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: Month _____Day_____ 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. 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.

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 all 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.
6. 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/Downloads/CMS1696.pdf
7. 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:

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IMPORTANT REMINDERS

1. The DMR Claim Form must 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.