Student Claim Form

1) Student Insurance Number: _____

2) Patient's Name:

_____ _____
Last Name **First Name**

3) Date of Birth: (Month/Day/Year)
_____/_____/_____

4) Relationship to Subscriber (Student)
Self ☐ **Spouse** ☐ **Child** ☐

5)

Student Name **Phone Number**

_____ _____

6) Provider/Facility Name, Address & Phone Number
Name: _____

Phone: _____

Address: _____

7) Date of Service: (Month/Day/Year)
_____/_____/_____

8) Service Description:

9) Student Signature: **Date:**

_____ _____

Please submit this form to CIGNA Health Care as soon as you or your dependents do any medical or/and dental services.

1. **<u>FOR MEDICAL SERVICES, THIS FORM SHOULD BE SENT TO</u>:**
   CIGNA HEALTH CARE
   P.O.BOX 2005
   FARMINGTON CT 06034

2. **<u>FOR DENTAL SERVICES, THIS FORM SHOULD BE SENT TO</u>**:
   CIGNA DENTAL
   P.O.BOX 15558
   WILMINGTON DE 19850