Service	UTC Build Your Own Plan			
	Option 1	Option 2	Option 3	All Build Your Own Options
	In-Network	In-Network	In-Network	Out-Of-Network
Vision Care Items	Plan Pays	Plan Pays	Plan Pays	Plan Pays
-Single vision lenses	$15	$15	$15	$15
-Bifocal lenses	$30	$30	$30	$30
-Trifocal lenses	$42	$42	$42	$42
-Lenticular lens	$54	$54	$54	$54
-Contact lens (if needed following cataract surgery or if conventional lenses cannot bring the better eye to 20/70).	$72	$72	$72	$72
-Other contact lens (no more than one pair of lenses every 12 months).	$30	$30	$30	$30
-Frames (no more than one frame every 24 months).	$15	$15	$15	$15

HOURLY BARGAINING UNIT ONLY – CONNECTICUT OPERATIONS

CIGNA Vision Claim Form

Insured and/or Administered by
Connecticut General Life Insurance Company

CIGNA HealthCare

CIGNA

IMPORTANT: This claim form is intended for subscribers and covered dependents who receive services from providers outside the CIGNA Vision network. If your plan permits a non-participating provider to accept assignment, the provider must submit a completed CMS-1500 form (also known as a HCFA-1500 form) to CIGNA Vision at the address below. If you receive services from a participating provider, no claim form is necessary. Read the following instructions carefully as incorrect, incomplete or illegible claims may result in claim payment being delayed or denied.

1. Enter all requested information in the Patient Information and Subscriber Information sections. Claims may be delayed if information is missing.
2. If you have other insurance, submit the Explanation of Benefits, if any, received from your other insurance provider.
3. Enter the Name, Address and Telephone Number of the provider of services in the Provider Information Section.
4. **Attach the original itemized receipts which include a breakdown of the services and/or materials you received including lens type - i.e. single vision, bifocal, or trifocal - if applicable.**
5. Sign and Date the claim form. *Submission of this claim form does not guarantee payment for services.*

Mail the completed claim form to: CIGNA Vision
PO Box 5200
Scranton, PA 18505-5200

If you are a subscriber or a dependent of a subscriber and you have any questions, please call 1-877-478-7557.
If you are a provider and you have any questions, please call 1-877-478-7557.

PATIENT INFORMATION *(Required)*

LAST NAME		FIRST NAME		M.I.	IDENTIFICATION NUMBER OR SSN
STREET ADDRESS		CITY	STATE	POSTAL CODE	TELEPHONE # ( )
BIRTH DATE	SEX ☐ M ☐ F	RELATIONSHIP TO THE SUBSCRIBER ☐ Self ☐ Spouse ☐ Child ☐ Other		PATIENT STATUS ☐ Employed ☐ Full-Time Student	
IS PATIENT'S CONDITION RELATED TO: ☐ Employment ☐ Auto Accident ☐ Other Accident		IS THERE ANOTHER HEALTH BENEFIT PLAN ☐ Yes ☐ No *If yes, complete other insurance information.*			

SUBSCRIBER INFORMATION *(Required)*

LAST NAME		FIRST NAME		M.I.	IDENTIFICATION NUMBER OR SSN
STREET ADDRESS		CITY	STATE	POSTAL CODE	TELEPHONE NO. ( )
BIRTH DATE	SEX ☐ M ☐ F	EMPLOYER NAME			
INSURANCE PLAN NAME			SUBSCRIBER'S GROUP NUMBER		

REQUEST FOR REIMBURSEMENT - Please enter amount charged. *REMEMBER TO INCLUDE PAID RECEIPT.*

EXAM $______	FRAME $______	LENSES $______	CONTACTS $______
IF LENSES WERE PURCHASED, PLEASE CHECK TYPE: ☐ Single ☐ Bifocal ☐ Trifocal ☐ Progressive		DATE OF SERVICE: ____/____/______	

PROVIDER INFORMATION *(Required)*

PROVIDER NAME			TELEPHONE NO. ( )
STREET ADDRESS	CITY	STATE	POSTAL CODE

FRAUD WARNING: Any person who knowingly files a statement of claim containing any misrepresentations or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

Patient's or Authorized Person's Signature: I authorize the release of any medical or other information necessary to process this claim. By signing below, I acknowledge that I have read the applicable Fraud Warning Statements on the back of this form.

Signed ______________________________ Date ______________