



CIGNA Behavioral Health

Mail to:
CIGNA Behavioral Health
Post Office Box 46790
Eden Prairie, MN 55344

EAP/STC Claim Form
1a. INSURED'S I.D. NUMBER
2. PATIENT'S NAME
3. PATIENT'S BIRTH DATE
4. INSURED'S NAME
5. PATIENT'S ADDRESS
6. PATIENT RELATIONSHIP TO INSURED
7. INSURED'S ADDRESS
8. PATIENT STATUS
9. OTHER INSURED'S NAME
10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE
14. DATE OF CURRENT ILLNESS OR INJURY
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
19. RESERVED FOR LOCAL USE
20. OUTSIDE LAB?
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY
22. MEDICAID RESUBMISSION
23. PRIOR AUTHORIZATION NUMBER
24. A. DATE(S) OF SERVICE, B. PLACE OF SERVICE, C. EMG, D. PROCEDURES, SERVICES, OR SUPPLIES, E. DIAGNOSIS POINTER, F. \$ CHARGES, G. DAYS OR UNITS, H. EPSDT Family Plan, I. ID. QUAL, J. RENDERING PROVIDER ID. #
25. FEDERAL TAX I.D. NUMBER
26. PATIENT'S ACCOUNT NO.
27. ACCEPT ASSIGNMENT?
28. TOTAL CHARGE
29. AMOUNT PAID
30. BALANCE DUE
31. SIGNATURE OF PHYSICIAN OR SUPPLIER
32. SERVICE FACILITY LOCATION INFORMATION
33. BILLING PROVIDER INFO & PH #

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION