CIGNA Dental Oral Health Integration Program® Reimbursement Form

INSTRUCTIONS:
Complete sections A-G.
Checklist of items required for reimbursement:

- ☐ Completed CIGNA Dental Oral Health Integration Program Reimbursement Form
- ☐ Proof of Payment
- ☐ Dental Explanation of Benefits (EOB) OR Itemized Receipt from Dentist OR, Completed Claim Form (primary and secondary if applicable)

Mail completed form and attachments to: CIGNA Dental
P.O. Box 188044
Chattanooga, TN 37422-8044

A. INSURED/SUBSCRIBER INFORMATION

INSURED/SUBSCRIBER NAME: *(Last, First, Middle Initial)*			SSN OR CIGNA CUSTOMER ID:
ADDRESS: *(Street)*	*(City)*	*(State)*	*(Zip Code)*
TELEPHONE NUMBER:	E-MAIL ADDRESS:	EMPLOYER NAME:	EMPLOYER GROUP NUMBER:

B. OTHER COVERAGE INFORMATION

OTHER DENTAL OR MEDICAL COVERAGE? ☐ Yes ☐ No	PATIENT'S RELATIONSHIP TO POLICYHOLDER/SUBSCRIBER: ☐ Self ☐ Spouse ☐ Dependent ☐ Other
POLICYHOLDER/SUBSCRIBER NAME: *(Last, First, Middle Initial)*	DATE OF BIRTH:

C. PATIENT INFORMATION

PATIENT NAME:	PATIENT DATE OF BIRTH:

D. DENTIST INFORMATION

DENTIST NAME:	TELEPHONE NUMBER:
DENTIST ADDRESS: *(Street)* *(City)* *(State)* *(Zip Code)*	

E. CLAIM INFORMATION

DATE(S) OF DENTAL SERVICE:	AMOUNT PAID TO DENTIST:

Please check the appropriate procedure(s) for which you are requesting reimbursement:

Cardiovascular, Cerebrovascular (Stroke) and Diabetes:
- ☐ D4341 - Periodontal Scaling and Root Planing - 4 or more teeth per quadrant
- ☐ D4342 - Periodontal Scaling and Root Planing - 1-3 teeth per quadrant
- ☐ D4910 - Periodontal Maintenance*

Chronic Kidney Disease, Organ Transplants and Head and Neck Cancer Radiation:
- ☐ D1203 - Topical Application of Fluoride - Child***
- ☐ D1204 - Topical Application of Fluoride - Adult***
- ☐ D1206 - Topical Fluoride Varnish; Therapeutic Application for Moderate to High Caries Risk Patients***
- ☐ D1351 - Sealant - One Tooth***
- ☐ D4341 - Periodontal Scaling and Root Planing - 4 or more teeth per quadrant
- ☐ D4342 - Periodontal Scaling and Root Planing - 1-3 teeth per quadrant
- ☐ D4910 - Periodontal Maintenance

Maternity:
- ☐ D0120 - Periodic Oral Evaluation**
- ☐ D0140 - Limited Oral Evaluation**
- ☐ D0150 - Comprehensive Oral Evaluation**
- ☐ D0180 - Periodontal Evaluation
- ☐ D1110 - Prophylaxis - Adult (Cleaning)**
- ☐ D4341 - Periodontal Scaling and Root Planing - 4 or more teeth per quadrant
- ☐ D4342 - Periodontal Scaling and Root Planing - 1-3 teeth per quadrant
- ☐ D9110 - Palliative Treatment

* Limited to four times per year.
** One additional cleaning and one additional exam per year.
***Age limitations removed, all other limitations apply.

F. ADDITIONAL PERKS AVAILABLE FOR CIGNA DENTAL ORAL HEALTH INTEGRATION PROGRAM CUSTOMERS

I would like information e-mailed at no charge to me at the e-mail address above under Section A on the following topics:
☐ Tobacco Cessation ☐ Fear of the Dentist ☐ Stress and the Impact on Oral Health

I would like information on how to get free samples and discounts for non-prescription dental products developed for patients with a higher risk of oral health problems. By indicating yes, I authorize CIGNA Dental to only release my name and address for one-time use only to outside companies so they may provide me with products and information. ☐ Yes ☐ No

I would like information on how I can obtain discounts on my prescription dental products from CIGNA Home Delivery Pharmacy. ☐ Yes ☐ No

G. CERTIFICATION

I certify that checking the box(es) below indicates that I am eligible for this additional dental coverage based on the criteria set by my employer. I understand this submission does not guarantee payment and that plan maximums may apply. I also understand CIGNA has the right to check my medical records to confirm my medical condition.

☐ Cardiovascular Disease ☐ Cerebrovascular (Stroke) Disease ☐ Chronic Kidney Disease ☐ Diabetes
☐ Head and Neck Cancer Radiation ☐ Pregnancy ☐ Organ Transplants

MEDICAL PHYSICIAN'S NAME:	TELEPHONE NUMBER:	MEDICAL CARRIER:
PATIENT SIGNATURE: ***(Required)***		**DATE:**

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Click Here to Print Clear Fields

Frequently Asked Questions about Getting Reimbursed for CIGNA Dental Oral Health Integration Program® Coverage

What is the reimbursement process?

To get reimbursed for your coinsurance or copay amount, complete the information on the reverse side of this form and mail it to the address at the top of the form. It typically takes 2-4 weeks from receipt of the Reimbursement Form for you to get payment. Please keep in mind that all requests for reimbursement will be reviewed and only requests eligible under the CIGNA Dental Oral Health Integration Program guidelines will be granted.

What is the difference between a claim form and a CIGNA Dental Oral Health Integration Program Reimbursement Form?

A claim form is typically submitted by your dentist. Once we receive the claim form from the dentist, we pay him/her for their services. With the CIGNA Dental Oral Health Integration Program, you pay the dentist your normal coinsurance or copay (depending on your plan) at the time of service, and then you submit a Reimbursement Form for the amount of your coinsurance or copay.

Who submits the claim form and who submits the CIGNA Dental Oral Health Integration Program Reimbursement Form?

Your dentist will submit the claim form in most cases, and you should submit the CIGNA Dental Oral Health Integration Program Reimbursement Form (see question above).

If I'm a dependent (spouse, partner or child), do I provide my ID number or the person who is the primary insured individual?

Please provide the ID number of the person who is the primary insured individual on the policy.

Where can I find my Employer Group Number?

Please check a previous Explanation of Benefits, your dental page on mycigna.com, call 1.800.CIGNA24 and follow the prompts to get your Employer Group Number. You can also provide your ID and/or social security number and a Customer Service Representative will identify your Employer Group Number for you. If you have a CIGNA Medical or Dental ID card the Employer Group Number is listed on the cards.

What does "Other Coverage" mean?

Please complete the Other Coverage section if you have additional insurance from a separate policy (sometimes referred to as secondary insurance), typically through your spouse or partner.

If I don't have an e-mail address but still want information on discounted prescription products, discounted non-prescription products or information on behavioral conditions affecting my oral health, how can I get the information?

Please include a note when you submit your CIGNA Dental Oral Health Integration Reimbursement Form indicating the address where you would like the information mailed and it will be sent through the U.S. Postal Service.

Do I have to include anything that proves I have a condition and does CIGNA have the right to verify my condition?

You do not have to include any documentation with your Reimbursement Form that proves you have a specific condition. However, at the bottom of the form you must sign your name verifying that you have the condition and acknowledge that CIGNA reserves the right to request medical records or check with your physician prior to reimbursement.

If I have questions about the CIGNA Dental Oral Health Integration Program or how to complete and submit the Reimbursement Form who do I call?

Please call 1.800.CIGNA24 with any questions you may have.