HOSPITAL CARE CLAIM FORM INSTRUCTIONS

Please complete the claim form in its entirety, including supporting medical documentation.

- ✓ UB-04 Form – Can be requested from hospital billing department. **This is the preferred option for the fastest claim processing time.**

  OR

- ✓ Have your Physician complete Section 7: Physician Statement.

  OR

- ✓ Provide ALL of the below:
  - o Documentation outlining room and board charges or observation stay (with hospital arrival and discharge times)
  - o Medical documentation with procedure and diagnosis codes associated with the date(s) of treatment

Note: the claim review process will start once we receive all documentation supporting your claim.

File this claim form using one of these methods:

Email SuppHealthClaims@CignaHealthcare.com

Mail Cigna Supplemental Health Solutions
P. O. Box 188028
Chattanooga, TN 37422

Additional documentation is required if you qualify for one of these special situations:

- If the claimant was a driver in a motor vehicle accident, also provide the police report.
- If claimant is a child dependent who is 26 or more years old and has a mental or physical handicap that requires employee support, also include the SSDI Award letter.
- If you are filing a claim on behalf of an insured claimant who is deceased, also provide the death certificate AND a disclosure authorization for the deceased, which can be obtained from the employee's Human Resources department.

Cigna Healthcare Supplemental Health Solutions
Hospital Care Claim Form

CLEAR FORM

Note: * = Required field

Note: The Claimant must complete Sections 1-6.

Proof of hospitalization is required for this claim. Include the **UB-04** form with the submission for **fastest claim processing**. Otherwise, have your Attending Physician complete Section 7.

We will contact you if we need additional information to process the claim.

SECTION 1: EMPLOYEE INFORMATION

Name *(First & Last)*:*	Social Security Number:*	Date of Birth *(mm/dd/yyyy)*:*

Address:*	Daytime Phone Number:*

City:*	State:*	Zip Code:*	Email Address:*

Was the employee considered actively at work on the date of the incident?* ☐ Yes ☐ No

If no, what was the reason the employee was not actively at work?*
☐ Family Leave (FMLA) ☐ Unpaid Leave of Absence
☐ Paid Leave of Absence ☐ Other:

Does the employee have health care coverage with Cigna? ☐ Yes ☐ No

SECTION 2: EMPLOYER INFORMATION

Name of Employer *(at time of claim)*:*	Group Policy Number:

SECTION 3: CLAIMANT DEMOGRAPHIC INFORMATION *(Complete for Spouse or Child claim only)*

Name *(First & Last)*:*	Date of Birth *(mm/dd/yyyy)*:*	Relationship to Insured:*

Address:*

City:*	State:*	Zip Code:*	SSN: ☐ Does not have SSN

Does the claimant have health care coverage with Cigna? ☐ Yes ☐ No

SECTION 4: CHILD'S ADDITIONAL INFORMATION: *(Complete for Child claim only)*

Is the Child a full-time student?* ☐ Yes ☐ No

If Child is not a full-time student, is he/she totally disabled?* ☐ Yes ☐ No

If adult child is disabled, please provide the SSDI Award Letter.*

SECTION 5: DESCRIPTION OF YOUR HOSPITALIZATION

SECTION 6: LIST OF HOSPITALS, CLINICS OR PHYSICIANS

Physician/Facility Name:*	Specialty:	Phone Number:*	Fax Number:
Address:*		Treatment Period:	
Physician/Facility Name:	Specialty:	Phone Number:	Fax Number:
Address:		Treatment Period:	
Physician/Facility Name:	Specialty:	Phone Number:	Fax Number:
Address:		Treatment Period:	
Physician/Facility Name:	Specialty:	Phone Number:	Fax Number:
Address:		Treatment Period:	

SECTION 7: HOSPITAL CARE PHYSICIAN'S STATEMENT

Present Condition

Diagnosis*

History

When did the current symptoms first appear?* | Confirmed Diagnosis Date*

Has the patient ever had the same or a similar condition? (If "yes," provide date and description below.)* ☐ Yes ☐ No

Treatment Details

Observation Unit

Admission Date and Time* Discharge Date and Time* Number of Hours in Observation Unit*

Standard Inpatient Hospital Bed

Admission Date* Discharge Date* Number of Days in Standard Hospital Bed*

Intensive Care Unit *(Critical Care Unit and includes ICU Step Down Facility)*

Admission Date* Discharge Date* Number of Days in ICU

Inpatient Substance Abuse Rehabilitation Facility

Admission Date* Discharge Date* Number of Days in Rehabilitation Facility

Inpatient Skilled Nursing Facility

Admission Date* Discharge Date* Number of Days in Skilled Nursing Facility

Childbirth

Newborn Birth Date* Newborn Discharge Date*

Number of days newborn was hospitalized* | Was newborn in NICU?* ☐ Yes ☐ No | If so, how many days?*

SECTION 7: HOSPITAL CARE PHYSICIAN'S STATEMENT (cont'd)

Physician Information / Signature

Attending Physician Name *(First & Last)*:*		Degree:*	
Street Address:*			Phone Number:*
City:*	State:*	Zip Code:*	Fax Number:*

Attending Physician Signature*

Date Signed*

Proof of hospitalization is required for this claim.

- Include the **UB-04** form with the submission for **fastest claim processing**.

Otherwise, have your Attending Physician complete Section 7.

We will contact you if we need additional information to process the claim.

CAUTION: 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; (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act. For residents of the following states, please see the last page of this form: ***Alaska, Alabama, Arizona, Arkansas, California, Colorado, District of Columbia, Florida, Kansas, Kentucky, Louisiana, Maine, Maryland, Minnesota, New Hampshire, New Jersey, New Mexico, Ohio, Oklahoma, Pennsylvania, Puerto Rico, Rhode Island, Tennessee, Texas, Virginia, Washington, West Virginia.***

New York Residents: FRAUD WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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, and shall also be subject to a civil penalty not to exceed $5000 and the stated value of the claim for each such violation.

Claimant's Signature*
(or Parent/Guardian if Claimant is under 18 years old)

Date Signed*

The issuance of this form is not the admission of the existence of any insurance nor does it recognize the validity of any claim and is without prejudice to the company's legal rights.

Disclosure Authorization

Claimant's Name *(can be Employee, Spouse, or Child)*:* _____

NOTE: This authorization is designed to comply with HIPAA and relates to information necessary to administer coverage and services under your employer's employee health and welfare plan(s) ("the Plan") and similar or coordinating governmental benefits. You are not required to sign the authorization, but if you do not, the Plan, insurers or other providers of services or coverage under the Plan may not be able to process your request for Plan benefits, coverage or services.

AUTHORIZATION

I authorize any physician, medical professional or other health care provider, hospital or other medical facility; pharmacy; health plan; other medically related entity; rehabilitation professional; vocational evaluator; employee assistance plan; insurance company, reinsurer, health maintenance organization, third party administrator, broker or other insurance service provider, or similar entity; the Medical Information Bureau; the Association of Life Insurance Companies, which operates the Health Claims Index and the Disability Income Record System; government organization or agency, including the Social Security Administration; any of your social security disability advocates or representatives; financial institution, accountant or tax preparer; consumer reporting agency; and employer or group policyholder that has information about my health, prescriptions, financial, earnings or employment history, or other insurance claims and benefits to provide access to or copies of this information to the Plan and to any individual or entity who provides services to or insurance benefits on behalf of the Plan, including but not limited to the requesting company(ies) named below ("Company"). To the extent I may be eligible for governmental benefits similar to or that coordinate with those available to me under the Plan, I also authorize disclosure of information necessary to apply for or determine my eligibility for such benefits to the relevant government agency and/or vendor providing application assistance.

Information about my health may relate to any disorder of the immune system including but not limited to HIV and AIDS; use of drugs or alcohol; and mental and physical history, condition, advice or treatment, but does not include psychotherapy notes.

I understand that any information obtained with this authorization will be used for evaluating and administering my coverage, including any claim for benefits, or otherwise providing services related to or on behalf of the Plan, which may include, but is not limited to assisting me in returning to work and Plan administration. With respect to governmental benefits similar to or that coordinate with benefits available to me under the Plan, I understand that the information will be used to help determine my eligibility for any such benefits and may include assisting me in applying for the benefits. I understand that the information disclosed under this authorization is subject to redisclosure and may no longer be protected by certain federal regulations governing the privacy of health information, although it will continue to be protected by other applicable privacy laws and regulations.

If my employer, union, and/or group association sponsors any other plans, whether or not underwritten or administered by a Cigna company, the information and/or records obtained may also be shared with the underwriting company (insurer) or administrators of those other plans, including their internal or external health management, disease management, wellness, employee/member assistance program or other similar programs, for the purpose of administering any service, benefit or feature described in those plans.

For any claim for insurance benefits, this authorization is valid for the shorter of 24 months or the duration of my claim. For all other permitted disclosures, this authorization is valid for one (1) year from the date below. I am entitled to a copy of this authorization and a photographic or electronic copy of it is as valid as the original.

_____ _____

Claimant's Signature*
(or Parent/Guardian if Claimant is under 18 years old)

Date Signed*

_____ _____

Print Name*

Date of Birth *(mm/dd/yyyy)*:*

I signed on behalf of the claimant as _____ (indicate relationship). If Power of Attorney Designee, Guardian, or Conservator, please attach a copy of the document granting authority.

Company Names: Cigna Health and Life Insurance Company, Life Insurance Company of North America (LINA), and New York Life Group Insurance Company of NY (NYLGICNY) (formerly Cigna Life Insurance Company of New York).

IMPORTANT CLAIM NOTICES

Alaska Residents: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Alabama Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Arizona Residents: For your protection Arizona law requires the following statement to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Arkansas Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California Residents: For your protection California law requires the following statement appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado Residents: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

District of Columbia Residents: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Kansas Residents: 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, may be guilty of insurance fraud determined by a court of law.

Kentucky Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

Louisiana Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Maine Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland Residents: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Minnesota Residents: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire Residents: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

New Jersey Residents: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

Ohio Residents: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma Residents: Warning: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Pennsylvania Residents: Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or 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 and subjects such person to criminal and civil penalties.

Puerto Rico Residents: Caution: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

Rhode Island Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Tennessee Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Texas Residents: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Virginia Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Washington Residents: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

West Virginia Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

THESE POLICIES PAY LIMITED BENEFITS ONLY. THEY ARE NOT COMPREHENSIVE HEALTH INSURANCE COVERAGE AND DO NOT COVER ALL MEDICAL EXPENSES. THIS COVERAGE DOES NOT SATISFY THE "MINIMUM ESSENTIAL COVERAGE" OR INDIVIDUAL MANDATE REQUIREMENTS OF THE AFFORDABLE CARE ACT (ACA). THIS COVERAGE IS NOT MEDICAID OR MEDICARE SUPPLEMENT INSURANCE.

Product availability may vary by location and plan type and is subject to change. All group insurance policies may contain exclusions, limitations, reduction in benefits, and terms under which the policy may be continued in force or discontinued. For costs and details of coverage, review your plan documents or contact a Cigna representative.