

REIMBURSEMENT CLAIM FORM



STEP 1 COLLECT THE RIGHT DOCUMENTS

DOCUMENTS CHECKLIST:

<p>Must have</p> <ul style="list-style-type: none"> > Invoices > Payment receipts/ proof of payment > Diagnosis 	<p>If applicable</p> <ul style="list-style-type: none"> > Medical Report > Prescription > Breakdown of treatment (i.e. x-rays, scan, laboratory test, physiotherapy, etc.) > Discharge summary for in-patient cases (hospital stays)
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The document scans and images should be clear and legible.

STEP 2 SUBMIT YOUR CLAIM REIMBURSEMENT REQUEST

FAST TRACK - SUBMIT VIA MOBILE APP OR WEBSITE

- > Scan or take a photo of the applicable documents as per checklist
- > Visit www.CignaEnvoy.com or submit via our mobile app Cigna Envoy®

OR FILL IN THE REIMBURSEMENT CLAIM FORM BELOW AND SEND BY EMAIL

1. Fill in the reimbursement claim form for each patient.
2. Scan the reimbursement claim form, and any applicable documents from the table above and email them to Ice.Team@Cigna.com.

FEW FINAL NOTES TO CONSIDER

- > Claim should be submitted no later than 12 months following treatment.
- > For status on your reimbursement claim - follow up on www.CignaEnvoy.com or via the **Cigna Envoy mobile App**

CONTACT INFORMATION

For claim forms outside the USA	+44 (0) 1475 492197
For claim forms in the USA	1 800 768 1725
Customer Service Email:	Ice.Team@Cigna.com
Online claims:	www.CignaEnvoy.com

1. PATIENT INFORMATION (All fields are mandatory)

Patient Cigna ID #:	Patient's Full Name:		
Employee's full name (If different from Patient):			
Patient's Address:			
Patient's relationship to employee:		e-Mail:	
<input type="checkbox"/> Male	<input type="checkbox"/> Female	Mobile #: _____ <small>(Country code - Mobile code - Number)</small>	Date of Birth: _____ <small>(DD/ MM / YYYY)</small>

2. MEDICAL INFORMATION

Type of Visit: Outpatient Inpatient Dental Vision Maternity

Details of trauma (if applicable): Work related Road Traffic Accident related - include a police report
 Sports related, if yes: Professional Non-professional

Treatment Date	Diagnosis (eg. headache, cold etc.)	Country of Treatment	Invoice Amount and Currency
Total Amount			

Are you eligible for reimbursement for these expenses from another insurer: No Full Partial

If **Full** or **Partial** is selected above, please specify insurer name and amount settled:

3. CLAIMS PAYMENT DETAILS. (Select one of the method of Payment specified below)

A - I authorise Cigna to make ELECTRONIC TRANSFER payment against this Reimbursement Claim Form.

Beneficiary Name:	Bank Name		
Bank Address:	Bank Account No:		
If reimbursement currency is EURO, please supply both IBAN and SWIFT codes below If reimbursement currency is Dominican Peso or Moroccan Dirham, please supply tax ID	Account Type: <input type="checkbox"/> Savings <input type="checkbox"/> Checking / Current <input type="checkbox"/> Other		
	Specify payment currency:		
IBAN below:	Swift Code / BIC Code No:	Tax ID:	Routing Code:

Note: We recommend you to choose ELECTRONIC TRANSFER instead of cheque for faster settlement

B - I authorise Cigna to pay my reimbursement claims via cheque as per the provided details below.

Beneficiary Name:	Specify payment currency:		
Building No./Name:	Street:	Town/City:	
Area/Postal Code:	P.O. Box:	Country:	

4. DECLARATION AND AUTHORISATION

I declare that the information entered above is complete and accurate and that the services described were received and paid for.

Representation and Consent: By signing this form you confirm that you have the authority to act on behalf of your dependants in respect of all personal information you provide to us, and that you consent to the disclosure, processing, usage and retention of this information in relation to yourself and on behalf of your dependants.

Data Protection

All personal data that You provide to Cigna directly or through authorised third parties (i.e. healthcare providers, brokers or someone else on your behalf) will be collected (or may be collected on behalf of) by the Cigna's company that provides the Insurance cover or the Services to you ("Services") as can be found in your member booklet or certificate of insurance. This company will be the data controller of the Personal information collected. Your Personal Information is collected and used in order to provide the Services you are entitled to. Please refer to the Data Protection Notice that has been provided to you for further details or how we handle and protect your Personal Information. For easy access our Data Protection Notice is always available to you in Cigna Envoy. You can be reassured that Cigna only collects and processes your Personal Information in order to provide our Services to you and comply with our obligations and only discloses personal Information with other parties if necessary for providing you with the Services.

Patient Declaration

I have been made aware of my rights and I hereby consent and authorise Cigna to obtain information from my healthcare providers, as it may be required to assess and process this claim, with regard to the condition for which I am submitting this claim. I authorise the involved healthcare providers to disclose the requested and needed information to Cigna.

Name and signature of patient _____
(Or Name and signature of the principal/legal guardian for patients below 18 years old)

Date: _____
(DD / MM / YYYY)

DENTAL TREATMENT (If applicable to be completed by Dental Practitioner)

PREVENTATIVE TREATMENT					MAJOR TREATMENT				
Code Treatment	No. of Unit	Tooth Number	Date of Treatment	Charge to Patient	Code Treatment	No. of Unit	Tooth Number	Date of Treatment	Charge to Patient
EXAMINATIONS					PERIODONTAL TREATMENT (NON SURGICAL)				
A01 Normal					E21 Prolonged (Curettage/Root Planing)				
A11 Extensive					F51 Splinting				
A21 Full Case Assessment					PERIODONTAL TREATMENT (SURGICAL)				
X-RAYS					F01 Gingivectomy				
B01 Bitewing					F11 Mucoperio, Flap Bone Surgery				
B02 Intra Oral					DENTURES - METAL/ACRYLIC				
B03 O.P.G.					R63 Additional Tooth				
SCALING AND POLISHING					R61 Addition of Clasp				
E01 One Visit					K71 Denture Repair				
MISCELLANEOUS TREATMENT					CROWNS/BRIDGES				
D01 Fissure Sealants					J01 Veneers (per tooth)				
D11 Topical Fluoride Application					K32 Adhesive Bridges				
M0U Occlusal Splint					K41 Conventional Bridgework				
MINOR TREATMENT					K12 Standard Post & Core				
FILLINGS					K11 Gold Post & Core				
G01 Amalgam-One Surface					K07 Bonded Precious Crown				
G02 Amalgam-Two+Surfaces					K05 Bonded Non Precious Crown				
G03 Amalgam-Three+Surfaces					K08 Full Cast Crown				
G21 Composite Anterior-One Surface					K06 Full Porcelain Crown				
G22 Composite Anterior-Two+Surfaces					INLAYS				
ROOT CANAL TREATMENT					K02 Precious				
H01 Upper & Lower Anterior (1 root)					K01 Non Precious				
H02 Upper Premolar (2 roots)					K03 Porcelain				
H03 Lower Premolar (1 root)					Orthodontist (if applicable in the table of benefit)				
H04 Molars (3 + roots)									
EXTRACTIONS									
L01 Single					Other Treatment				
L02 Per additional tooth									
N11 Post-Operative Care									
D7140 Extraction (ERUPTED)									
D7210 Surgical removal (ERUPTED)									
D7220 Removal IMPACTED – Soft tissue					Total Amount and Currency				
D7230 Removal IMPACTED – Partially bony									
D7240 Removal IMPACTED – Completely bony									
D7241 Removal IMPACTED – Completely bony with surgical complications									

_____ Dental practitioner Stamp and Signature

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