

Out-of-Network Reimbursement if not able to use In-Network Provider

Use this form to request reimbursement for your out-of-network claim using your in-network benefits. One of the following exceptions must apply:

Based from your home or work (office) location, you were unable to:

1. Locate an in-network provider within a reasonable distance, considering whether you live in an urban, suburban or rural area;
2. Schedule a visit with an in-network provider within 30 calendar days or as required by state law (e.g. within 15 days for Connecticut members); or
3. Access an in-network provider during a declared emergency in the state where you live.

If one of the three exceptions above applies to you, you may complete this form online.

By mail, you can print, complete and sign this claim form. The mailing address is:

Cigna Healthcare Claims Department
c/o First American Administrators, Inc.
Attn: OON Claims, P.O. Box 8504, Mason, OH 45040-7111

Caution, this option is not available when you choose to use an out-of-network provider due to:

1. Your preference;
2. When your personal schedule does not permit you to schedule an appointment with an available provider within 30 calendar days or as required by state law (e.g. within 15 days for Connecticut members); or
3. You are outside of your home or work (office) location for anything other than a declared emergency.

NOTE: Any person who submits a request or files a claim containing a false or deceptive statement, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, is guilty of insurance fraud.

CLAIM FORM 2: EXCEPTION REQUEST

Check only one reason that applies. If you fail to provide the requested information for your selection, you may not qualify for an exception to the requirement to use network providers:

I was unable to locate an in-network provider within a reasonable distance.
I live or work in the following zip code:

Zip Code

I believe my area is:

Urban

Suburban

Rural

OR -----

I was unable to schedule a visit with an in-network provider within 30 calendar days or as required by state law (e.g. within 15 days for Connecticut members). Please provide the in-network provider's name, address and phone number who could not provide an appointment within 30 calendar days or as required by state law:

Provider's Name

**Provider Telephone
Number (000) 000-0000**

Provider Street Address

City

State

Zip Code

OR -----

I was unable to find an in-network provider during a state of emergency impacting my area. Please provide the zip code of the emergency and approximate date the state of emergency was declared:

Zip Code

Month/Year of the Declared Emergency

CLAIM FORM 2: EXCEPTION REQUEST

Patient Last Name[†] **Patient First Name[†]** **MI**

Birth Date (MM/DD/YYYY)[†] **Street Address[†]**

City[†] **State[†]** **Zip Code[†]**

Patient Customer ID # **Relationship to Subscriber[†]**

Self Dependent

Subscriber Last Name[†] **Subscriber First Name[†]** **MI**

Birth Date (MM/DD/YYYY)[†] **Street Address[†]**

City[†] **State[†]** **Zip Code[†]**

Vision Plan Name **Date of Service[†] (MM/DD/YYYY)**

Cigna Healthcare

Vision Plan Group # **Subscriber Customer ID #**

Provider or Retailer where patient received services

Provider's Name[†] **Provider's NPI**

Provider Street Address[†]

City[†] **State[†]** **Zip Code[†]**

[†]Required

CLAIM FORM 2: EXCEPTION REQUEST

Request for Reimbursement

Enter Amount Charged.† Remember to include itemized paid receipts.†

Service Type	Amount Charged	Lens Type	Please Check	Lens Options: (if purchased)	Amount Charged
Exam *92014*	\$	Single *V2100*		Anti-Reflective *V2750*	\$ <input type="text"/>
Refraction *92015*	\$	Bifocal *V2200*		Polycarbonate *V2784*	\$ <input type="text"/>
Frame *V2025*	\$	Trifocal *V2300*		Scratch *V2760*	\$ <input type="text"/>
Contact Lens *S0500*	\$	Progressive *V2781*		Tint *V2745*	\$ <input type="text"/>
Contact Lens Fitting *92310*	\$	Prem Prog *V278126*		UV *V2755*	\$ <input type="text"/>
Lenses	\$	Other	\$	Roll and Polish *V2702*	\$ <input type="text"/>

Enter Total Amount Paid as shown on receipt, excluding sales tax† \$

I certify that I have read the [state fraud warnings](#). If I want a printed copy, I can contact the customer call center. I understand that I may be denied reimbursement if I am not eligible for out-of-network benefits or if I do not supply the requested information for the claim. I authorize any insurance company, organization employer, ophthalmologist, optometrist and optician to release any information with respect to this claim. I agree with all statements above and certify all of the information furnished on this form is true and correct.

Customer/Guardian/Patient Signature (not a minor)†

Date

†Required

Cigna Healthcare products and services are provided exclusively by or through operating subsidiaries of The Cigna Group, including Cigna Health and Life Insurance Company (Bloomfield, CT), or its affiliates. In Utah, offered/insured by Cigna Health and Life Insurance Company. The Cigna Healthcare name, logo, and other Cigna marks are owned by Cigna Intellectual Property, Inc.