Claim Form

Allegiance℠ by Cigna Healthcare

Patient Information

Patient ID # *(Use the identification number from your insurance card or policy holder's Social Security Number)*	
Patient's Full Legal Name *(including middle)*	**Patient's Date of Birth** *(mm/dd/yyyy)*
Diagnosis *(briefly describe the illness, injury, or symptoms requiring treatment.)*	

Provider Name *(List the name of the provider as indicated on your bill. Multiple bills from the same provider may be included on the same line if they are for the same type of service.)*	**Description of Services** *(i.e., hospital admission, chest e-ray, appendectomy, acupuncture, etc.)*	**Dates of Service or Purchase** *(Inclusive dates may be indicated for bills containing multiple dates of service.)*	**Charge Amount** *(Bills must be itemized to show service. If the bill was already paid, please indicate the date that payment was initiated.)*

Signature

I verify the above is complete and correct and that I am claiming benefits only for charges incurred by the patient named above. Authorization is hereby given to any provider of service, which participated in any way in the patient's care, to release to the participant's Plan any medical information which they deem necessary to adjudicate this claim.

Signature of Patient
(If patient is younger than 18 years old, then a guardian must sign.)

Date *(mm/dd/yyyy)*

Printed name of person signing above

Claim Form

Allegiance℠ by Cigna Healthcare

Itemized Bill Information

Each provider's itemized bill must be attached and must contain the following:

- The provider's Tax ID Number
- The full name of the patient receiving services
- The letterhead indicating the name and address of the person or organization providing the service
- A description of each service
- The charge amount for each service

Important Form Information

Primary Insurance Information

If other insurance is primary, please submit the explanation of benefits from the primary insurance company.

Form Completion

Please complete all items on the claim form. If the information requested does not apply to the patient, indicate N/A (Not Applicable).

Language & Currency Requirements

Claims in foreign languages or currency must be translated into English and United States currency.

Form Submission Instructions

Completed forms and information should be submitted to Allegiance at the mailing address below or you may fax the claim to Allegiance at (406) 523-3111.

Allegiance Benefit Plan Management, Inc. | Attention: Claims
P.O. Box 3018 | Missoula, MT 59806-3018