

**Disclosure Form for Participant
Referral to a Provider that does not participate on the CIGNA HealthCare Network**

This form will summarize our discussion about a referral to another medical provider or facility for _____
(describe service).

We have discussed the possibility of referral to _____.

This provider is not a participating provider with CIGNA HealthCare. If you obtain these services from this provider and the service is a covered service under your benefit plan, *the costs of the service will be covered under the out of network portion of your benefit plan. If your benefit plan does not have out of network benefits, it is probable that you will not have coverage for this service and will be required to pay the costs yourself.*

If you have any questions regarding whether you have out of network benefits or your financial obligations under your benefit plan if you use an out of network provider, please call the member services number on your CIGNA identification card.

Physician Disclosure of Financial Interest

[] I do not have any financial interest in the non-participating provider listed above.

[] I DO HAVE A FINANCIAL INTEREST IN THE NON-PARTICIPATING PROVIDER LISTED ABOVE AND I MAY BENEFIT BY REFERRING YOU TO THIS NON-PARTICIPATING PROVIDER. THAT INTEREST IS:

Did you offer your patient, our participant, the option of an in-network referral? [] Yes [] No

If no, please explain _____

Notice to Participant regarding “fee forgiving” by providers that do not participate in the CIGNA HealthCare network.

Some non-participating providers may offer to waive the amount that you are obligated to pay when you use your out of network benefits by stating that they will “accept what insurance pays as payment in full.” This conduct may impact your benefit claim. The amount waived may adversely affect the amount of the benefit under your plan. Claims submitted by providers that engage in fee forgiving may be denied in total or you may be required to pay the non-participating provider and then file a claim for reimbursement.

If a non-participating provider offers to waive or forgive any part its charges, please notify the CIGNA HealthCare Special Investigations Hotline at 1.800.667.7145

Patient's Decision

I have reviewed the information provided above and understand that:

- *I have the choice of using either a participating provider or non-participating provider.*
- *I understand that if I choose to use a provider that does not participate with CIGNA HealthCare, such services may not be covered under my plan if my plan does not have out of network benefits.*
- *If my plan has out of network benefits, I understand that by using my out-of-network benefits I may incur greater costs for which I will be financially responsible than if I had obtained services from a participating provider.*

I have made the following decision:

I wish to use my in-network benefits and obtain a referral to a CIGNA HealthCare participating provider.

I wish to obtain services from _____ .
I understand he/she is NOT a CIGNA HealthCare participating provider.

I also acknowledge that I have been provided with a copy with this form.

Patient Signature

Date

Please print name

I certify that I have reviewed this form with the patient prior to treatment for which the referral is being made and that the patient has acknowledged the information contained in this form and was provided a copy for the patient's records:

Physician Signature

Date