LSUfirst
THE LSU SYSTEM HEALTH PLAN

CIGNA

Critical Illness
Direct Cash Benefit Form

7555 Goodwin Road, Chattanooga, TN 37421
For questions call, 1-866-929-LSU1

HOW TO SUBMIT YOUR CLAIM - PLEASE PRINT

STEP 1. Complete Part A. Date and sign for all claims.
STEP 2. Sign and date the Authorization for Release of Information.
STEP 3. Have your attending physician complete Part B.
STEP 4. When you and your attending physician have completed the form, mail it along with the signed Authorization for Release of Information to the address listed above for review and processing.

PART A TO BE COMPLETED BY EMPLOYEE

Please Note: Failure to complete this form IN FULL may delay payment of your claim.

Complete For All Claims

1. Employee's Name _____
2. Member ID Number _____
3. Date of Birth _____
4. Home Address _____
5. Home Phone _____
6. Office Phone _____

Complete For All Claims

7. Describe condition: _____
8. Was condition caused by claimant's employment? ❒ Yes ❒ No If "Yes" has or will a claim be filed with the Workers' Compensation carrier? ❒ Yes ❒ No Result? ❒ Accepted ❒ Denied ❒ Pending Name of Workers' Compensation carrier _____
9. Date symptoms first noticed _____
10. Date first consulted physician _____
11. Name(s) and address(es) of physician(s) consulted for this condition or any similar or related condition: _____
12. Did the injury or illness require hospital confinement? ❒ Yes ❒ No If "Yes" provide the name of the hospital and dates confined:
13. Is the person for whom this claim is made covered under any other group health or service plan, or Medicare program? ❒ Yes ❒ No
14. If "Yes" is other coverage: ❒ Employer Plan ❒ Union Plan ❒ Private Plan ❒ Student Plan ❒ Other: _____
    A. Member's Name _____
    B. Policy/Member No. _____
    C. Member's Soc. Sec. No. _____
    D. Effective Date _____
    E. Name, address, and phone number of insurance company or organization providing benefits or service:

Complete For Accident Claims Only

15. Date of accident _____
22. Was claimant at work when accident happened? ❒ Yes ❒ No
16. Where did accident happen? _____
17. How did accident happen? _____

Date and Sign for ALL Claims

18. I certify that the above information is true and correct. A photographic copy of this certification shall be considered as effective and valid as the original. I have read the Fraud Statement included with this form.

Date _____ Signature of Claimant _____

PART B TO BE COMPLETED BY ATTENDING PHYSICIAN

1. Patient's Name _____ Date of Birth: _____
   If patient is a minor, Member's name: _____
2. Diagnosis and concurrent conditions: (If diagnosis code other than ICD* used, give name)

   _____

   _____

   _____

3. Pregnancy? ❒ Yes ❒ No If "Yes", what is the expected date of delivery? _____
4. Is condition due to injury or sickness arising out of patient's employment? ❒ Yes ❒ No
5. Report of Services (or attach itemized bill*) (If previous form submitted to this carrier, you need show only dates and services since last report.)

DATE OF SERVICES	PLACE† OF SERVICES	DESCRIPTION OF SURGICAL OR MEDICAL SERVICES RENDERED	CODE IF USED RVS** OR CPT***

†DO – Doctor's Office IH – Inpatient Hospital NH – Nursing Home
PH – Patient's Home OH – Outpatient Hospital OL – Other Locations

*ICD – International Classification of Diseases
**RVS – Relative Value Studies
***CPT – Current Procedural Terminology (Current edition)

6. Date symptoms first appeared or accident happened _____
7. Date patient first consulted you for this condition _____
8. Has the patient ever had the same or similar condition? ❒ Yes ❒ No If "Yes" when and describe _____

   _____
9. Is the patient still under your care for this condition? ❒ Yes ❒ No (If "No" give date your services terminated.)

   _____
10. Was laboratory work performed outside your office? ❒ Yes ❒ No If "Yes" name of facility _____
11. Name of referring physician _____
12. Was the patient hospital confined? ❒ Yes ❒ No If "Yes", From _____ Thru _____
    Name and address of hospital _____
13. Is the person for whom this claim is made covered under any other Health/Service plan? ❒ Yes ❒ No
    If "Yes" Name _____ Medicare? ❒ Yes ❒ No (Medicare No. _____)
    Other Government/Welfare/Aid program? ❒ Yes ❒ No If "Yes" Name _____

SIGNATURE (Attending Physician)	DATE	PHONE NUMBER	
PHYSICIAN'S NAME (Please Print)	TAX ID NUMBER	PATIENT'S ACCOUNT NUMBER	
STREET ADDRESS	CITY	STATE	ZIP CODE

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Authorization for Release of Information

7555 Goodwin Road, Chattanooga, TN 37421
For questions call, 1-866-929-LSU1

Claimant's Name	Date of Birth	Social Security Number

I hereby authorize all of the people and organizations listed below to give CIGNA, MCC and their authorized representatives, (collectively, the "Recipient"), the following information:

- any and all information relating to my health (except psychotherapy notes) and my insurance policies and claims, including, but not limited to, information relating to any medical consultations, treatments, or surgeries; hospital confinements for physical and mental conditions (other than psychotherapy notes); use of drugs or alcohol; and communicable diseases including HIV or AIDS if the party executing this authorization has expressly authorized the release of mental health records (other than psychotherapy notes), records of drug, alcohol or substance abuse treatment, or HIV/AIDS information as indicated at the bottom of this authorization.

I hereby authorize each of the following entities to provide the information outlined above:

- any physician or medical practitioner;
- any hospital, clinic or other health care facility;
- any insurance or reinsurance company (including, but not limited to, the Recipient or any other CIGNA company which may have provided me with life, accident, health, and/or disability insurance coverage, or to which I may have applied for insurance coverage, but coverage was not issued);
- any consumer reporting agency or insurance support organization;
- my employer, group policy holder, or benefit plan administrator; and
- the Medical Information Bureau (MIB).

I understand that the information obtained will be used by the Recipient to:

- determine my eligibility for benefits and/or the contestability under LSU First; and
- detect health care fraud or abuse or for compliance activities, which may include disclosure to MIB and participation in MIB's fraud prevention or fraud detection programs.

I hereby acknowledge that LSU First is subject to federal privacy regulations. I understand that information released to the Recipient will be used and disclosed as described in the CIGNA Notice of Health Information Privacy Practices, but that upon disclosure to any person or organization that is not a health plan or health care provider, the information may no longer be protected by federal privacy regulations. I understand that redisclosure of any alcohol or substance abuse information I may have released is subject to the requirements of 42 C.F.R. Part 2.

I may revoke this authorization at any time, except to the extent that action has been taken in reliance on this authorization or other law allows the Recipient to contest a claim under LSU First, by sending a written request to: **7555 Goodwin Road, Chattanooga, TN 37421.**
I understand that my revocation of this authorization will not affect uses and disclosure of my health information by the Recipient for purposes of claims administration and other matters associated with my claim for benefits under LSU First and the administration of the Plan.

I understand that the signing of this authorization is voluntary; however, if I do not sign the authorization, LSU First may not be able to obtain the medical information necessary to consider my claim for benefits.

This authorization will be valid for 24 months or the duration of any claim for benefits under my insurance coverage, whichever is later. A copy of this authorization will be as valid as the original. I understand that I am entitled to receive a copy of this authorization.

Date and Sign for ALL Claims

I certify that the above information is true and correct. A photographic copy of this certification shall be considered as effective and valid as the original. I have read the Fraud Statement included with this form.

Date _____ Signature of Claimant _____

Unless you sign here, no information about alcohol/substance abuse, HIV/AIDS, or mental health will be disclosed:

Yes, disclose this information _____

No, do not disclose this information _____

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Fraud Statement

FOR RESIDENTS OF:

ALASKA: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

ARIZONA: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

ARKANSAS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

CALIFORNIA: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

DELAWARE: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

IDAHO: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete or misleading information is guilty of a felony.

INDIANA: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete or misleading information commits a felony.

KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

LOUISIANA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

MAINE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

MINNESOTA: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NEVADA: Any person who misrepresents or falsifies essential information requested on this form may, upon conviction, be subject to a fine and imprisonment under state or federal law, or both.

NEW HAMPSHIRE: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NEW JERSEY: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NEW MEXICO: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

NEW YORK: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

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

OKLAHOMA: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

OREGON: Any person who knowingly and with intent to defraud or solicit another to defraud an insurer: (1) by submitting an application, or (2) by filing a claim containing a false statement as to any material fact, may be violating state law.

PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

TENNESSEE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

TEXAS: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

VIRGINIA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

WASHINGTON: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

WEST VIRGINIA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

FOR RESIDENTS OF ALL OTHER STATES NOT LISTED ABOVE:

Warning: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim, containing any materially false information, or conceals for the purpose of misleading, information concerning any facts materially thereto, commits a fraudulent insurance act, which may be a crime and subject such person to criminal and civil penalties.

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