



**NOTICE OF CONTINUING CLAIM
(Direct Pay)**

INSTRUCTIONS

1. Complete this form only when submitting continuing claims for you or one of your covered dependents.
2. Complete one form per patient.
3. Attach itemized bills.
4. A full claim form is required once per year or if there has been a change in family status or other insurance

Employee	Patient
Policy # 00052665	Subscriber ID #
Employer State of Wyoming	

Employee Signature _____ Dated _____

M4487

**CIGNA Healthcare
PO Box 12018
Cheyenne, WY 82003**