# Claim Form
## Submission Guide

**SECTION A REQUIRED INFORMATION:**

- Country Where Services were Rendered: Include the name of the country where the patient received care.
- Diagnosis/Reason for Treatment: Include the initial reason the patient sought treatment or the doctor's diagnosis (or conclusion) from the medical exam.
- ID Number: Include the patient's ID number, found on the front of the patient's white Cigna ID card.
- Employee Name (Last Name, First Name, Middle Initial): Include the individual's name who holds the insurance. First include the surname (or familial name) followed by the first name, and then the first letter of their middle name. If the employee does not have a middle name, no letter is needed.
- Patient Name (If Multiple, Use Individual Claim Forms for Each): Include the name of the individual who received care. If there is more than one patient, please complete a separate form for each patient.
- Patient Date of Birth (Month/Day/Year): Include the date of birth for the person who received care. Please use this format: Month/Day/Year.

**SECTION B REQUIRED INFORMATION:**

If payment should be sent to the Employee, place an "x" in the corresponding box. If payment should be sent to the doctor or facility, place an "x" in the corresponding box. Please note that if the information on this form is incorrect or no box is checked, the payment may be sent to the employee's primary mailing address.

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If you check "PAY EMPLOYEE," complete the payment details in the bottom half of the claim form. In the box labeled, "PAYMENT TYPE," place an "x" in the corresponding box describing how you'd like to receive payment. If you would like to receive a check in a different currency than the US dollar, place an "x" in the "OTHER CURRENCY" box and then include the name of the currency in which you'd like to receive the check.

**SECTION C REQUIRED INFORMATION:**

This section only needs to be completed if the patient sought treatment related to an accident. If the patient is not seeking care following an accident, skip to section D.

**SECTION D REQUIRED INFORMATION:**

The employee must sign the first signature line and include the date the form was signed. The patient must sign the second signature line and include the date the form was signed. If the employee is the patient, only one signature is needed.

*PLEASE NOTE THE FOLLOWING WHEN DISCUSSING TREATMENT OPTIONS AND BILLING ISSUES WITH YOUR DOCTOR/FACILITY:*

**REQUIRED INFORMATION FOR THE BILLING/INVOICE:**

All bills and/or invoices must include:

- The patient name.
- Name of the doctor or facility where you received care.
- Dates that the patient received care and amount that was billed for each procedure.
- Description of the type of service or procedure that was received (such as an office visit or an x-ray).
- Diagnosis/Reason for treatment (the conclusion the doctor received or the reason the patient sought care).

**REQUIRED INFORMATION FOR PRESCRIPTION DRUG CLAIMS:**

- Name of the prescription drug.
- Quantity of prescription.
- Billed amount and date the prescription was received.