DUE

YOUR PATIENT'S ACCOUNT NO.	PROVIDER I.D. NUMBER	PROVIDER'S NAME, ADDRESS, ZIP CODE, AND TELEPHONE NUMBER

If the services were rendered by a psychiatric worker, the following certification must be completed by the attending physician.

Therapy performed by _____

was conducted at my direction and under my supervision and I have consulted with the Therapist regarding the patient within the last 90 days. Further, I have reviewed and approved the Plan of Treatment and have examined the patient on the date indicated below.

NAME OF ATTENDING PHYSICIAN	DATE OF EXAMINATION
ADDRESS OF ATTENDING PHYSICIAN	ATTENDING PHYSICIAN'S SIGNATURE
	PROFESSIONAL STATUS

*** Place of service codes**

1-(IH)	Inpatient Hospital	4-(H)	Patient's Home	7-(NH)	Nursing Home	0-(OL)	Other Location
2-(OH)	Outpatient Hospital	5-	Daycare Facility (PSY)	8-(SNF)	Skilled Nursing Facility	A-(IL)	Independent Laboratory
3-(O)	Doctor's Office	6-	Night Care Facility (PSY)	9-	Ambulance	B-	Other Medical Surgical Facility