

## **APPENDIX B**

### **Claims Information**



**Instructions for Completing the CMS-1500 (08-05) Form – Image below**

Field	Description/Instruction
1	Type of insurance. Insured's ID number found on insured's card.
2	Patient's last name, first name, middle initial.
3	Patient's date of birth: Jan. 10 1939 = 011039. Sex—check Male or Female.
4	Insured's last name, first name, and middle initial.
5	Patient's address: street, city, state (two-letter abbreviation), zip code, and telephone number.
6	Patient's relationship to insured.
7	Insured's address: street, city, state (two letter abbreviation), zip code, and telephone number.
8	Indicate patient's status.
9	If the patient has additional coverage under another carrier, indicate the policyholder or insured's last name, first name, middle initial.
a	The number of this group or policy.
b	Date of birth and sex of person in #9.
c	The employer's name or school name of the person in #9.
d	Program or plan name of the other carrier.
10	Is patient's condition related to: Complete a, b, and c.
a	Employment (check applicable)
b	Auto accident (check applicable) and enter State abbreviation of PLACE of accident
c	Other accident (check applicable)
11	Group number of insured. This can be found on the insured's health plan card.
a	Insured's date of birth and sex: Jan. 10, 1939 = 011039. Male/Female.
b	Employer's name or school name.
c	Program or plan name.
d	Indicate if there is another health benefit plan or insurance policy providing coverage. <b>If yes</b> , complete #9 and #9A through #9D.
12	To indicate you have a Release of Information form on file, include either the patient's signature or the notation 'signature on file'.
13	To indicate you have assignment of benefits from your patient, either the patient's signature or the notation 'signature on file' must be present. <b>DO NOT SIGN HERE</b> if you would like payment directed to the policy holder. Note: If participating practitioner, payment will be directed to the practitioner
14	Date of onset of condition/accident: Feb. 10, 1997 = 021097.
15	If the patient has had similar illness or injury, give first date seen.
16	Not applicable.
17	Name of referring physician or source.
17a	Other ID. Enter the two digit code source (see list below) and then the corresponding referring physician's number.
OB	State License Number
1B	Blue Shield Provider Number
1C	Medicare Provider Number
1D	Medicaid Provider Number
1G	Provider UPIN Number
1H	CHAMPUS Identification Number
EI	Employer's Identification Number
G2	Provider Commercial Number
LU	Location Number
N5	Provider Plan Network Identification Number
SY	Social Security Number (this number may not be used for Medicare.)

	X5	State Industrial Accident Provider Number
	ZZ	Provider Taxonomy
	17b	NPI. The referring physician's NPI number.
18	Hospital admit and discharge dates Jan. 10, 1997 to Jan. 15, 1997 = 011097 to 011597.	
19	Not applicable. Note: Practitioners can use this box to indicate supervising practitioner.	
20	Laboratory work performed outside the office and charges for that work.	
21	Diagnosis code: ICD-9 codes-complete with all required digits. Primary diagnosis should be listed first followed by subsequent diagnoses.	
22	Medicaid Resubmission Code/Original Ref. No. Use only with Medicaid claims	
23	Enter the assigned CIGNA authorization number.	
24	Service Information	
	A	Date(s) of service – From and To (enter each date of service individually)
	B	Place of service. Use these codes for place of service:
	11	Office, clinic
	12	Home
	21	Hospital inpatient
	22	Hospital outpatient
	23	Emergency room
	41	Ambulance, land
	99	Other unlisted facility
	C	EMG. Enter Y if service is an emergency service. If not, N.
	D	Use procedure codes as indicated in Exhibit A—Compensation attached to your CIGNA agreement. Patient's/Policyholders will find these codes on itemized statements billed by their provider/practitioner. Note: Modifiers not required by CIGNA.
	E	Diagnosis Pointer: ICD-9 codes-complete with all required digits or enter position (1, 2, 3, or 4) as listed in field 21.
	F	Charges. Enter the charge amount that corresponds to the date and procedure code for each line on the claim.
	G	Indicate days or units of service.
	H	Not applicable.
	I	ID Qual (top half). Enter the two digit code source (see list below) and then the corresponding rendering provider number. NPI (bottom half)
	OB	State License Number
	1B	Blue Shield Provider Number
	1C	Medicare Provider Number
	1D	Medicaid Provider Number
	1G	Provider UPIN Number
	1H	CHAMPUS Identification Number
	EI	Employer's Identification Number
	G2	Provider Commercial Number
	LU	Location Number
	N5	Provider Plan Network Identification Number
	SY	Social Security Number (this number may not be used for Medicare.)
	X5	State Industrial Accident Provider Number
	ZZ	Provider Taxonomy
	J	ID Qual (top half): Enter the corresponding rendering provider number. NPI (bottom half) Enter the corresponding rendering provider NPI number.
25	Federal Tax ID number. Indicate if SSN = Social Security number or EIN = Employer Identification Number.	
26	For provider/practitioner's internal audit use.	



27	Indicate if the provider/practitioner accepts government assignment. An indicator in the 'yes' box means the Provider/Practitioner of services accepts assignments.		
28	Total Charges: Total of all individual line charges.		
29	Indicate the amount of copayments or deductibles paid by the policyholder.		
30	Balance due: Calculate the balance due.		
31	Signature of the rendering provider/practitioner of service with degree and date. Please print name as well.		
32	Name and address of facility where services were rendered if other than home or office.		
	a	Enter the servicing locations NPI number	
	b	ID Qual. Enter the two digit code source (see list below) and then the servicing provider's ID number (e.g., 1C-XXXXXXXXXX).	
		0B	State License Number
		1B	Blue Shield Provider Number
		1C	Medicare Provider Number
		1D	Medicaid Provider Number
		1G	Provider UPIN Number
		1H	CHAMPUS Identification Number
		E1	Employer's Identification Number
		G2	Provider Commercial Number
		LU	Location Number
		N5	Provider Plan Network Identification Number
		SY	Social Security Number (this number may not be used for Medicare.)
X5		State Industrial Accident Provider Number	
ZZ	Provider Taxonomy		
33	Provider/Practitioner billing name with complete billing address, phone number, and tax identification number.		
	a	Enter the billing providers NPI number	
	b	ID Qual. Enter the two digit code source (see list below) and then the billing provider's ID number (e.g., 1G-XXXXXXXXXX).	
		0B	State License Number
		1B	Blue Shield Provider Number
		1C	Medicare Provider Number
		1D	Medicaid Provider Number
		1G	Provider UPIN Number
		1H	CHAMPUS Identification Number
		E1	Employer's Identification Number
		G2	Provider Commercial Number
		LU	Location Number
		N5	Provider Plan Network Identification Number
		SY	Social Security Number (this number may not be used for Medicare.)
X5		State Industrial Accident Provider Number	
ZZ	Provider Taxonomy		

Please complete as much as possible to the best of your knowledge. If you have questions completing the CMS-1500 form, please contact our Customer Service department at 800.926.2273 or check out the NUCC website.



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA										PICA																																																	
1. MEDICARE <input type="checkbox"/> (Medicare #) MEDICAID <input type="checkbox"/> (Medicaid #) TRICARE <input type="checkbox"/> (Sponsor's SSN) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) FECA <input type="checkbox"/> (SSN) OTHER <input type="checkbox"/> (ID)										1a. INSURED'S I.D. NUMBER (For Program in Item 1)																																																	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)										3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>																																																	
5. PATIENT'S ADDRESS (No., Street)										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>																																																	
CITY					STATE					7. INSURED'S ADDRESS (No., Street)					8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>																																												
ZIP CODE					TELEPHONE (Include Area Code) ( )					CITY					STATE																																												
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) _____ c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> 10d. RESERVED FOR LOCAL USE					11. INSURED'S POLICY GROUP OR FECA NUMBER					a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>																																												
a. OTHER INSURED'S POLICY OR GROUP NUMBER					b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>					b. EMPLOYER'S NAME OR SCHOOL NAME					c. INSURANCE PLAN NAME OR PROGRAM NAME																																												
c. EMPLOYER'S NAME OR SCHOOL NAME					d. INSURANCE PLAN NAME OR PROGRAM NAME					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, return to and complete item 9 a-d.					13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.																																												
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____																																																	
14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)										15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY																																																	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a. _____					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES. FROM MM DD YY TO MM DD YY																																												
19. RESERVED FOR LOCAL USE										17b. NPI _____					20. OUTSIDE LAB? \$ CHARGES YES <input type="checkbox"/> NO <input type="checkbox"/>																																												
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate items 1, 2, 3 or 4 to item 24E by line) 1. _____ 3. _____ 2. _____ 4. _____										22. MEDICAID RESUBMISSION CODE _____ ORIGINAL REF. NO. _____					23. PRIOR AUTHORIZATION NUMBER _____																																												
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER										F. \$ CHARGES					G. DAYS OR UNITS					H. EPSON Refill Plan					I. ID. QUAL.					J. RENDERING PROVIDER ID. #																													
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25. FEDERAL TAX I.D. NUMBER SSN EIN										26. PATIENT'S ACCOUNT NO.										27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>										28. TOTAL CHARGE \$										29. AMOUNT PAID \$										30. BALANCE DUE \$									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED _____ DATE _____										32. SERVICE FACILITY LOCATION INFORMATION a. NPI _____ b. _____										33. BILLING PROVIDER INFO & PH # ( ) a. NPI _____ b. _____																																							

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

**Instructions for Completing the UB-04 Form – Image below**

<b>Field</b>	<b>Description/Instruction</b>
1	Provider's name Provider's address Provider's city, state, zip Provider's telephone, fax, country code
2	Pay-to name Pay-to address Pay-to city, state
3	a Patient control number: The number assigned by the provider to facilitate retrieval of individual
	b Medical record number: The facilities medical record number of the patient
4	Type of Bill: 3-digit alphanumeric code gives 3 specific pieces of information <ul style="list-style-type: none"> <li>• First digit identifies facility type.</li> <li>• Second digit classifies type of care.</li> <li>• Third digit indicates the sequence of this bill in this particular episode of care.</li> </ul>
5	Federal tax identification number
6	The 'From' and 'Through' dates this bill covers
7	Unlabeled
8	a Patient's name – ID
	b Patient's name
9	a Patient's address
	b Patient's city
	c Patient's state
	d Patient's zip
	e Patient's country code
10	Patient's birth date (MM/DD/YYYY)
11	Patient's sex
12	Date of admission
13	Hour of admission
14	Type of admission
15	Source of admission
16	Hour of discharge
17	Patient discharge status
18-28	Condition codes
29	Accident state
30	Unlabeled
31-34	Occurrence code/date
35-36	Occurrence span code (from/through)
37	Unlabeled
38	Responsible party name/address
39	a-d Value code (2 digits)/value code (9 spaces)
40	a-d Value code (2 digits)/value code (9 spaces)
41	a-d Value code (2 digits)/value code (9 spaces)
42	Revenue code
43	Revenue code description
44	HCPCS/rate/HIPPS code (procedure code/rate)
45	Date of service
46	Service units
47	Total charges per line item
48	Non-covered charges



49	Unlabeled	
49.23	Page ____ of ____, Creation Date _____, Totals (column 47 & 48)	
50	Payer name (A-primary, B-secondary, C-tertiary)	
51	Health plan ID (A-primary, B-secondary, C-tertiary)	
52	Release of information (A-primary, B-secondary, C-tertiary)	
53	Assignment of benefits (A-primary, B-secondary, C-tertiary)	
54	Prior payments (A-primary, B-secondary, C-tertiary)	
55	Estimated amount due (A-primary, B-secondary, C-tertiary)	
56	NPI	
57	Other provider ID (A-primary, B-secondary, C-tertiary)	
58	Insured's name (A-primary, B-secondary, C-tertiary)	
59	Patient's relationship (A-primary, B-secondary, C-tertiary)	
60	Insured's unique ID (A-primary, B-secondary, C-tertiary)	
61	Insurance group name (A-primary, B-secondary, C-tertiary)	
62	Insurance group number (A-primary, B-secondary, C-tertiary)	
63	Treatment authorization code (A-primary, B-secondary, C-tertiary)	
64	Document control number (A-primary, B-secondary, C-tertiary)	
65	Employer name (A-primary, B-secondary, C-tertiary)	
66	Diagnosis version qualifier	
67	Principal diagnosis code	
	A-Q	Other diagnosis codes
68	Unlabeled	
69	Admitting diagnosis code	
70	Patient's reason for visit code(s)	
71	PPS code	
72	External cause of injury code(s)	
73	Unlabeled	
74	Principal procedure code	
	a-e	Other procedure code
75	Unlabeled	
76	Attending physician NPI/Qual ID	
	Attending physician Last name, first name	
77	Operating physician NPI/Qual ID	
	Operating physician Last name, first name	
78	Other ID – Qual/NPI/Qual/ID	
	Other ID physician Last name, first name	
79	Other ID – Qual/NPI/Qual/ID	
	Other ID physician Last name, first name	
80	Remarks	
81	a-d	Code-Code – Qual/code/value

Please complete as much as possible to the best of your knowledge. If you have questions completing the CMS-1500 form, please contact our Customer Service department at 800.926.2273 or check out the CMS.gov website.



1										2										3a PAT. CNTRL. #					4 TYPE OF BILL																																		
																				5 FED. TAX NO.					6 STATEMENT COVERS PERIOD FROM THROUGH																																		
8 PATIENT NAME										9 PATIENT ADDRESS																																																	
10 BIRTHDATE										11 SEX					12 DATE					ADMISSION 13 HR 14 TYPE 15 SRC 16 DHR 17 STAT					CONDITION CODES 22 23 24 25 26 27 28					29 ACCT STATE 30																													
31 OCCURRENCE DATE					32 OCCURRENCE DATE					33 OCCURRENCE DATE					34 OCCURRENCE DATE					35 OCCURRENCE SPAN FROM THROUGH					36 OCCURRENCE SPAN FROM THROUGH					37																													
38										39 VALUE CODES AMOUNT					40 VALUE CODES AMOUNT					41 VALUE CODES AMOUNT																																							
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42 REV. CD.										43 DESCRIPTION										44 HCPCS / RATE / HPPS CODE										45 SERV. DATE					46 SERV. UNITS					47 TOTAL CHARGES					48 NON-COVERED CHARGES					49									
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23										PAGE ____ OF ____										CREATION DATE										TOTALS																													
A										50 PAYER NAME										51 HEALTH PLAN ID										52 REL. INFO					53 ASS. DETL.					54 PRIOR PAYMENTS					55 EST. AMOUNT DUE					56 NPI									
B																																													57 OTHER PRV ID														
C																																																											
A										58 INSURED'S NAME										59 P. REL.					60 INSURED'S UNIQUE ID										61 GROUP NAME										62 INSURANCE GROUP NO.														
B																																																											
C																																																											
A										63 TREATMENT AUTHORIZATION CODES										64 DOCUMENT CONTROL NUMBER										65 EMPLOYER NAME																													
B																																																											
C																																																											
66 DX										67 A					67 B					67 C					67 D					67 E					67 F					67 G					67 H					68									
69 ADMIT DX										70 PATIENT REASON DX					a					b					c					71 PPS CODE					72 ECI					a					b					c					73				
										74 PRINCIPAL PROCEDURE CODE					75 OTHER PROCEDURE CODE					76 OTHER PROCEDURE CODE					76 ATTENDING NPI					QUAL																													
																									LAST					FIRST																													
										e					d					e					77 OPERATING NPI					QUAL																													
																									LAST					FIRST																													
80 REMARKS										81 CC a					b					c					78 OTHER NPI					QUAL																													
										b															LAST					FIRST																													
										c															79 OTHER NPI					QUAL																													
										d															LAST					FIRST																													



**Explanation Of Benefits (Practitioner Copy) Reference Sheet**

<b>A</b>	<b>Claim Administrator and Employee information</b>	
	1	Claim Administrator's name and claim address
	2	Claim Administrator's toll-free Customer Service number
	3	Participant's group name, if applicable
	4	Provider/Practitioner's name and mailing address
	5	Date of the Explanation of Benefits
	6	Provider/Practitioner's Tax Identification Number
	7	CIGNA vendor number—an internally assigned number based on Provider/Practitioner's Tax ID
	8	Check number of the payment. Cross-reference D1
<b>B</b>	<b>Claim Summary</b>	
	1	Participant name
	2	Provider/Practitioner's Participant account number taken from corresponding claim
	3	Number assigned to document(s) for identification and tracking by CIGNA based on the date claim was received
	4	CIGNA Participant ID—an internally assigned number
	5	Name of the person holding the policy
	6	Name of the Provider/Practitioner who rendered the services
<b>C</b>	<b>Claim Payment Detail</b>	
	1	Date service was rendered
	2	General description of procedure rendered to the Participant by the above named Provider/Practitioner
	3	Amount billed for services rendered
	4	Amount over the contracted fee maximum. The Participant is not liable for this amount
	5	Amount for which the Provider/Practitioner is responsible. (Example: Medicare contracted rates, amounts over the fee maximum.) The Participant is not liable for this amount
	6	Total amount eligible for reimbursement by CIGNA
	7	Amount for services that are not covered by CIGNA. Refer to remarks for an explanation of any amounts not covered. These could be amounts excluded under the plan or amounts incorrectly submitted to the Mental Health/Substance Abuse claim administrator
	8	Eligible dollar amount applied towards the Participant's deductible. This amount does not reflect the total for the plan year, only the total for this charge. However, any amounts previously applied towards the deductible are taken into consideration when calculating this amount
	9	Fixed dollar amount set by the participant's benefit plan—Participant responsibility
	10	Dollar amount based on a fixed percentage set by the participant's benefit plan—Participant responsibility. (Example: If a benefit is paid at 70%, this field will show the 30% the Participant/Member will owe.)
	11	Total amount paid by CIGNA on this charge
	12	Remark codes assigned to explain adjusted and noncovered amounts
	13	Summation of the amounts corresponding to the columns named above
	14	Amount paid by other insurance carrier and subtracted from the CIGNA payment
	15	Total amount applied to Participant's deductible from all eligible charges detailed above plus the amounts not covered
	16	Total copay/coinsurance amounts due from participant from all eligible charges detailed above
17	Total payment made for all eligible charges detailed above	
<b>D</b>	<b>Payment Summary</b>	
	1	Summation and total amount paid for all claims detailed on the explanation of benefits
	2	Check number of the payment. Cross-reference A8
	3	Remark code narrative/explanation referenced in #12 in the claim payment detail



A CIGNA (1)  
 11095 VIKING DRIVE  
 SUITE 350  
 EDEN PRAIRIE MN 55344  
 800.926.2273

**SAMPLE COPY**

PAGE 1 OF 1

CIGNA  
 FOR (3)

Date 00-00-0000 (5)

PROVIDER NAME (4)  
 ADDRESS  
 CITY STATE ZIP

Provider TIN (6)  
 Vendor # (7)  
 Check # (8)  
 Control #

THIS STATEMENT COVERS (PROVIDER NAME) PAYMENTS FOR THE FOLLOWING PARTICIPANT(S):  
 CLAIM DETAIL SECTION (IF THERE ARE NUMBERS IN THE 'SEE REMARKS' COLUMN, SEE THE REMARKS SECTION FOR EXPLANATION.)

B	PARTICIPANT NAME (1)	PARTICIPANT ACCT # (2)	DOC # (3)
	MEMBER ID (4)	SUBSCRIBER NAME (5)	
	THERAPIST (7)	INVOICE #	

C	SERVICE DATE(S) (1)	PROCEDURE (2)	CHARGES (3)	AGREEMENT ADJUSTMENT (4)	PROV. RESP. (5)	ALLOWED/ CONTRACTED (6)	NOT COVERED (7)	DEDUCT (8)	COPAY (9)	COINSURANCE (10)	TOTAL PAYMENT (11)	SEE REMARKS (12)
-----												
TOTALS:				(13)								
ADJUSTMENT DUE TO OTHER INSURANCE/PREVIOUSLY PAID				(14)								
BALANCE DUE FROM PARTICIPANT					PT'S DED NOT COV	0.00		(15)	TOTAL PAID:		(17)	
					PT'S COINS/COPAY	0.00 = 0.00		(16)				

D PAYMENT SUMMARY SECTION (1)

TOTAL CHARGES	TOTAL AGREEMENT ADJUSTMENT	TOTAL PROVIDER RESP.	TOTAL ALLOWED/ CONTRACTED	TOTAL NOT COVERED	TOTAL DEDUCT	TOTAL COPAY	TOTAL COINSURANCE	TOTAL PAYMENT	CHECK #
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-REMARKS- (3)

(2)



<b>Explanation Of Benefits (Participant Copy) Reference Sheet</b>	
A	Claim Administrator and Employee information
	1 Claim Administrator's claim address
	2 Claim Administrator's toll-free Customer Service number
	3 Employee's name and mailing address
	4 Date of the Explanation of Benefits
	5 Employee's Name
	6 CIGNA Participant ID—an internally assigned number
B	Claim Summary
	1 Participant name
	2 CIGNA Participant ID—an internally assigned number
	3 Number assigned to document(s) for identification and tracking by CIGNA based on the date claim was received
C	Claim Payment Detail
	1 Date service was rendered
	2 General description of the procedure rendered to the Participant by the above named Provider/Practitioner
	3 Amount billed for services rendered
	4 Amount over the contracted fee maximum. The Participant is not liable for this amount
	5 Amount for which the Provider/Practitioner is responsible. (Example: Medicare contracted rates, amounts over the fee maximum.) The Participant is not liable for this amount
	6 Total amount eligible for reimbursement by CIGNA
	7 Amount for services that are not covered by CIGNA. Refer to remarks for an explanation of any amounts not covered. These could be amounts excluded under the plan or amounts incorrectly submitted to the Mental Health/Substance Abuse claim administrator
	8 Eligible dollar amount applied towards the Participant's deductible. This amount does not reflect the total for the plan year, only the total for this charge. However, any amounts previously applied towards the deductible are taken into consideration when calculating this amount
	9 Fixed dollar amount set by the member's benefit plan—Participant responsibility
	10 Dollar amount based on a fixed percentage set by the participant's benefit plan—Participant responsibility. (Example: If a benefit is paid at 70%, this field will show the 30% the Participant will owe.)
	11 Total amount paid by CIGNA on this charge
	12 Remark codes assigned to explain adjusted and noncovered amounts
	13 Summation of the amounts corresponding to the columns named above
	14 Amount paid by other insurance carrier and subtracted from the CIGNA payment
	15 Total amount applied to Participant's deductible from all eligible charges detailed above plus the amounts not covered
	16 Total copay/coinsurance amounts due from participant from all eligible charges detailed above
17 Total payment made for all eligible charges detailed above.	
D	Payment Summary
	1 Payment was made to (This indicates to whom the check was sent.): PROVIDER/PRACTITIONER—Provider/Practitioner of services or SUBSCRIBER—Employee
	2 Total amount paid for all claims detailed on the explanation of benefits
	3 Check number of the payment
	4 Remark code narrative/explanation referenced in #12 in the claim payment detail
	5 This is not a bill for the Participant to pay. The Provider/Practitioner will bill for any amounts due from the Participant



CIGNA (1)  
 11095 VIKING DRIVE  
 SUITE 350  
 EDEN PRAIRIE MN 55344  
 800.926.2273 (2)

**SAMPLE COPY**

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**A** EMPLOYEE (4) Date 00-00-0000 (3)  
 1234 MAIN STREET  
 ANYTOWN, US 12345  
 Subscriber Name EMPLOYEE (5)  
 Participant ID (6)  
 Control # 0000000000

BELOW IS AN EXPLANATION OF BENEFITS FOR SERVICES PROVIDED FOR THE FOLLOWING PARTICIPANT(S):  
 CLAIM DETAIL SECTION (IF THERE ARE NUMBERS IN THE 'SEE REMARKS' COLUMN, SEE THE REMARKS SECTION FOR EXPLANATION.)

**B** PARTICIPANT NAME (1) DOCUMENT NUMBER (2)  
 PROVIDER NAME (4) INVOICE # (3)

<b>C</b>	SERVICE DATE(S)	PROCEDURE	CHARGES	AGREEMENT ADJUSTMENT	PROV. RESP.	ALLOWED/ CONTRACTED	NOT COVERED	DEDUCT	COPAY	COINSURANCE	TOTAL PAYMENT	SEE REMARKS
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)
TOTALS:				(13)								
ADJUSTMENT DUE TO OTHER INSURANCE/PREVIOUSLY PAID				(14)								
BALANCE DUE FROM PARTICIPANT				PT'S DED NOT COV	0.00			(15)	TOTAL PAID:		(17)	
				PT'S COINS/COPAY	0.00 = 0.00			(16)				

**D** PAYMENT SUMMARY SECTION  
 Payment Made to Provider (1) TOTAL PAYMENT AMOUNT (2) CHECK # (3)

-REMARKS- (4)

THE PARTICIPANT'S EMPLOYEE BENEFIT PLAN PROVIDES REIMBURSEMENT FOR MEDICAL SERVICES PROVIDED TO THE PARTICIPANT THAT ARE DETERMINED TO BE COVERED UNDER THE PLAN. THE EMPLOYEE BENEFIT PLAN AND ITS CONTRACTORS DO NOT DETERMINE WHAT MEDICAL SERVICES WILL BE PROVIDED TO THE PARTICIPANT. THE PARTICIPANT MUST MAKE THE DETERMINATION OF THE MEDICAL SERVICES HE OR SHE WISHES TO RECEIVE IN CONSULTATION WITH HIS OR HER PROVIDER, AND THE PARTICIPANT WILL BE FINANCIALLY RESPONSIBLE FOR MEDICAL SERVICES NOT COVERED BY THE PLAN.

**THIS IS NOT A BILL** (5)



### COORDINATION OF BENEFITS

Please complete the information below. If you have any questions regarding this form, please contact CIGNA Customer Service at the number on the participant's medical card.

Your policy contains a "coordination of benefits" provision that allows CIGNA to share responsibility in covering health care expenses with any other company covering you or your family for medical benefits. When health care expenses are shared between two or more companies, out-of-pocket expenses for the participant may be reduced. In addition to benefiting the individual member, coordination of benefits is beneficial to all participants because it avoids duplication of payments that would result in higher premium rates.

- 1. Employee \_\_\_\_\_ Date of Birth \_\_\_\_\_
- 2. Employer Name \_\_\_\_\_ Account Name \_\_\_\_\_
- 3. Social Security Number \_\_\_\_\_
- 4. Patient Name \_\_\_\_\_ Participant Date of Birth \_\_\_\_\_
- 5. Patient Address \_\_\_\_\_

If married complete the following:

Name of spouse of employee \_\_\_\_\_ Date of Birth \_\_\_\_\_

Spouse's employer & address \_\_\_\_\_

Is spouse covered under his/her employer's health plan? Yes \_\_\_ No \_\_\_

If yes, please complete the following:

Employer's health plan name \_\_\_\_\_

Address for submitting claims \_\_\_\_\_

Policy # \_\_\_\_\_ Effective Date \_\_\_\_\_

Single Coverage \_\_\_\_\_ Family Coverage \_\_\_\_\_

If family coverage, list all covered members \_\_\_\_\_

If you are divorced and/or remarried with dependents, please complete the following:

Dependents	Person with Physical Custody	Relationship	Person Responsible for Dependent Health care Expenses per Divorce Decree
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If you or your family members are covered under any other medical/dental plan in addition to the coverage listed above (i.e., Medicare or Medicaid, other insurance), please complete the following section. (This does not include the employee's current insurance plan.)

Health Plan Name	Name of Person Covered	Policy Number	Effective Date
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**I certify the above information is true and correct. I understand that the purpose of this information is to assure appropriate coordination of benefits of all plans.**

\_\_\_\_\_  
Participant Signature

\_\_\_\_\_  
Date

CIGNA  
PO Box 46270  
Eden Prairie, MN 55344-6270