

Behavioral Care Out of Network Claim Form

Insured and/or Administered by
Connecticut General Life Insurance Company
CIGNA Behavioral Care



CIGNA HealthCare

Columbia University

DO NOT USE STAPLES

Provider Section, Instructions and Mailing Information on Reverse Side

EMPLOYEE INFORMATION: Employee Complete This Section			
A. EMPLOYEE'S NAME (First, M.I., Last)		B. DATE OF BIRTH mm/dd/yyyy	C. SEX <input type="checkbox"/> M <input type="checkbox"/> F
D. EMPLOYEE'S MAILING ADDRESS (Street, City, State, Zip) and DAYTIME PHONE #		IS THIS A CHANGE OF ADDRESS? <input type="checkbox"/> YES <input type="checkbox"/> NO	E. EMPLOYEE'S SOC. SEC. / ID NO.
F. MARITAL STATUS	G. POLICY/ACCOUNT NO. 3205616	H. DIVISION/BRANCH OR CLASS/LOCATION	
I. EMPLOYER Columbia University		J. EMPLOYEE STATUS <input type="checkbox"/> ACTIVE <input type="checkbox"/> HOURLY <input type="checkbox"/> RETIRED <input type="checkbox"/> SALARIED <input type="checkbox"/> DISABLED	DATE mm/dd/yyyy
PATIENT INFORMATION: Complete Only if Patient is Other Than Employee			
A. PATIENT'S NAME (First, M.I., Last)		B. RELATIONSHIP TO EMPLOYEE	C. DATE OF BIRTH mm/dd/yyyy
D. SEX <input type="checkbox"/> M <input type="checkbox"/> F		E. COMPLETE THIS INFORMATION IF PATIENT IS AN UNMARRIED DEPENDENT CHILD	
DEPENDENT CHILD IS: <input type="checkbox"/> EMPLOYED FULL-TIME <input type="checkbox"/> STUDENT FULL-TIME		NAME, ADDRESS AND PHONE # OF CHILD'S SCHOOL/EMPLOYER	
ACCIDENT/OCCUPATIONAL CLAIM INFORMATION: Complete Only if Claim is a Result of an Accident or Occupational Illness/Injury			
A. DESCRIPTION OF ILLNESS (How, When, Where)		B. ILLNESS DUE TO EMPLOYMENT <input type="checkbox"/> YES <input type="checkbox"/> NO	
C. DATE OF BEGINNING OF ILLNESS	D. INJURY DUE TO AUTO ACCIDENT <input type="checkbox"/> YES <input type="checkbox"/> NO	E. HAVE YOU OR YOUR DEPENDENT, OR WILL YOU OR YOUR DEPENDENT FILE CLAIM FOR WORKERS' COMPENSATION BENEFITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
F. ARE YOU OR YOUR DEPENDENTS FILING A CLAIM OR LAWSUIT AGAINST A THIRD PARTY IN ORDER TO RECOVER THE COST OF EXPENSES INCURRED AS A RESULT OF THIS ILLNESS? <input type="checkbox"/> YES <input type="checkbox"/> NO			
FAMILY/OTHER COVERAGE INFORMATION: Complete Only if Claim is for a Dependent and/or Other Coverage is in Effect			
A. SPOUSE EMPLOYED <input type="checkbox"/> YES <input type="checkbox"/> NO	IF NO, HAS SPOUSE BEEN EMPLOYED DURING LAST 12 MONTHS? <input type="checkbox"/> YES <input type="checkbox"/> NO	B. NAME OF SPOUSE	SPOUSE'S DATE OF BIRTH
C. SPOUSE'S SOC. SEC. / ID NO.	D. NAME, ADDRESS AND PHONE # OF SPOUSE'S EMPLOYER		
E. IS THE PATIENT COVERED UNDER ANOTHER GROUP INSURANCE OR GOVERNMENT PLAN SUCH AS MEDICARE, AN HMO PLAN OR AUTOMOBILE MANDATORY NO-FAULT COVERAGE WHICH WILL ALSO COVER ANY OF THE MEDICAL EXPENSES OR DISABILITY LOSSES OF THIS CLAIM? IF YES, GIVE NAME AND ADDRESS OF INSURANCE COMPANY, ORGANIZATION, OR HMO PROVIDING BENEFITS. <input type="checkbox"/> YES <input type="checkbox"/> NO			
NAME & ADDRESS			POLICY NUMBER
EMPLOYEE'S/PATIENT'S SIGNATURE AND RELEASE: Employee Must Sign all Claims			
A. AUTHORIZATION TO RELEASE INFORMATION- I authorize any Health Care Provider, Insurance Company, Employer, Person or Organization to release any information regarding the medical, dental, mental, alcohol or drug abuse history, treatment, or benefits payable, including disability or employment related information, to any CIGNA company, the Plan Administrator, or their authorized agents for the purpose of validating and determining benefits payable. I will receive a copy of this authorization upon request. This authorization or a copy shall be valid for one year from the date of signature.			
PATIENT'S SIGNATURE (Parent or Guardian if Claim is on a Minor)			DATE
NOTE: If you wish your benefits paid directly to the physician or provider of service, sign in box B, below. Benefits will be paid directly to the hospital for a hospital confinement.			
B. PAYMENT AUTHORIZATION - I authorize payment directly to those Health Care Providers described below, and/or as indicated on the enclosed bills, of Mental Health / Substance Abuse Benefits otherwise payable to me, for services rendered by them.		IF YES, EMPLOYEE'S SIGNATURE	DATE
C. CERTIFICATION I certify that this information is true and correct.		EMPLOYEE'S SIGNATURE	DATE

