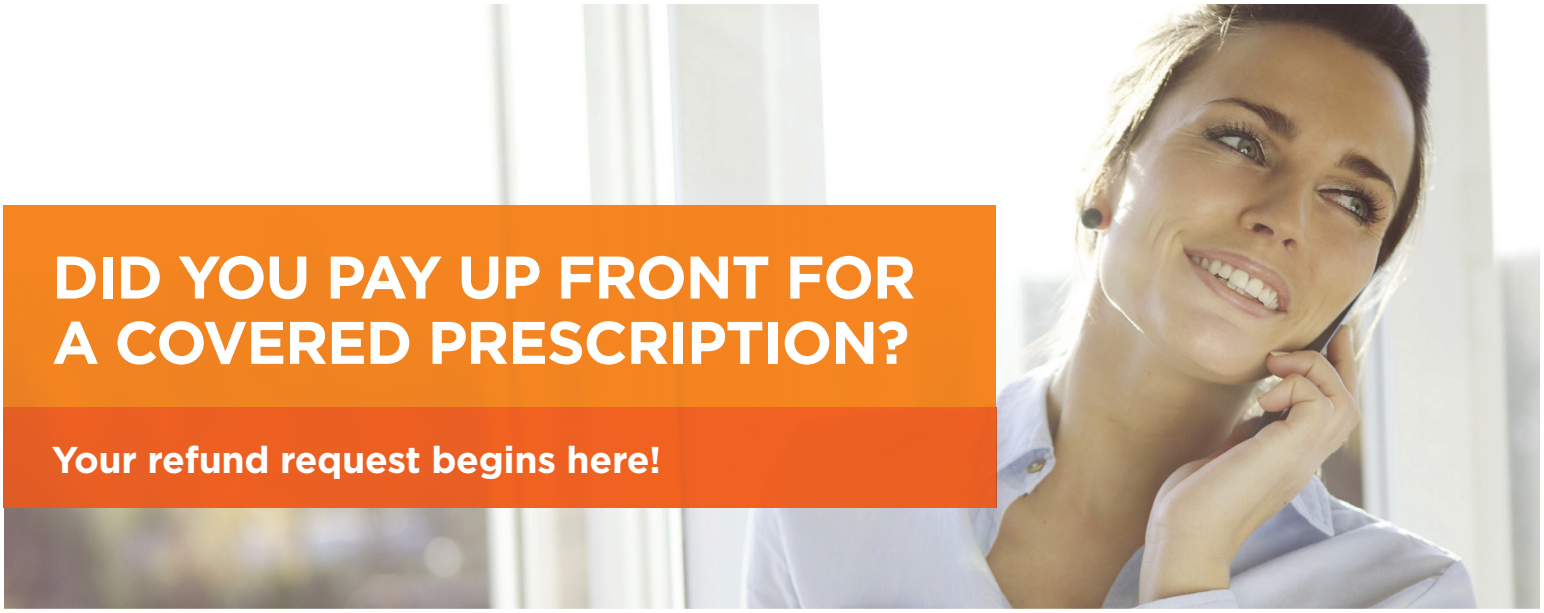


DID YOU PAY UP FRONT FOR A COVERED PRESCRIPTION?

Your refund request begins here!

Requirements

This type of payment request (a personal drug claim) cannot be processed without the following items.

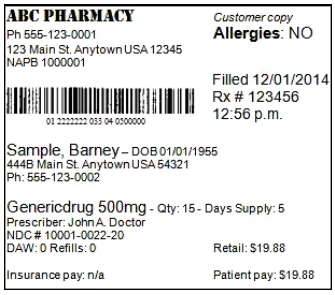
1. Your Cigna ID number
2. Your Cigna Group number
3. Detailed pharmacy-generated label receipts

Claims missing information may be denied or delayed.

Submitting receipts

For all prescriptions, label receipts must display:

1. Patient's name
2. Fill date
3. Drug name and strength
4. 11-digit National Drug Code (NDC)
5. Quantity received and day supply
6. Pharmacy name and address
7. Pharmacy identifier (NABP or NPI #)
8. Prescriber's name
9. Cost of each medication (shown as paid in full)



ABC PHARMACY
Ph 555-123-0001
123 Main St. Anytown USA 12345
NAPB 1000001

Customer copy
Allergies: NO

Filled 12/01/2014
Rx # 123456
12:56 p.m.

Sample, Barney – DOB 01/01/1955
444B Main St. Anytown USA 54321
Ph: 555-123-0002

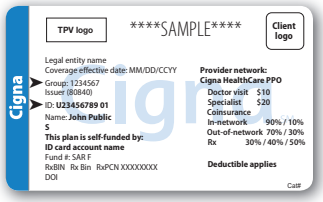
Genericdrug 500mg - Qty: 15 - Days Supply: 5
Prescriber: John A. Doctor
NDC # 10001-0022-20
DAW: 0 Refills: 0
Retail: $19.88

Insurance pay: n/a
Patient pay: $19.88

Using the claim form

For a TIMELY response to your prescription refund:

- Use a Prescription Drug Claim Form, which has been designed for Cigna drug plans.
- Submit a separate form for each family member.
- Clearly write your Cigna ID number and the plan's group number on the claim form.
- Be sure that you are referencing your Cigna ID card (see example above).



TPV logo
****SAMPLE****
Client logo
Cigna
Legal entity name
Coverage effective date: MM/DD/CCYY
Group: 1234567
Issuer: (80840)
ID: U23456789 01
Name: John Public
S
This plan is self-funded by:
ID card account name
Fund #: SAR F
RxBIN Rx Bin RxPCN XXXXXXXX
DOI
Provider network:
Cigna HealthCare PPO
Doctor visit $10
Specialist $20
Coinsurance
In-network 90% / 10%
Out-of-network 70% / 30%
Rx 30% / 40% / 50%
Deductible applies
Cat#

Did you fill a compound prescription?

If you filled a compound prescription out-of-network:

- The compound receipt must show details for each prescription ingredient.
  - Example: Your compound product was made using three ingredients. The receipt should list ALL three ingredients in detail.
- If the compound prescription receipt does not itemize each prescription ingredient, we will not be able to process your request.
- A Universal Claim Form for a Compounded Medication can be accepted in place of a Cigna claim form.

Important: Customers who send paper claims for In-network compound purchases may receive a lower refund. Compounds should be billed by the pharmacy, and paper claims are not necessary.

Together, all the way.℠

Cigna®

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Prescription Drug Claim Form

Insured and/or Administered by
Connecticut General Life Insurance Company
Cigna Health and Life Insurance Company
Cigna HealthCare*

Cigna

REASON FOR REIMBURSEMENT

This claim form can be used to request reimbursement for covered expenses. Please check which reason applies *(at least one must be checked):*

- ☐ Emergency
- ☐ Primary coverage is with another insurance carrier. Please provide explanation of benefits (EOB) or denial letter from the primary insurance carrier.
- ☐ Eligibility *(Please explain)*
- ☐ Non-Participating Pharmacy
- ☐ Out-of-Network Compound Prescription (*Pharmacist:* Claims must list ALL ingredients along with itemized NDCs, quantities and charges.)
- ☐ Other *(Please explain)*

PARTICIPANT/PATIENT INFORMATION

Participant Name:	Employer:
Cigna ID Number or Participant Social Security Number: (*on the front of your Cigna ID card)*	Account Number: *(on the front of your Cigna ID card)*
Patient Name *(use a separate form for each family member)*:	Patient Birth Date: *(Mo., Day, Year)*
Patient Relationship to Participant: ☐ Self (Participant) ☐ Spouse ☐ Dependent	Patient Sex: ☐ Male ☐ Female

I represent that the patient information entered on this form is correct, that the patient named is eligible for the benefits and that the patient has received the medication described. I also represent that the medication received is not for treatment of an on-the-job injury. I also authorize release of all information pertaining to this claim to the plan administrator or its designees.

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 which is a crime. For residents in the following states, please see the last page of this form: Alaska, Arizona, California, Colorado, District of Columbia, Florida, Kentucky, Maryland, Minnesota, New Jersey, New York, Oregon, Pennsylvania, Tennessee, Texas and Virginia.

Patient Signature:	Date:	Daytime Phone Number:

PRESCRIPTION INFORMATION

For Health Care Reform related Over-the-Counter reimbursement requests, include your Doctor's prescription.

1)

_____/_____/_____ _____ _____ _____
DATE FILLED RX NUMBER QTY DAY SUPPLY

_____ _ _ _ _ _ _ _ _ _ _ $_____
DRUG NAME & STRENGTH NDC AMT. PAID

_____ _ _ _ _ _ _ _
PHARMACY NAME PHARMACY NABP

_____
PHARMACY ADDRESS

2)

_____/_____/_____ _____ _____ _____
DATE FILLED RX NUMBER QTY DAY SUPPLY

_____ _ _ _ _ _ _ _ _ _ _ $_____
DRUG NAME & STRENGTH NDC AMT. PAID

_____ _ _ _ _ _ _ _
PHARMACY NAME PHARMACY NABP

_____
PHARMACY ADDRESS

Multi-Ingredient Compound Prescription Information - To be Completed by Dispensing Pharmacy.

Pharmacist: If an itemized compound drug receipt is not available, please use this form to list the ingredients.
1. Use one form for each multi-ingredient compound prescription. Copy the form as needed.
2. The patient should send receipt(s) showing the out-of-pocket cost, and the Prescriber's name and DEA #.
3. SIGN the receipt.

The information below is required to process multi-ingredient claim submissions. For each NDC number, indicate the "metric quantity" expressed in the number of tablets, grams, milliliters, injectables, etc. and the cost.

	Quantity	Valid NDC	Drug Name	Customer's Charge
1				
2				
3				
4				
5				

This Prescription Drug Claim Form is for Cigna customer use only.

Did you know?

We may be able to reimburse you for any prescriptions you paid for directly and didn't use your insurance to cover. For instance, if you used a non-participating pharmacy, and your plan covers out-of-network purchases, file a claim. We'll review it and look to see if we can get you a possible refund.

This form is not used for:

- Prescribed medical equipment (or supplies) - Ask your medical plan about benefits for equipment.
- FSA and HRA expenses - Contact your FSA (or HRA) payer for a claim address and instructions.
- Prescriptions purchased by customers not enrolled with a Cigna drug plan - Check your benefit materials to see if your employer chose a Pharmacy Benefits Company *other than* Cigna.
- Non-covered drugs - See the "Exclusions and limitations" section of your plan's drug list.

INSTRUCTIONS

1. Complete ALL information on the front side of this form. Forms missing information may be denied, delayed or returned. If you need help completing this form, contact your pharmacist.
2. Sign and date the Certification Statement in the area provided. Keep a copy of all forms and receipts for your records.
3. The Prescription Information section must be completed for each prescription for which you are seeking payment.
4. For Health Care Reform related over-the-counter payment requests, include your Doctor's prescription. Please keep a copy of the prescription for your records.
5. Submit a separate form for each family member.
6. Mail the claim form within 12 months of the prescription fill date, along with original receipts (cash register receipts alone are not acceptable), to: Cigna Pharmacy Service Center
   P.O. Box 188053
   Chattanooga, TN 37422-8053
7. Questions? Please call the Cigna number located on your ID card.

Fold

Fold

RETURN ADDRESS

IMPORTANT: PLEASE PROVIDE CURRENT ADDRESS INFORMATION BELOW:

_____ **CUSTOMER NAME**

_____ **CUSTOMER STREET ADDRESS**

_____ **CUSTOMER CITY, STATE, ZIP**

Click Here to Print | Clear Fields

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.

IMPORTANT CLAIM NOTICE

Alaska Residents: A person who knowingly and with intent to injure, defraud or deceive an insurance company or files a claim containing false, incomplete or misleading information may be prosecuted under state law.

Arizona Residents: For your protection, Arizona law requires the following statement to appear on/with this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

California Residents: For your protection, California law requires the following to appear on/with this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado Residents: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

District of Columbia Residents: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Kentucky Residents: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maryland Residents: Any person who knowingly OR willfully presents false or fraudulent claim for payment of a loss or benefit or who knowingly OR willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Minnesota Residents: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Jersey Residents: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

New York Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed $5000 and the stated value of the claim for each such violation.

Oregon Residents: 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, may have committed a fraudulent insurance act.

Pennsylvania Residents: Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Rhode Island Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Tennessee Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Texas Residents: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Virginia Residents: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

*"Cigna HealthCare" refers to the various HMO subsidiaries of Cigna Health Corporation. If you are enrolled in a Cigna HMO plan, complete details can be found in your plan documents or Evidence of Coverage.

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583522k Rev. 01/2017

DISCRIMINATION IS AGAINST THE LAW

Medical coverage

Cigna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Cigna does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Cigna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact customer service at the toll-free number shown on your ID card, and ask a Customer Service Associate for assistance.

If you believe that Cigna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by sending an email to ACAGrievance@Cigna.com or by writing to the following address:

Cigna
Nondiscrimination Complaint Coordinator
PO Box 188016
Chattanooga, TN 37422

If you need assistance filing a written grievance, please call the number on the back of your ID card or send an email to ACAGrievance@Cigna.com. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
1.800.368.1019, 800.537.7697 (TDD)
Complaint forms are available at
http://www.hhs.gov/ocr/office/file/index.html.

Cigna®

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Proficiency of Language Assistance Services

English – ATTENTION: Language assistance services, free of charge, are available to you. For current Cigna customers, call the number on the back of your ID card. Otherwise, call 1.800.244.6224 (TTY: Dial 711).

Spanish – ATENCIÓN: Hay servicios de asistencia de idiomas, sin cargo, a su disposición. Si es un cliente actual de Cigna, llame al número que figura en el reverso de su tarjeta de identificación. Si no lo es, llame al 1.800.244.6224 (los usuarios de TTY deben llamar al 711).

Chinese – 注意：我們可為您免費提供語言協助服務。對於 Cigna 的現有客戶，請致電您的 ID 卡背面的號碼。其他客戶請致電 1.800.244.6224 （聽障專線：請撥 711）。

Vietnamese – XIN LƯU Ý: Quý vị được cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Dành cho khách hàng hiện tại của Cigna, vui lòng gọi số ở mặt sau thẻ Hội viên. Các trường hợp khác xin gọi số 1.800.244.6224 (TTY: Quay số 711).

Korean – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 현재 Cigna 가입자님들께서는 ID 카드 뒷면에 있는 전화번호로 연락해주십시오. 기타 다른 경우에는 1.800.244.6224 (TTY: 다이얼 711)번으로 전화해주십시오.

Tagalog – PAUNAWA: Makakakuha ka ng mga serbisyo sa tulong sa wika nang libre. Para sa mga kasalukuyang customer ng Cigna, tawagan ang numero sa likuran ng iyong ID card. O kaya, tumawag sa 1.800.244.6224 (TTY: I-dial ang 711).

Russian – ВНИМАНИЕ: вам могут предоставить бесплатные услуги перевода. Если вы уже участвуете в плане Cigna, позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки участника плана. Если вы не являетесь участником одного из наших планов, позвоните по номеру 1.800.244.6224 (TTY: 711).

Arabic – برجاء الانتباه خدمات الترجمة المجانية متاحة لكم. لعملاء Cigna الحاليين برجاء الاتصال بالرقم المدون علي ظهر بطاقتكم الشخصية. او اتصل ب 1.800.244.6224 (TTY: اتصل ب 711).

French Creole – ATANSYON: Gen sèvis èd nan lang ki disponib gratis pou ou. Pou kliyan Cigna yo, rele nimewo ki dèyè kat ID ou. Sinon, rele nimewo 1.800.244.6224 (TTY: Rele 711).

French – ATTENTION: Des services d'aide linguistique vous sont proposés gratuitement. Si vous êtes un client actuel de Cigna, veuillez appeler le numéro indiqué au verso de votre carte d'identité. Sinon, veuillez appeler le numéro 1.800.244.6224 (ATS : composez le numéro 711).

Portuguese – ATENÇÃO: Tem ao seu dispor serviços de assistência linguística, totalmente gratuitos. Para clientes Cigna atuais, ligue para o número que se encontra no verso do seu cartão de identificação. Caso contrário, ligue para 1.800.244.6224 (Dispositivos TTY: marque 711).

Polish – UWAGA: w celu skorzystania z dostępnej, bezpłatnej pomocy językowej, obecni klienci firmy Cigna mogą dzwonić pod numer podany na odwrocie karty identyfikacyjnej. Wszystkie inne osoby prosimy o skorzystanie z numeru 1 800 244 6224 (TTY: wybierz 711).

Japanese – 注意事項：日本語を話される場合、無料の言語支援サービスをご利用いただけます。現在のCignaのお客様は、IDカード裏面の電話番号まで、お電話にてご連絡ください。その他の方は、1.800.244.6224（TTY: 711）まで、お電話にてご連絡ください。

Italian – ATTENZIONE: Sono disponibili servizi di assistenza linguistica gratuiti. Per i clienti Cigna attuali, chiamare il numero sul retro della tessera di identificazione. In caso contrario, chiamare il numero 1.800.244.6224 (utenti TTY: chiamare il numero 711).

German – ACHTUNG: Die Leistungen der Sprachunterstützung stehen Ihnen kostenlos zur Verfügung. Wenn Sie gegenwärtiger Cigna-Kunde sind, rufen Sie bitte die Nummer auf der Rückseite Ihrer Krankenversicherungskarte an. Andernfalls rufen Sie 1.800.244.6224 an (TTY: Wählen Sie 711).

Persian (Farsi) – توجه: خدمات کمک زبانی، به صورت رایگان به شما ارائه می‌شود. برای مشتریان فعلی Cigna، لطفاً با شماره‌ای که در پشت کارت شناسایی شماست تماس بگیرید. در غیر اینصورت با شماره 1.800.244.6224 تماس بگیرید (شماره تلفن ویژه ناشنوایان: شماره 711 را شماره‌گیری کنید).

896375a 05/17