REIMBURSEMENT CLAIM FORM

STEP 1: Collect the right documents

DOCUMENTS CHECKLIST:

Must have
- > Invoices
- > Payment receipts/ proof of payment
- > Diagnosis

If applicable
- > Medical Report
- > Prescription
- > Breakdown of treatment (i.e. x-rays, scan, laboratory test, physiotherapy, etc.)
- > Discharge summary for inpatient cases (hospital stays)

The document scans and images should be clear and legible.

STEP 2: Submit your claim reimbursement request

FAST TRACK - SUBMIT VIA MOBILE APP OR WEBSITE

> Scan or take photo of the applicable documents as per checklist

> Send to www.CignaEnvoy.com or submit via our mobile app CIGNA ENVOY

OR, SEND BY EMAIL

1. Fill the claims reimbursement form for each patient.
2. Scan the claims reimbursement form, and the applicable documents from the table above.
3. Email the document scanned to IceMe@Cigna.com

Few final notes to consider

> Claim should be submitted no later than 12 months following treatment.

> For status on your reimbursement claim - follow up on www.cignaenvoy.com or via the Cigna Envoy mobile App

Contact Information

UAE:	800 1 CIGNA (800 1 24462)
Oman:	800 74256
Bahrain:	800 11309
Kuwait:	+965 22069101
Qatar:	00800 100398
KSA:	+966 920009150
International helpline:	+44 (0) 1475 788618
Customer Service Email:	IceME@Cigna.com
Online claims:	www.CignaEnvoy.com

1. PATIENT INFORMATION (All fields are mandatory)

Patient Cigna ID #:	Patient's Full Name:	
Employee's full name (If different from Patient):		
Patient's Address:		
Patient's relationship to employee:	e-Mail:	
☐ Male ☐ Female	Mobile #: _____ (Country code - Mobile code - Number)	Date of Birth: _____ (DD/ MM / YYYY)

2. MEDICAL INFORMATION

Type of Visit: ☐ Outpatient ☐ Inpatient ☐ Dental ☐ Vision ☐ Maternity

Details of trauma (if applicable): ☐ Work related ☐ Road Traffic Accident related - include a police report ☐ Sports related, if yes: ☐ Professional ☐ Non-professional

Treatment Date	Diagnosis (eg. headache, cold etc.)	Country of Treatment	Invoice Amount and Currency
		Total Amount	

Are you eligible for reimbursement for these expenses from another insurer: ☐ No ☐ Full ☐ Partial

If **Full** or **Partial** is selected above, please specify insurer name and amount settled:

3. CLAIMS PAYMENT DETAILS. (Select one of the method of Payment specified below)

A - ☐ I authorise Cigna to make ELECTRONIC TRANSFER payment against this Reimbursement Claim Form.

Beneficiary Name:		Bank Name	
Bank Address:		Bank Account No:	
If reimbursement currency is EURO, please supply both IBAN and SWIFT codes below If reimbursement currency is Dominican Peso or Moroccan Dirham, please supply tax ID		Account Type: ☐ Savings ☐ Checking / Current ☐ Other Specify payment currency:	
IBAN below:	Swift Code / BIC Code No:	Tax ID:	Routing Code:

Note: We recommend you to choose ELECTRONIC TRANSFER instead of cheque for faster settlement

B - ☐ I authorise Cigna to pay my reimbursement claims via cheque as per the provided details below.

Beneficiary Name:		Specify payment currency:
Building No./Name:	Street:	Town/City:
Area/Postal Code:	P.O. Box:	Country:

4. DECLARATION AND AUTHORISATION

I declare that the information entered above is complete and accurate and that the services described were received and paid for.

Representation and Consent: By signing this form you confirm that you have the authority to act on behalf of your dependants in respect of all personal information you provide to us, and that you consent to the disclosure, processing, usage and retention of this information in relation to yourself and on behalf of your dependants.

Data Protection

All personal data that You provide to Cigna directly or through authorised third parties (i.e. healthcare providers, brokers or someone else on your behalf) will be collected (or may be collected on behalf of) by the Cigna's company that provides the Insurance cover or the Services to you ("Services") as can be found in your member booklet or certificate of insurance. This company will be the data controller of the Personal information collected. Your Personal Information is collected and used in order to provide the Services you are entitled to. Please refer to the Data Protection Notice that has been provided to you for further details or how we handle and protect your Personal Information. For easy access our Data Protection Notice is always available to you in Cigna Envoy. You can be reassured that Cigna only collects and processes your Personal Information in order to provide our Services to you and comply with our obligations and only discloses personal Information with other parties if necessary for providing you with the Services.

Patient Declaration

I have been made aware of my rights and I hereby consent and authorise Cigna to obtain information from my healthcare providers, as it may be required to assess and process this claim, with regard to the condition for which I am submitting this claim. I authorise the involved healthcare providers to disclose the requested and needed information to Cigna.

Name and signature of patient _____
(Or Name and signature of the principal/legal guardian for patients below 18 years old)

Date: _____
(DD / MM / YYYY)

DENTAL TREATMENT (If applicable to be completed by Dental Practitioner)

PREVENTATIVE TREATMENT

Code Treatment	No. of Unit	Tooth Number	Date of Treatment	Charge to Patient
EXAMINATIONS				
A01 Normal				
A11 Extensive				
A21 Full Case Assessment				
X-RAYS				
B01 Bitewing				
B02 Intra Oral				
B03 O.P.G.				
SCALING AND POLISHING				
E01 One Visit				
MISCELLANEOUS TREATMENT				
D01 Fissure Sealants				
D11 Topical Fluoride Application				
M0U Occlusal Splint				
MINOR TREATMENT				
FILLINGS				
G01 Amalgam-One Surface				
G02 Amalgam-Two+Surfaces				
G03 Amalgam-Three+Surfaces				
G21 Composite Anterior-One Surface				
G22 Composite Anterior-Two+Surfaces				
ROOT CANAL TREATMENT				
H01 Upper & Lower Anterior (1 root)				
H02 Upper Premolar (2 roots)				
H03 Lower Premolar (1 root)				
H04 Molars (3 + roots)				
EXTRACTIONS				
L01 Single				
L02 Per additional tooth				
N11 Post-Operative Care				
D7140 Extraction (ERUPTED)				
D7210 Surgical removal (ERUPTED)				
D7220 Removal IMPACTED – Soft tissue				
D7230 Removal IMPACTED – Partially bony				
D7240 Removal IMPACTED – Completely bony				
D7241 Removal IMPACTED – Completely bony with surgical complications				

MAJOR TREATMENT

Code Treatment	No. of Unit	Tooth Number	Date of Treatment	Charge to Patient
PERIODONTAL TREATMENT (NON SURGICAL)				
E21 Prolonged (Curettage/Root Planing)				
F51 Splinting				
PERIODONTAL TREATMENT (SURGICAL)				
F01 Gingivectomy				
F11 Mucoperio, Flap Bone Surgery				
DENTURES - METAL/ACRYLIC				
R63 Additional Tooth				
R61 Addition of Clasp				
K71 Denture Repair				
CROWNS/BRIDGES				
J01 Veneers (per tooth)				
K32 Adhesive Bridges				
K41 Conventional Bridgework				
K12 Standard Post & Core				
K11 Gold Post & Core				
K07 Bonded Precious Crown				
K05 Bonded Non Precious Crown				
K08 Full Cast Crown				
K06 Full Porcelain Crown				
INLAYS				
K02 Precious				
K01 Non Precious				
K03 Porcelain				
Orthodontist (if applicable in the table of benefit)				
Other Treatment				
Total Amount and Currency				

_____
Dental practitioner Stamp and Signature