ACCIDENT CLAIM FORM

Instructions

This form is for accidental injury benefits. Your claim will be subject to delay or return if these instructions are not followed. Insured should complete pages one and two. The treating physician should complete page three. If you need additional space, please attach an additional sheet with the same information as the form and policy number.

How to submit your claim:

Fax your claim paperwork to **877.826.6237**, or mail to **PO Box 5700, Scranton, PA 18505**.

Questions?

Call Customer Service at **866.459.4272** (Monday – Friday, 8 a.m – 8 p.m. ET), or email the Health & Life Claims Department at **CSBHealthClaims@Cigna.com**.

Patient/policyholder information

1. Policyholder name (first, middle, last)	2. Policy/contract number	3. Daytime telephone number	
4. Patient name (first, middle, last)	5. Patient date of birth	6. Patient gender ☐ Female ☐ Male	7. Patient social security number
8. Patient mailing address (street, city, state, and zip code)		9. Please include a written request to have your name or address updated.	9a. Address change ☐ Yes 9b. Name change ☐ Yes

10. Does the patient have Medicaid or other insurance coverage such as Workman's Compensation Insurance, employer sponsored health insurance, or any other third party insurance coverage ?	10a. ☐ Yes 10b. ☐ No	If yes, provide insurance information (insurance name/policy#/phone#):

Benefit information

11. Location of Treatment ☐ Hospital ☐ Urgent Care ☐ Emergency Room ☐ Family Physician	12. Vehicular Accident? ☐ Yes ☐ No Were you the ☐ driver or ☐ passenger?
13. Are there other filed claims/reports specific to this injury including: certified reports filed with law enforcement, Worker's Comp Insurance claims, claims filed against other insurance coverages or entities?	13 a. ☐ Yes If Yes, please attach claims/reports. 13 b. ☐ No

Certification

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. Please refer to "Fraud Warning Notices" insert for your state. I CERTIFY THAT THE INFORMATION HEREIN IS TRUE AND CORRECT.

Patient signature (or policy owner if the patient is a minor)	Date of signature

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Patient name	Policy number

Please describe in detail how the accident happened.

Please describe in detail where the accident happened (city, state, location).

Please describe in detail the injuries sustained in accident; include date symptoms first appeared.

Please provide name and phone numbers of all witnesses.

Date and time of accident	Date first treated for this accident

List any hospitals, clinics or physicians that treated the patient for this injury.

Name	Complete address	Phone number	Date first treated

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Physician's statement - please answer each question completely and attach an itemized bill for all accident related treatment

Patient's name			Policy number	Date of birth

Date of service	Procedure code	Procedure description	Place of service

1. Was this due to an accident? ☐ Yes ☐ No	2. Please provide your diagnosis (code and description).

3. Please give a full description of the injury and how it occurred.

4. On what date did the accident occur?	5. On what date did the patient first consult you for this injury?	6. Date last treated

7. Was the patient treated by other physicians for the injury? If so, please list names and addresses if known.

Name	Address

8. If surgery was performed, please indicate the type of surgery performed and the date.	9. Please list the name and address of the hospital where the surgery was performed.

10. Please outline the treatment plan that was recommended and prescribed.

11. Remarks

Physician's name (please print)	Signature		Date

Fax number	Telephone number	Tax id#	

Street address	City	State	Zip code