



CIGNA
International

INTER-AMERICAN DEVELOPMENT BANK

MEDICAL CLAIM FORM

Please mail completed Claim Form with itemized bills and receipts to:

For Mail Delivery: **OR**
CIGNA International
P. O. Box 15050
Wilmington, DE 19850-5050
USA

For Courier Mail Delivery:
CIGNA International
590 Naamans Road
Claymont, DE 19703
USA

(800) 441-2668 (Inside USA)
(302) 797-3100 (Outside USA)
(302) 797-3150 (FAX)

10/23/01

You must complete Sections A and B. In addition, you must complete Section C if the claim is for a dependent and/or other coverage is in effect or if the claim is accident or work related. Employee must sign Claim Form. You must complete a separate Claim Form for each patient. You may include multiple services for the same patient on the same Claim Form.

SECTION A. EMPLOYEE/PATIENT INFORMATION

Employer INTER-AMERICAN DEVELOPMENT BANK Patient's Name _____

Employee's Name _____ Policy # on CIGNA ID Card 00390A999

Employee/Retiree Number, if applicable _____

Home Address _____

Please provide telephone and facsimile numbers, with country and city codes, and indicate where you wish to be called:

Home # _____ Work # _____ Fax # _____

SECTION B. PAYMENT. Please select Option # 1 or Option # 2. Payment will be in United States Dollars.

OPTION # 1 (You wish payment to be made payable to you, the Employee).

Please indicate where you wish the payment to be sent. You must be an owner of the bank account to which funds are to be sent.

Your home address as listed above

Your bank account for direct deposit

Name on Account _____ Bank Name _____

Bank Account # _____ Bank Address _____

OPTION # 2 (You wish payment to be made payable to the PROVIDER).

Please complete Provider's name and address in Section D on the reverse side of this Claim Form.

WARNING Any person who files a statement of claim containing any false, incomplete, or misleading information, who knowingly and with intent to injure, defraud, or deceive any insurer, is guilty of a crime.

Payment Authorization: I authorize payment directly to me or to the healthcare provider in Section D of this Claim Form.

EMPLOYEE'S SIGNATURE: _____ **DATE (M/D/Y):** _____

Patient's Signature Release (Parent or Guardian, if claim is for a minor): I certify, to the best of my knowledge, that this Claim Form does not contain any false, misleading or incomplete information. I authorize the release of all records or other information which may be necessary to determine benefits payable.

PATIENT'S SIGNATURE: _____ **DATE (M/D/Y):** _____

SECTION C. OTHER COVERAGE INFORMATION. *If the claim is for a dependent and/or other coverage is in effect or if the claim is accident or work related.*

Do you have any other insurance? Yes No If yes, please provide source of insurance.

Please indicate source _____

Is this claim accident related? Yes No Is this claim work related? Yes No

If yes, please provide documents relating to accident or work injury.

If the claim is due to an accident, are you seeking reimbursement from another source? Yes No

Please indicate source _____

Spouse's name _____

Spouse's insurance company _____

Spouse's employer and telephone # _____

Dependent's date of birth (M/D/Y) _____ Is your dependent a full-time student? Yes No

If yes, please provide documentation of current academic registration.

SECTION D. PHYSICIAN OR PROVIDER. *Please complete this section.*

Name, address, and telephone # of physician or provider of service _____

Diagnosis or nature of illness or injury _____

Date of illness (first symptom) or injury (M/D/Y) _____ Date first consulted for this condition (M/D/Y) _____

Hospital confinement dates (M/D/Y) From _____ To _____ Date able to return to work (M/D/Y) _____

Total disability dates (M/D/Y) From _____ To _____ Partial disability dates (M/D/Y), From _____ To _____

Patient's account # _____ Amount paid _____ Balance due _____

Place of service _____ Diagnosis code and description _____

Date of Service	Procedure code and description	Charges	Total Charges

I certify that the foregoing information is true and correct and that the charges are the actual charges to the patient.

PHYSICIAN'S OR PROVIDER'S SIGNATURE: _____ **DATE (M/D/A)** _____