

Direct Member Reimbursement (DMR) Claim Form

See instructions at the end of the form.

This claim form is used to request reimbursement of covered expenses. Mark the box of the reason(s) below to tell us more about your request. Please note that the use of a claim form, such as this Direct Member Reimbursement Claim Form, is not required to receive a reimbursement.

See your *Evidence of Coverage* (EOC) for benefit guidelines and reimbursement allowable amounts.

REASON FOR REIMBURSEMENT		
 □ Did not use my medical ID card □ Went to a non-participating provider (Please provide details in the Explanation area.) □ Vision □ Hearing Aids □ Have primary coverage with another insurance carrier (Please include your Explanation of Benefits (EOB) or the denial letter from your primary insurance carrier.) □ Was waiting for a medical referral or approval □ Traveled out of the country 	□ Air Conditioner Allowance (Texas) □ Adult Daycare Allowance (New Jersey) □ Acupuncture Allowance (AL, CO, DE, GA, IL, NC, PA, TN) □ Other Explanation: □	
,		
CUSTOMER INFORMATION		
Customer ID number (on the front of your Medicare Advantage ID card):		
Customer name:	Customer sex: Male Female	
Customer birth date: MonthDay	_ Year Daytime phone:	
I am the: ☐ Customer ☐ Beneficiary Representative* *If you are filling this form out for someone other than yourself, please see instruction #6 at the end of the form for further steps.		
CUSTOMER CERTIFICATION		
I represent that the customer information entered on this form is correct, that the customer named is eligible for the benefits and that the customer has received the service described. I also represent that the treatment received is not for treatment of an on-the-job injury. Lalso 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.		
Customer signature:	Date:	
Beneficiary Representative(if applicable):	Date:	
MEDICAL CLAIM INFORMATION (Complete applicable information.)		
Date of service:	Amount requested: \$:	
Description of service:		
Provider's name:	Provider's phone:	
Provider's address:		
Provider's signature:		

INSTRUCTIONS

- 1. Complete <u>all</u> sections of this form, including your signature and date in the Customer Certification statement.
- 2. Submit a separate form for each request.
- 3. Include receipts or printed invoices that show a detailed list of the services received and amounts paid. Claims missing information may result in this request being denied.
- 4. If you do not have a detailed receipt for each service related to your request, you can ask your doctor or provider for a replacement receipt or a patient printout. The receipt must show proof of payment.
- 5. Include receipts for any prescriptions related to this request. Keep a copy of these receipts for your records.
- If you are submitting this request for someone other than yourself, please include the required Appointment of Representative (AOR), Power of Attorney or Executor of Estate form. The AOR form can be found at: cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms/Downloads/CMS1696.pdf
- Mail your request to: Cigna Medicare, Attn: Claims, P.O. Box 20002, Nashville, TN 37202-9640
- 8. If you need help completing this form, please call Customer Service at the number located on your ID card.

9.	Feel free to include any additional information here to help us better review your request:		

IMPORTANT REMINDERS

- 1. The DMR Claim Form <u>must</u> be submitted within one year of the date you received the specific service or benefit.
- 2. If your DMR Claim Form is incomplete, it will be returned to you and will cause delays in processing.
- 3. Once your request for reimbursement is approved, it can take up to 45 days for Cigna Medicare to send your reimbursement.

All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation, including Cigna Health and Life Insurance Company, Cigna HealthCare of South Carolina, Inc., Cigna HealthCare of North Carolina, Inc., Cigna HealthCare of Georgia, Inc., Cigna HealthCare of Arizona, Inc., Cigna HealthCare of St. Louis, Inc., HealthSpring Life & Health Insurance Company, Inc., HealthSpring of Florida, Inc., Bravo Health Mid-Atlantic, Inc., and Bravo Health Pennsylvania, Inc. The Cigna name, logos, and other Cigna marks are owned by Cigna Intellectual Property, Inc. Cigna-HealthSpring is contracted with Medicare for PDP plans, HMO and PPO plans in select states, and with select State Medicaid programs. Enrollment in Cigna-HealthSpring depends on contract renewal. © 2019 Cigna