

CIGNA Health Care Flexible Spending Account Reimbursement Request Form - HR

(See instructions on reverse side)



A. EMPLOYEE INFORMATION			
CIGNA IDENTIFICATION NUMBER OR SUBSCRIBER'S SOCIAL SECURITY NUMBER <i>(Required)</i>	EMPLOYER NAME <i>(Required)</i> Boyd Gaming/PERCS	ACCOUNT NUMBER(S) 3328095	
LAST NAME	FIRST NAME		
ADDRESS	CITY	STATE	ZIP/POSTAL CODE

B. HEALTH CARE EXPENSES			
PLEASE INDICATE IF YOU HAVE THE FOLLOWING TYPES OF COVERAGE:			
DENTAL COVERAGE?	<input type="checkbox"/>	YES*	<input type="checkbox"/>
			NO
MEDICAL COVERAGE?	<input type="checkbox"/>	YES*	<input type="checkbox"/>
			NO
VISION COVERAGE?	<input type="checkbox"/>	YES*	<input type="checkbox"/>
			NO
* IF YES, PLEASE BE SURE TO PROVIDE AN EXPLANATION OF BENEFITS (EOB) OR CO-PAYMENT RECEIPT.			
CIGNA will submit only items and amounts listed below. If this section is not completed, all qualified items on the submitted documentation will be processed including associated tax and shipping charges			

PATIENT NAME	PROVIDER NAME AND ADDRESS <i>(i.e., Doctor Name/Pharmacy Name)</i>	DATE(S) OF SERVICE	TYPE OF SERVICE	(A) TOTAL CHARGE	(B) AMOUNT PAID BY OTHER SOURCES <i>(i.e., Other Insurance, Medicare, etc.)</i>	(C) AMOUNT TO BE REIMBURSED (A - B = C)
Total Reimbursement Request:						\$

C. CERTIFICATION	
<p>I certify that the expenses for which I am requesting reimbursement meet all of the following conditions listed below:</p> <ul style="list-style-type: none"> They were incurred for services or supplies by me or my eligible dependents under the plan. They were for services or supplies furnished on or after the effective date of my employee spending account. I have not been, nor do I expect to be, reimbursed for these expenses in any other way. <p>I understand that reimbursement of these expenses should be requested and made only after I have collected all benefit payments available from all plans under which my eligible dependents and I are covered. I further certify that I have not deducted or will not deduct on my individual income tax return any of the expenses reimbursed through my CIGNA Health Care Flexible Spending Account. I understand that reimbursement will be made in accordance with the provisions of the plan. I accept responsibility for the proper treatment of benefits paid under this plan with respect to eligibility, income tax reporting, and liability.</p>	
EMPLOYEE SIGNATURE <i>(Required - unsigned Reimbursement Request Forms will not be considered for reimbursement)</i>	DATE

INSTRUCTIONS

- COMPLETE SECTIONS A, B AND C IN ITS ENTIRETY. UNSIGNED REIMBURSEMENT REQUEST FORMS WILL NOT BE CONSIDERED FOR REIMBURSEMENT.
- IF AN EXPENSE IS COVERED BY INSURANCE, SUBMIT TO THE APPROPRIATE CARRIER(S).
- ATTACH AN EXPLANATION OF BENEFITS (EOB) OR COPAYMENT RECEIPTS FROM THE INSURANCE CARRIER(S).
- RECEIPTS SHOULD FIT STANDARD PAPER FORMAT (8 1/2" x 11"). EACH RECEIPT MUST BE INDIVIDUALLY ATTACHED TO ONE BLANK SHEET OF PAPER IF THEY DO NOT FIT THE STANDARD PAPER FORMAT.
- IF YOU ARE SUBMITTING AN ITEMIZED BILL ONLY, INDICATE WHY THIS BILL HAS NOT BEEN PAID BY YOUR INSURANCE PLAN(S).
- ITEMIZED BILLS SHOULD INCLUDE THE FOLLOWING:
 - Provider Name and Address
 - Patient Name
 - Itemized Charges
 - Date of Service
 - Type of Service
- KEEP A COPY OF COMPLETED REIMBURSEMENT REQUEST FORMS AND ANY ATTACHED DOCUMENTATION.
- CANCELLED CHECKS, NON-ITEMIZED RECEIPTS, AND BALANCE DUE BILLS ARE **NOT ACCEPTABLE** PROOF OF EXPENSES.
- IF YOU HAVE ANY QUESTIONS, PLEASE CALL THE TOLL-FREE NUMBER PROVIDED ON THE BACK OF YOUR ID CARD OR 1.800.CIGNA.24.
- FOR GENERAL INFORMATION/CLAIM FORMS, VISIT OUR WEBSITE: www.mycigna.com
- MAIL COMPLETED FORM ALONG WITH APPROPRIATE DOCUMENTATION TO: **CIGNA HEALTHCARE
P.O. BOX 5200
SCRANTON, PA 18505-5200**
- ALL REIMBURSEMENTS ARE PAID TO THE EMPLOYEE.

ADDITIONAL INFORMATION

(If applicable, please use this space to explain why this bill is not being paid by your insurance plan(s).)