



DID YOU PAY OUT-OF-POCKET FOR A COVERED PRESCRIPTION?

Get paid back for your prescription costs.

You can ask for re-payment if you paid the full price for your medication out-of-pocket. It's easy - just follow these simple instructions.

Two easy ways to submit a claim.

- › **Online.** Log in to myCigna.com and click on the “Find a Form” link. Under Your Plan Forms, look for Pharmacy claims. Then click on “Complete online form” to get started.
- › **By mail.** Fill out and return the attached prescription drug claim form.

What we need to process your payment.

- › Submit a separate form for each covered family member.
- › Clearly write your Cigna ID number and the plan's group number on the claim form.
- › You must provide this information:
 - Your Cigna ID number
 - Your Cigna Group number, and
 - A pharmacy receipt with details about the purchase. This is the store/medication paperwork that's attached to the pharmacy bag.

Your pharmacy receipt (store/medication paperwork) must show ALL of this information.

- › Patient's name
- › Fill date
- › Drug name and strength
- › 11-digit National Drug Code (NDC) number
- › Quantity filled and day supply
- › Pharmacy name and address
- › Pharmacy identifier (NABP or NPI #)
- › Prescriber's name
- › Cost of each medication (shown as paid in full)



Did you fill a prescription for a compounded medication out-of-network?

Here are some things to know.

- › Your receipt must show details for each prescription ingredient or we can't process your payment.
 - Example: Your compounded product was made using three ingredients. The receipt should list ALL three ingredients in detail.
- › If you can't submit the Cigna claim form, we'll also accept a universal claim form for compounded medications.

Important: If you send in a paper claim for a compounded medication you filled **in-network**, you may get a lesser refund. The pharmacy should send you a bill for the compounded medication. You shouldn't need to submit a claim.

Together, all the way.®



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Prescription Drug Claim Form

Insured and/or Administered by
 Connecticut General Life Insurance Company
 Cigna Health and Life Insurance Company
 Cigna HealthCare*



REASON FOR REIMBURSEMENT

This claim form can be used to request reimbursement for covered expenses. Please check which reason applies (at least one must be checked):

- | | |
|--|--|
| <input type="checkbox"/> Emergency | <input type="checkbox"/> Non-Participating Pharmacy |
| <input type="checkbox"/> Primary coverage is with another insurance carrier. Please provide explanation of benefits (EOB) or denial letter from the primary insurance carrier. | <input type="checkbox"/> Out-of-Network Compound Prescription
<i>(Pharmacist: Claims must list ALL ingredients along with itemized NDCs, quantities and charges.)</i> |
| <input type="checkbox"/> Eligibility <i>(Please explain)</i> | <input type="checkbox"/> Other <i>(Please explain)</i> |

PARTICIPANT/PATIENT INFORMATION

Participant Name:	Employer:
Cigna ID Number or Participant Social Security Number: <i>(on the front of your Cigna ID card)</i>	Account Number: <i>(on the front of your Cigna ID card)</i>
Patient Name <i>(use a separate form for each family member):</i>	Patient Birth Date: <i>(Mo., Day, Year)</i>
Patient Relationship to Participant: <input type="checkbox"/> Self (Participant) <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	Patient Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female

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.

Patient Signature:	Date:	Daytime Phone Number:
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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
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Multi-Ingredient Compound Prescription Information - To be Completed by Dispensing Pharmacy.

Pharmacist: If an itemized compound drug receipt is not available, please use this form to list the ingredients.

- Use one form for each multi-ingredient compound prescription. Copy the form as needed.
- The patient should send receipt(s) showing the out-of-pocket cost, and the Prescriber's name and DEA #.
- SIGN the receipt.

The information below is required to process multi-ingredient claim submissions. For each NDC number, indicate the "metric quantity" expressed in the number of tablets, grams, milliliters, injectables, etc. and the cost.

	Quantity	Valid NDC	Drug Name	Customer's Charge
1				
2				
3				
4				
5				

This Prescription Drug Claim Form is for Cigna customer use only.

Did you know?

We may be able to reimburse you for any prescriptions you paid for directly and didn't use your insurance to cover. For instance, if you used a non-participating pharmacy, and your plan covers out-of-network purchases, file a claim. We'll review it and look to see if we can get you a possible refund.

This form is not used for:

- Prescribed medical equipment (or supplies) - Ask your medical plan about benefits for equipment.
- FSA and HRA expenses - Contact your FSA (or HRA) payer for a claim address and instructions.
- Prescriptions purchased by customers not enrolled with a Cigna drug plan - Check your benefit materials to see if your employer chose a Pharmacy Benefits Company *other than* Cigna.
- Non-covered drugs - See the "Exclusions and limitations" section of your plan's drug list.

INSTRUCTIONS

1. Complete ALL information on the front side of this form. Forms missing information may be denied, delayed or returned. If you need help completing this form, contact your pharmacist.
2. Sign and date the Certification Statement in the area provided. Keep a copy of all forms and receipts for your records.
3. The Prescription Information section must be completed for each prescription for which you are seeking payment.
4. For Health Care Reform related over-the-counter payment requests, include your Doctor's prescription. Please keep a copy of the prescription for your records.
5. Submit a separate form for each family member.
6. Mail the claim form within 12 months of the prescription fill date, along with original receipts (cash register receipts alone are not acceptable), to:
Cigna Pharmacy Service Center
P.O. Box 188053
Chattanooga, TN 37422-8053
7. Questions? Please call the Cigna number located on your ID card.

Fold

Fold

RETURN ADDRESS

IMPORTANT: PLEASE PROVIDE CURRENT ADDRESS INFORMATION BELOW:

CUSTOMER NAME

CUSTOMER STREET ADDRESS

CUSTOMER CITY, STATE, ZIP

[Click Here to Print](#)

[Clear Fields](#)

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; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act.

IMPORTANT CLAIM NOTICE

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

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

California Residents: For your protection, California law requires the following to appear on/with this form. 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.

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 a 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.

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

Maryland Residents: Any person who knowingly OR willfully presents 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 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.

New York 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 shall also be subject to a civil penalty not to exceed \$5000 and the stated value of the claim for each such violation.

Oregon 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, may have committed a fraudulent insurance act.

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.

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: Any person who, with the 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 may have violated state law.

*"Cigna HealthCare" refers to the various HMO subsidiaries of Cigna Health Corporation. If you are enrolled in a Cigna HMO plan, complete details can be found in your plan documents or Evidence of Coverage.

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DISCRIMINATION IS AGAINST THE LAW

Medical coverage

Cigna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Cigna does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Cigna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact customer service at the toll-free number shown on your ID card, and ask a Customer Service Associate for assistance.

If you believe that Cigna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by sending an email to ACAGrievance@Cigna.com or by writing to the following address:

Cigna
Nondiscrimination Complaint Coordinator
PO Box 188016
Chattanooga, TN 37422

If you need assistance filing a written grievance, please call the number on the back of your ID card or send an email to ACAGrievance@Cigna.com. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
1.800.368.1019, 800.537.7697 (TDD)
Complaint forms are available at
<http://www.hhs.gov/ocr/office/file/index.html>.



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