Statement of Claim

To Be Completed By The Employee

SELF INSURED PLANS LLC

GWH-CIGNA
PO Box 188061
Chattanooga, TN 37422-8061
phone 239.403.7884
CIGNA does not accept faxed claims.

Employer Name _____

Group No. _____

Submit only itemized bills. Drug receipts should always include a prescription number.
If you submit bills for covered services not reported on an "Attending Physician's Statement," each bill must describe name of patient, diagnosis, nature of services or supplies furnished, as well as the date and amount charged for each.

Full Name		Employment status: ☐ Active ☐ Retired	Social Security Number
Home Address		Marital status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Legally Separated	First name of spouse / Is your spouse employed? ☐ Yes ☐ No
City State ZIP Code		Name and address of company where spouse is employed	
Date of Birth	Telephone Number	Spouses's Social Security Number	

Patient's Name	Date of birth	☐ Male ☐ Female	☐ Employee ☐ Spouse ☐ Child	Marital status if other than spouse: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Legally Separated

Is patient eligible for Medicare as a disabled person or due to renal dialysis or kidney transplant? ☐ Yes ☐ No

If yes, effective date of Medicare is:

If patient is a child 19 or over: name and address of school	Date of enrollment	☐ Full time ☐ Part time

If bills are being submitted for nursing services or physiotherapy, enclose a statement from your physician showing that he ordered all such services. ☐ Yes
Also, were any such services rendered by a close relative, that is, your spouse or child, brother, sister or parent of either yourself or your spouse? ☐ No

Date accident occurred or sickness began?	Description of injury or sickness. If accident, date, how and where it occurred.

Is condition due to injury or sickness arising out of patient's employment? ☐ Yes ☐ No - If "Yes," explain

IS PATIENT COVERED BY ANOTHER PLAN

1. Any other Group Plan, Welfare Plan or other arrangement of coverage for individuals in a group? ☐ Yes ☐ No
2. Blue Cross, Blue Shield or any other prepayment arrangement maintained on a group basis? ☐ Yes ☐ No
3. Any other coverage provided by an employer or any federal, state, or other governmental agency? ☐ Yes ☐ No
4. No-fault automobile plan as a result of injuries sustained in an automobile accident? ☐ Yes ☐ No

If "Yes" please furnish name and address of employer, insurance company or governmental agency, type of coverage, and policy number.

THE ABOVE ANSWERS ARE TRUE AND COMPLETE ACCORDING TO THE BEST OF MY KNOWLEDGE AND BELIEF. I AUTHORIZE ANY EMPLOYER, INSURANCE COMPANY, MEDICAL PREPAYMENT PLAN, SERVICE ORGANIZATION, PHYSICIAN, PRACTITIONER OR OTHER PERSON; ANY HOSPITAL, INCLUDING THE VETERANS ADMINISTRATION, OR OTHER INSTITUTION TO RELEASE OR OBTAIN FROM SIP, ANY MEDICAL OR BENEFIT PAYMENT INFORMATION THAT MAY BE REQUIRED TO ESTABLISH THE VALIDITY OF THIS CLAIM, AND FURTHER AUTHORIZE SAID COMPANY, PERSON OR ORGANIZATION, TO DISCLOSE ANY PERSONAL OR CLAIM INFORMATION REQUIRED FOR MEDICAL CASE STUDY OR REVIEW. A PHOTOSTAT OF THIS AUTHORIZATION SHALL BE VALID AS THE ORIGINAL.

Spouse's Signature and date _____ _____

Employee's Signature and date _____ _____

Assignment of Benefits

I hereby authorize payment directly to the physician, hospital, or supplier who provided services for which benefits are payable, but not exceed the usual and prevailing charge.

Employee's Signature _____ Date _____

Hospital/Attending Physician's Statement

To Be Completed By Physician/Supplier (THIS SECTION DOES NOT HAVE TO BE COMPLETED IF YOU PROVIDE ITEMIZED BILLS)

Employee's Last Name	First Name	Patient's Name (if patient is dependent)	Date of birth

1. Diagnosis and concurrent conditions (if diagnosis code other than ICDA* used, give name)

2. Is condition due to injury or sickness arising out of patient's employment? ☐ Yes ☐ No	Pregnancy? ☐ Yes ☐ No	If yes, approximate date pregnancy commenced

3. Report of Services (or inclose itemized bill((if previous form submitted to SIP, you need to show only the dates and services since last report)

Date of Services	Place of Services†	Description of surgical or medical services rendered	Procedure Code-If used (If code other than CPT** used, give name)	Charges

† O - Doctor's Office
H - Patient's Home
IH - Inpatient Hospital
OH - Outpatient Hospital
NH - Nursing Home
OL - Other Locations

* ICDA - International Classification of Diseases

** CPT - Current Procedural Terminology (current edition)

Total Charges $ _____

Amount Paid $ _____

Balance Due $ _____

4. Date symptoms first appeared or accident happened	5. Date patient first consulted you for this condition
6. Patient ever had same or similar condition? ☐ Yes ☐ No If yes, when and describe:	7. Patient still under your care for this condition ☐ Yes ☐ No
	8. I accept Medicare's assignment ☐ Yes ☐ No

Physicians's Name	Individual health care practitioners enter your social security number *	All others enter your employer identification number *

Signature	Degree	Telephone No.	Date

Street Address	City or Town	State	ZIP Code

* Under Section 6109 of the Internal Revenue Code, recipients of medical and health care payments are required to furnish identifying numbers to payers who must report such payments to the Internal Revenue Service.

"NOTICE to all parties completing this form: It is fraudulent to fill out this form with information you know to be false or to omit important facts. Criminal and/or civil penalties can result from such acts."

GWH-CIGNA
1000 Great-West Drive
Kennett, MO 63857-3749
phone 239.403.7884
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For information about claim payments, employees may call: 239-403-7884