# *Request for Health Care Professional Payment Review*

**BEFORE PROCEEDING, NOTE THE FOLLOWING:**

- Corrected claims should be submitted to the claim address on the back of the patient's Cigna identification card (ID card). If the claim in question has had no payments to date or you are submitting additional information for the initial review of payment, please forward to the address on the back of the patient's ID card.
- Fee schedule or reimbursement terms for multiple patients do not require individual appeals. Contact Cigna Customer Service at the toll-free number listed on the back on the patient's ID card for further assistance. If you are a contracted health care professional and you feel your contract is being inappropriately applied, please contact your Experience Manager or Experience Consultant at Cigna.

**Step 1:** Contact Cigna Customer Service at the toll-free number listed on the back of the patient's Cigna ID card to review any adverse determinations/payment reductions. If a Customer Service representative is unable to change the initial decision, you will be advised at that time of your right to request an appeal.

**Step2:** Complete and mail this form and/or appeal letter along with all supporting documentation to the address identified in Step 3 on this form. Your appeal should be submitted within 180 days and allow 60 days for processing your appeal, unless other timelines are required by state law.

**REQUESTS FOR REVIEW SHOULD INCLUDE:**

1. This completed form and/or an appeal letter requesting an appeal review and indicating the reason(s) why you believe the claim payment is incorrect and should be changed. If submitting a letter, please include all information requested on this form. If only submitting a letter, please specify in the letter this is a Health Care Professional Appeal.
2. Include a copy of the original claim and the Explanation of Payment (EOP) or Explanation of Benefits (EOB), if applicable.
3. For reviews involving a previous clinical denial, such as denied hospital days, level of care, medical necessity or services denied for no prior authorization, supporting documentation should include a narrative describing the situation, an operative report and medical records, as applicable.

**PLEASE COMPLETE:**

Are you contracted with Cigna? Yes☐ No☐
Tax identification number _____ National Provider Identifier (NPI) number _____

Have services been rendered? Yes☐ No☐
If no, and these services require prior authorization, we will resolve your appeal request for benefit coverage as expeditiously as possible and within the time permitted by applicable law.

**Please check the issue that best describes your appeal. The initial decision was related to:**

- ☐ Mutually exclusive, incidental, or bundling procedure code denial
- ☐ Your Cigna contract and the fee schedule or reimbursement terms
- ☐ Modifier reimbursement: List modifier(s):_____
- ☐ Inpatient Facility denial (level of care, length of stay, delayed treatment day)
- ☐ Experimental/Investigational procedure
- ☐ Medical necessity of the service
- ☐ Timely claim filing (without proof)
- ☐ Precertification or prior authorization not obtained
- ☐ Request for in-network benefits
- ☐ Benefit plan exclusion or limitation
- ☐ Maximum Reimbursable Amount
- ☐ Non participating anesthesiologist, radiologist, or pathologist requesting in-network benefits
- ☐ Other (please indicate) _____

**Cigna Subscriber Name:** _____ **Subscriber ID#:** _____

**Employer Name:** _____ **Account Number (from Cigna ID card):** _____

**Patient Name:** _____ **Date of Birth:** _____**State of Residence:** _____

**Date(s) of Service:** _____**Procedure/Type of Service:** _____

**Claim Number/Document Control Number, if payment related appeal:** _____

**Original Claim Amount Billed:** _____ **Original Claim Amount Paid:** _____
Indicate below where appeal correspondence should be directed:

**Health Care Provider (Practitioner/Facility Name):** _____

**Street/PO Box:** _____ **City:** _____ **State:** _____ **Zip:** _____

**Telephone:** _____ **Fax:** _____

**Referring Health Care Professional Name (if applicable):** _____



**Step3:** Refer to the patient's Cigna ID card to determine the appeal address to use below. Mail this completed form (Request for Health Care Professional Review) or a letter of appeal **along with all supporting documentation** to the address below:

**Cigna ID cards:**

**Cigna Appeals Unit**
**PO Box 188011**
**Chattanooga, TN 37422**

**If the Cigna ID card indicates: <u>GWH -Cigna or 'G' on the front of the card:</u>**

**Cigna Appeals Unit**
**P.O. Box 188062**
**Chattanooga, TN 37422-8062**

If a decision is made to change the initial decision and issue additional payment, you may be notified of the payment adjustment through an Explanation of Payment (EOP) or Explanation of Benefits (EOB). If a decision is made to uphold our initial decision, you will be notified in writing.

**State the reason for the appeal and expected outcome below. Note: please attach supporting documentation.**

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**Name of Requestor/Title:** _____ **Today's Date:** _____

**Phone #:** _____**Fax #:** _____

**Signature:** _____

☐ **Check if additional information is attached**