HEALTHCARE CLAIM FORM

Name of member		Date of birth	
Name of patient		Date of birth	
Cigna ID number		Team name	
Claim form expiry date			

Please forward all original relevant accounts upon receipt and clearly indicate all the accounts you have paid to ensure reimbursement. The appropriate provider will be paid unless you advise us you have paid the accounts.

SECTION ONE. To be completed by the patient

This claim may be rejected if you have not consulted a GP.

Name of referring General Practitioner		**Name of attending specialist**	
Address		Address	
Postcode		Postcode	
Date of referral by your GP		Tel. no.	

Was or is the treatment required as a result of an accident? (please supply all appropriate information, e.g. solicitor/third party/motor insurance details on a separate sheet).	Yes		No	
Have you any other insurance which covers medical expenses (e.g. other private medical insurance, travel insurance, motor insurance or credit card cover)?	Yes		No	

SECTION TWO. Important - Access to Medical Reports Act 1988. Your rights under this act.

Before your doctor can complete Section 5 which is a requirement of this claim, you must give your consent. Before giving your consent you should be aware of your rights under the Act, which are summarised as follows:

1. You may withhold your consent.
2. You may see the report before it is sent to us within 21 days from the date of the report.
3. You may ask to see the report for up to six months after the report is completed.
4. You may ask the doctor to amend any part of the report, which you consider to be incorrect or misleading. If the doctor does not agree with your request, you may attach your comments to the report.

NB: The doctor may withhold all or part of the report from you if he considers that you may be physically or mentally harmed by it.

Patient's declaration

Having been made aware of my statutory rights under the Access to Medical Reports Act 1988 in connection with my claim:

1. I hereby consent to Cigna seeking a medical report from my specialist or general practitioner as to the history and nature of the condition or its treatment. This consent only applies to the condition for which I am making a claim.
2. I DO/DO NOT* wish to see the report before it is sent to Cigna (*delete as required).
3. I authorise the doctor to disclose such information to Cigna.

Signature of patient (or parent/ guardian if under 18)		Date	

Data Protection Act 1998 - Under the Data Protection Act 1998, we draw your attention to the following; Cigna European Services (UK) Limited is your Data Controller - your personal data is used by us to process your claim. The data may include sensitive data which covers medical information. The above signature indicates your acceptance to allow us to process your claim as it may contain information of a sensitive nature (which includes medical information). **Full details of your rights under these acts are available from Cigna on written request.**

SECTION THREE

I hereby declare that the statements on this form are true and accurate.

Signature of patient (or parent/guardian if under 18)		Date	

Please ask your specialist to complete the reverse of this form.

SECTION FOUR. To be completed only if claiming the NHS Cash Benefit.

This section must only be completed by the hospital following free inpatient treatment in an NHS ward for each overnight stay, which must commence before midnight, or please attach the hospital discharge notice.

This is to certify that (patient's name)				
Patient was admitted to a hospital ward on:	Date:		Time	
Patient was discharged on: (or transferred to private/alternative facilities)	Date:		Time	
Suffering from				
Signed		Position		

Please authenticate with official hospital stamp over signature.

Hospital Contact Telephone Number	

SECTION FIVE. To be completed in block capitals by the attending specialist or referring GP.

N.B. Any charge made for the completion of this form is not recoverable under the policy.

Please give the date when the patient first became aware of this condition	
Patient referred to you or by you?	

Please describe the patient's present medical state

	ICD9 code	

Diagnosis - Please describe whether this condition is acute/chronic. Please give evidence to support this opinion.

	ICD9 code	

Please outline proposed investigations/treatment plan

DECLARATION

I confirm I am the patient's GP/Specialist (delete where appropriate)

Signed		Date	
Please print name			

Please return your completed claim form to :
Cigna HealthCare Benefits, 1 Knowe Road, Greenock, Scotland PA15 4RJ

Confidential, unpublished property of Cigna. Do not duplicate or distribute. Use and distribution limited solely to authorised personnel.
Copyright © Cigna 2015. All rights reserved.

Cigna HealthCare Benefits is a trading name. The following companies are part of that group: Cigna Life Insurance Company of Europe S.A.-N.V. - UK Branch, Chancery House, 1st Floor, St Nicholas Way, Sutton, Surrey SM1 1JB - registered in Belgium with limited liability (Brussels trade register no. 0421 437 284), Avenue de Cortenbergh 52, 1000 Brussels, Belgium, authorised by the National Bank of Belgium and subject to limited regulation by the Financial Conduct Authority and Prudential Regulation Authority. Details about the extent of our regulation by the Financial Conduct Authority and Prudential Regulation Authority are available from us on request. Cigna European Services (UK) Limited, registered in England (UK Company no. 199739), Chancery House, 1st Floor, St Nicholas Way, Sutton, Surrey SM1 1JB. VAT Registration No. 740445451