Prescription Drug Claim Form

Connecticut General Life Insurance Company CIGNA Health and Life Insurance Company



	REASON FOR RI				
This claim form can be used to request (at least one must be checked):	reimbursement o	of covered expen	ises. Please che	ck which	reason applie
☐ Emergency		Eligibility (PI	lease explain)		
Non-Participating Pharmacy					
Primary coverage is with another insura carrier. Please provide explanation of b (EOB) or denial letter from the primary insurance carrier.	ance enefits	Other (Pleas	se explain)	-	
PA	RTICIPANT/PATI	ENT INFORMATION	ON		CARLES E
PARTICIPANT NAME:				L U.S.	
			OYER:		· · · · · · · · · · · · · · · · · · ·
CIGNA ID NUMBER OR PARTICIPANT SOCIA	L SECURITY NUME	BER (on the front of	your CIGNA ID car	d):	arm s
PATIENT NAME:			PATIENT		100101
-USE A SEPARATE FO	ORM FOR EACH FAMIL	LY MEMBER-	BIRTHDATE:	/	DAY YEAR
PATIENT RELATIONSHIP TO PARTICIPANT:	SELF (P.	'ARTICIPANT)	SPOUSE		DEPENDENT
PATIENT SEX: MALE FEMALE	ACCOUNT NU	JMBER (on the fron	at of your CICMA ID		
an on-the-job injury. I also authorize releadesignees. Any person who knowingly and with intent	to defraud any inc	CUITORAS COMPONIA	this claim to the		ninistrator or it
Any person who knowingly and with intent insurance or statement of claim containing information concerning any material fact the following states, please see the last page of Kentucky, Maryland, Minnesota, New Jerse PARTICIPANT SIGNATURE:	to defraud any ins any materially fals ereto, commits a fr of this form: Alaska y, New York, Oreg	surance company se information; or raudulent insurance, Arizona, Californgon, Pennsylvania,	or other person: (2) conceals for the eact which is a conia, Colorado, Dis	(1) files and purpose rime. For trict of Coas and Vir	ninistrator or its n application for e of misleading residents in the olumbia, Florida ginia.
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