



**Federal Health Plan**

ESTABLISHED 1948

**Mail SAMBA Claims To:**  
**CIGNA**  
 P. O. Box 188007  
 Chattanooga, TN 37422  
 (301) 984-1440 • (800) 638-6589

**HEALTH INSURANCE CLAIM FORM**

Instructions are shown on reverse side.

1. MEDICARE <input type="checkbox"/> (Medicare #)            MEDICAID <input type="checkbox"/> (Medicaid #)            CHAMPUS <input type="checkbox"/> (Sponsor's SSN)            CHAMPVA <input type="checkbox"/> (VA File #)            GROUP HEALTH PLAN <input checked="" type="checkbox"/> (SSN or ID)            FECA BLK LUNG <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"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)					
5. PATIENT'S ADDRESS (No., Street)  CITY _____ STATE _____				6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)  CITY _____ STATE _____					
ZIP CODE _____		TELEPHONE (Include Area Code) (    ) _____		8. PATIENT STATUS  Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>		ZIP CODE _____		TELEPHONE (Include Area Code) (    ) _____			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				10. IS PATIENT'S CONDITION RELATED TO:		11. INSURED'S POLICY GROUP NUMBER					
a. OTHER INSURED'S POLICY OR GROUP NUMBER				a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO		a. INSURED'S DATE OF BIRTH MM DD YY    SEX M <input type="checkbox"/> F <input type="checkbox"/>					
b. OTHER INSURED'S DATE OF BIRTH MM DD YY    SEX M <input type="checkbox"/> F <input type="checkbox"/>				b. AUTO ACCIDENT? PLACE (State) _____ <input type="checkbox"/> YES <input type="checkbox"/> NO		b. EMPLOYER'S NAME					
c. EMPLOYER'S NAME				c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		c. INSURANCE PLAN NAME OR PROGRAM NAME					
d. INSURANCE PLAN NAME OR PROGRAM NAME				10d. RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO    If yes, return to and complete item 9 a-d					
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim.  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		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY					
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE				17a. _____ 17b. NPI# _____		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY					
19. RESERVED FOR LOCAL USE						20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO    \$CHARGES _____					
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1,2,3 or 4 to Item 24E by Line)						22. MEDICAID RESUBMISSION CODE _____ ORIGINAL REF. NO. _____					
1. _____    3. _____ 2. _____    4. _____						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. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID.#
									NPI #		
									NPI #		
									NPI #		
									NPI #		
									NPI #		
									NPI #		
									NPI #		
									NPI #		
									NPI #		
25. FEDERAL TAX I.D. NUMBER _____		SSN EIN <input type="checkbox"/> <input type="checkbox"/>		26. PATIENT'S ACCOUNT NO. _____		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		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  b. _____				33. BILLING PROVIDER INFORMATION & PHONE #  b. _____			

PLEASE PRINT OR TYPE

# HEALTH INSURANCE CLAIM FORM INSTRUCTIONS

## TO THE INSURED:

1. Complete items (1) through (13).
2. Attach itemized bills to the Claim Form. You do not need to have the provider of service complete the claim form if you attach fully itemized bills and/or receipts. Bills and receipts must show:
  - Name of patient and relationship to member
  - Plan identification number of the member
  - Name and address of physician or supplier providing the service or supply
  - Date service or supply was furnished
  - Type of service or supply and the charge
  - Diagnosis

## In addition:

- A copy of the Explanation of Benefits from any primary payer (such as Medicare) must be sent with your claim.
- Claims for rental or purchase of durable medical equipment, private duty nursing and physical, occupation and speech therapy require a written statement from the doctor specifying the medical necessity for the service or supply and the length of time needed.
- Claims for overseas (foreign) services should include an English translation. Charges should be converted to U.S. dollars using the exchange rate applicable at the time the expense was incurred.

Cancelled checks, cash register receipts or balance due statements are not acceptable.

## TO THE PHYSICIAN OR SUPPLIER:

1. The physician or supplier must complete items (14) through (33).

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### (Partial List)

#### PLACE OF SERVICE CODES:

11 - Office	41 - Ambulance-Land
12 - Home	42 - Ambulance-Air, Water
21 - Inpatient Hospital	51 - Inpatient Psychiatric Facility
22 - Outpatient Hospital	52 - Psychiatric Partial Hospitalization
23 - Emergency Room Hospital	55 - Substance Abuse Treatment Center
24 - Ambulatory Surgery Center	56 - Psychiatric Treatment Center
31 - Skilled Nursing Home	61 - Inpatient Rehabilitation Facility
32 - Nursing Facility	62 - Outpatient Rehabilitation Facility
33 - Custodial Care Facility	81 - Independent Lab
34 - Hospice	99 - Other

#### TYPE OF SERVICE CODES:

1 - Medical Care
2 - Surgery
3 - Consultation
4 - Diagnostic X-Ray
5 - Diagnostic Lab
6 - Radiation/Chemotherapy
7 - Anesthesia
8 - Assistant Surgery
F - ASC Facility Charge
T - Psychological Therapy