Prescription Drug Claim Form

Connecticut General Life Insurance Company
CIGNA Health and Life Insurance Company

CIGNA

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:*** _____

CIGNA ID NUMBER OR ***PARTICIPANT*** SOCIAL SECURITY NUMBER *(on the front of your CIGNA ID card)*: _____

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 ACCOUNT NUMBER *(on the front of your CIGNA ID card)*: _____

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: (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. For residents in the following states, please see the last page of this form: Alaska, Arizona, California, Colorado, District of Columbia, Florida, Kentucky, Maryland, Minnesota, New Jersey, New York, Oregon, Pennsylvania, Tennessee, Texas and Virginia.

PARTICIPANT SIGNATURE: _____ DATE: _____

DAYTIME PHONE NUMBER: _____

PRESCRIPTION INFORMATION

For Health Care Reform related Over-the-Counter reimbursement requests, include your Doctor's prescription.

1)
____ / ____ / ____ DATE FILLED | RX NUMBER | QTY | DAY SUPPLY
DRUG NAME & STRENGTH | NDC | $____ AMT. PAID
PHARMACY NAME | PHARMACY NABP
PHARMACY ADDRESS

2)
____ / ____ / ____ DATE FILLED | RX NUMBER | QTY | DAY SUPPLY
DRUG NAME & STRENGTH | NDC | $____ AMT. PAID
PHARMACY NAME | PHARMACY NABP
PHARMACY ADDRESS

3)
____ / ____ / ____ DATE FILLED | RX NUMBER | QTY | DAY SUPPLY
DRUG NAME & STRENGTH | NDC | $____ AMT. PAID
PHARMACY NAME | PHARMACY NABP
PHARMACY ADDRESS

4)
____ / ____ / ____ DATE FILLED | RX NUMBER | QTY | DAY SUPPLY
DRUG NAME & STRENGTH | NDC | $____ AMT. PAID
PHARMACY NAME | PHARMACY NABP
PHARMACY ADDRESS