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