Instructions for submitting a prior authorization form in Vermont

For Health Care Providers

To submit a prior authorization form electronically in Vermont, providers must register for access to the Cigna Healthcare online prior authorization tool.

To initiate registration for the tool, send an email to PMAC@Cigna.com. Include the following information:

- Provider or facility name
- Mailing address
- Email address
- Contact's name
- Contact's phone number

If you prefer to submit a prior authorization form via fax, please send it to **866.873.8279**.

To contact the Cigna Healthcare Coverage Review team, please call the phone number listed on the back of the customer's Cigna Healthcare ID card or **800.Cigna24 (800.244.6224)**.

PCOMM-2024-034-VT 01/2024

VERMONT
DEPARTMENT OF FINANCIAL REGULATION

Pre-Service ☐ Post-Service ☐ | Elective ☐ Non-Elective ☐ | Urgent ☐ Non-Urgent ☐

Uniform Medical Prior Authorization Form

Important: Please read your insurer's (for individuals with commercial insurance) or Vermont Medicaid's (for Medicaid beneficiaries) specific instructions for completing this form.

Patient/Member Information *(* Required Field)*

***First Name**	**Middle Initial**	***Last Name**
***Health Insurance ID#**	***DOB**	**Gender Identity**
***Address**		**Apt.#**
***City**	***State**	***Zip** / ***Tel.**

Referring/Requesting Provider Information *(* Required)*	**Rendering/Attending Provider Information** *(* Required)*
***First Name** ***Last Name**	***First Name** ***Last Name**
***NPI/TIN#** ***Specialty**	***NPI/TIN#** ***Specialty**
***Address** **Suite**	***Address** **Suite**
***City** ***State**	***City** ***State**
***Tel.** **Fax#**	***Tel.** **Fax#**

***Office Contact/Person Completing Form**

***Telephone No.** | **Fax No.**

Required Clinical Information (* Required Field)

***Date of Request** | ***Is this request for Out-of-Network Services?** **Y** ☐ **N** ☐

*Type of Service Requested *(check all that apply)*

Services:		**Therapies:**
Medical Admit ☐	Obstetrics ☐	Occupational Therapy ☐
Mental Health/SUD ☐	Immunotherapy Treatment ☐	Physical Therapy ☐
Oncology ☐	Surgery (including Oral Surgery) ☐	Speech Therapy ☐
Acupuncture ☐	Transplant ☐	Applied Behavior Analysis ☐
	Chiropractic ☐	

Testing/Imaging:
Diagnostic Imaging ☐
Diagnostic Medical Test ☐

Other:
DME ☐ SNF ☐ Home Health ☐ Vision/Glasses ☐
Home Infusion ☐ Other *(please specify)* ☐

***Date Diagnosed:**

***Place of Service:** Telehealth/Audio Only ☐
Inpatient ☐ Outpatient ☐ Office ☐ Other *(please specify)* ☐

***Proposed Dates of Service:** **From** **To**	***Facility Where Service Will be Performed:**
***Proposed Number of Inpatient Treatment Days**	***Proposed Number of Outpatient Treatment Visits**
***Primary Diagnosis**	***Primary Diagnosis Code**
***Secondary Diagnosis**	***Secondary Diagnosis Code**
***Name of Proposed Procedure**	***CPT/HCPCS or Revenue Code**
***Requested Durable Medical Equipment (DME)**	
***DME CPT/HCPCS Code**	***DME Duration**
***DME Purchase Price $**	***DME Monthly Rental Price $**

Additional Clinical Information Attached: ☐ **No. of pages:** ____