Customer Appeal Request



An appeal is a request to change a previous adverse decision made by Cigna. You or your representative (Including a physician on your behalf) may appeal the adverse decision related to your coverage.

STEP 1:

Contact Cigna's Customer Service Department at the toll-free number listed on the back of your ID card to review any adverse coverage determinations/payment reductions. We may be able to resolve your issue quickly outside of the formal appeal process. If a Customer Service representative cannot change the initial coverage decision, he or she will advise you of your right to request an appeal.

STEP 2:

Complete and mail this form and/or appeal letter along with any supporting documentation to the address identified below. Complete and accurate preparation of your appeal will help us perform a timely and thorough review. In most cases your appeal should be submitted within 180 days, but your particular benefit plan may allow a longer period.

You will receive an appeal decision in writing.

REQUESTS FOR AN APPEAL SHOULD INCLUDE:

- 1. If you submit a letter without a copy of the Customer Appeal form, please specify in your letter this is a "Customer Appeal". Please include all the information that is requested on this form.
- 2. A copy of the original claim and explanation of payment (EOP), explanation of benefit (EOB), or initial adverse decision letter, if applicable.
- 3. Any documentation supporting your appeal. For adverse decisions based upon lack of medical necessity, additional documentation may include a statement from your healthcare professional or facility describing the service or treatment and any applicable medical records.

Cigna Participant Name (Last) (First) (MI) Participant ID # Employer Name Account Number (from Cigna ID card) Patient Last Name (First) (MI) Date of Birth State of Residence Health Care Professional or Facility Name) Is Health Care Professional Contracted? Yes No Date of Service Procedure/Type of Service Claim Number/Document Control Number Appeal is being filed by: Health Care Professional Contracted? Yes No Other Representative (Indicate relationship to Participant): Today's Date Signature Home Phone # Business Phone # Have you already received services? Yes No If no, and these services require prior authorization, we will resolve your appeal request for coverage as guickly as possible, within 30 calendar days.								
Patient Last Name (First) (MI) Date of Birth State of Residence Health Care Professional or Facility Name) Is Health Care Professional Contracted? Yes No Date of Service Procedure/Type of Service Claim Number/Document Control Number Appeal is being filed by: Health Care Facility Other Representative (Indicate relationship to Participant): Name of person filling out the form Today's Date Signature Home Phone # Business Phone #	Cigna Participant Name (Last)		(First)		(MI)	Participant ID #		
Health Care Professional or Facility Name) Is Health Care Professional Contracted? Yes No Date of Service Procedure/Type of Service Claim Number/Document Control Number Appeal is being filed by: Participant Primary Care Physician Specialist/Ancillary Physician Health Care Facility Other Representative (Indicate relationship to Participant): Name of person filling out the form Today's Date Signature Home Phone # Business Phone # Have you already received services? Yes No	Employer Name				Account Number (from Cigna ID card)			
Date of Service Procedure/Type of Service Claim Number/Document Control Number	Patient Last Name		(First)		(MI)	Date of Birth	State of Residence	
Appeal is being filed by: Participant Primary Care Physician Specialist/Ancillary Physician Health Care Facility Other Representative (Indicate relationship to Participant): Name of person filling out the form Today's Date Signature Home Phone # Business Phone # Have you already received services? Yes No	Health Care Professional or Facility Name)				Is Healt			
Participant Primary Care Physician Specialist/Ancillary Physician Health Care Facility Other Representative (Indicate relationship to Participant): Name of person filling out the form Today's Date Signature Home Phone # Business Phone # Have you already received services? Yes No	Date of Service	Procedure/Type of Service	cedure/Type of Service Claim Number/Document			Number/Document Co	ontrol Number	
□ Other Representative (Indicate relationship to Participant): Name of person filling out the form Signature Home Phone # Business Phone # Have you already received services? □ Yes □ No	Appeal is being file	ed by:			1			
Name of person filling out the form Signature Home Phone # Business Phone # Have you already received services? Yes No	☐ Participant	Primary Care Physician	Specialist/Ancillary Physi	ician Health Care Faci	lity			
Signature Home Phone # Business Phone # Have you already received services? Yes No	Other Represe	ntative (Indicate relationship to	Participant):					
Home Phone # Business Phone # Have you already received services? Yes No	Name of person filling out the form					Today's Date		
Have you already received services? Yes No	Signature							
☐ Yes ☐ No	Home Phone #			Business Phone #				
i ii iio, ana tiese services readire prior autriorization, we will resorve vour appear readest 101 COVETAUE às AUICNIV às DOSSIDIE, WILLIIII 30 CAIETIUAI UAVS.	Yes No		, we will resolve your appeal rec	uest for coverage as guickly as	possible.	within 30 calendar da	avs.	

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if allowed by your Plan, is this a second appeal or external re	eview request?
Please check off the selection that best describes your appeal:	:
Request for in-network coverage	
Coverage Exclusion or Limitation	
Maximum Reimbursable Amount	
☐ Inpatient Facility Denial (Level of Care, Length of Stay)	
Mutually Exclusive, Incidental procedure code denials	
Additional reimbursement to your out of network health care	professional for a procedure code modifier
Experimental/Investigational Procedure	
☐ Medical Necessity	
☐ Timely Claim Filing (without proof)	
Benefits reduced due to re-pricing of billed procedures (Viant,	, Beech Street, Multiplan, etc.)
Reason why you believe the adverse coverage decision was inc As a reminder, please attach any supporting documentation (f documentation from your health care professional or facility).	for medical necessity-related denials, include medical record
Additional Comments:	
Refer to your ID card to determine the appeal address to use below Mail the completed Appeal Request Form or Appeal Letter along w	
If the ID card indicates: <u>Cigna Network</u> Cigna Appeals Unit P.O. Box 188011 Chattanooga, TN 37422-8011	If the ID card indicates: <u>GW - Cigna Network</u> Cigna Appeals Unit P.O. Box 188062 Chattanooga, TN 37422-8062
If the ID card indicates: Cigna-HealthSpring	
A7 Medicare Anneals Unit	

IMPORTANT: This address is intended only for appeals of coverage denials. Any other requests sent to this address will be forwarded to the appropriate Cigna location, which may result in a delay in handling your request or processing your claim.

25500 N Norterra Dr., Bldg. B Phoenix, AZ 85085-8200