CAREFULLY READ THE INFORMATION IN THIS PACKET AND KEEP IT FOR FUTURE
REFERENCE. IT HAS IMPORTANT INFORMATION ABOUT THE HOW TO APPEAL
DECISIONS WE MAKE ABOUT YOUR HEALTH CARE.

Getting Information About the Health Care Appeals Process

Help in Filing an Appeal: Standardized Forms and Consumer Assistance from the Department of
Insurance and Financial Institutions.

We must send you a copy of this information packet when you first receive your policy, at your request or
the request of your treating provider and provide access to a copy of the information packet on our
website. When your insurance coverage is renewed, we must also send you a separate statement to
remind you that you can request another copy of this packet. Just call our customer/member services
number at 1.800.244.6224 to ask.

At the back of this packet, you will find forms you can use for your appeal. The Arizona Department of
Insurance and Financial Institutions (“the Department”) developed these forms to help people who want
to file a health care appeal. You are not required to use them. We cannot reject your appeal if you do not
use them. If you need help in filing an appeal or you have questions about the appeals process, you may
call the Departments Consumer Services Section at (602) 364-2499 or 1-(800) 325-2545 (outside
Phoenix) or call our customer service.

How to Know When You Can Appeal

When we do not authorize or approve a service or pay for a claim, we must notify you of your right to
appeal that decision. Your notice may come directly from us, or through your treating provider.

Decisions You Can Appeal

1. We do not approve a service that you or your treating provider has requested.
2. We do not pay for a service that you have already received.
3. We do not authorize a service or pay for a claim because we say that it is not “medically necessary.”
4. We do not authorize a service or pay for a claim because we say that it is not covered under your insurance policy, and you believe it is covered.
5. We do not notify you, within 10 business days of receiving your request, whether or not we will authorize a requested service.
6. We do not authorize a referral to a specialist.

**Decisions You Cannot Appeal**

1. You disagree with our decision as to the amount of “usual and customary charges.”
2. You disagree with how we are coordinating benefits when you have health insurance with more than one insurer.
3. You disagree with how we have applied your claims or services to your plan deductible.
4. You disagree with the amount of coinsurance or copayments that you paid.
5. You disagree with our decision to issue or not issue a policy to you.
6. You are dissatisfied with any rate increases you may receive under your insurance policy.
7. You believe we have violated any other parts of the Arizona Insurance Code.

If you disagree with a decision that it not appealable according to this list, you may still file a complaint with the Arizona Department of Insurance and Financial Institutions, Consumer Services Section, 100 N. 15th Ave., Suite 261, Phoenix, AZ 85007. You can also file a complaint via our website: [www.difi.az.gov](http://www.difi.az.gov).

**Who Can File an Appeal?**

Either you or your treating provider can file an appeal on your behalf. At the end of this packet is a form you may use for filing your appeal. You are not required to use this form and can send us a letter with the same information. If you decide to appeal our decision to deny authorization for a service, you should tell your treating provider so the provider can help you with the information you need to present your case.

**Description of the Appeals Process**

There are two types of appeals: an expedited appeal for urgent matters, and a standard appeal. Each type of appeal has 3 levels. The appeals operate in a similar fashion, expect that expedited appeals are processed much faster because of the patient’s condition.

<table>
<thead>
<tr>
<th>Expedited Appeals</th>
<th>Standard Appeals</th>
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<tbody>
<tr>
<td>(For urgently needed services you have not yet received yet)</td>
<td>(For non-urgent services or denied claims)</td>
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<table>
<thead>
<tr>
<th>Level 1</th>
<th>Expedited Medical Review</th>
<th>Informal Reconsideration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 2</td>
<td>Expedited Appeal</td>
<td>Formal Appeal</td>
</tr>
<tr>
<td>Level 3</td>
<td>Expedited External Independent Medical Review</td>
<td>External Independent Medical Review</td>
</tr>
</tbody>
</table>

We make the decisions at Level 1 and Level 2. An outside review, who is completely independent from our company, makes Level 3 decisions. You are not responsible to pay the costs of the external review if you choose to appeal to Level 3.
EXPEDITED APPEAL PROCESS FOR URGENTLY NEEDED SERVICES NOT YET PROVIDED

Level 1 Expedited Medical Review

Your request: You may obtain Expedited Medical Review of your denied request for a service that has not already been provided if:

- You have coverage with us,
- We denied your request for a covered service, and
- Your treating provider certifies in writing and provides supporting documentation that the time required to process your request thru the Informal Reconsideration and Formal Appeal process (about 60 days) is likely to cause a significant negative change in your medical condition. (At the end of this packet is a form that your provider may use for this purpose. Your provider could use send a letter or make up a form with similar information.) your treating provider must send the certification and documentation to:

Medical Appeals
Appeals Processor, National Appeals Organization Cigna HealthCare
P.O. Box 188011
Chattanooga, TN 37422
Phone: 1.800.244.6224
Fax: 1.800.286.6797

Behavioral Health Appeals
Cigna Behavioral Health
Central Appeals Unit
P.O. Box 188064
Chattanooga, TN 37422
Phone: 1.800.241.4057 ext. 7962009
Fax: 1.877.815.4827

Our decision: We have 1 business day after we receive the information from the treating provider to decide whether we should change our decision and authorize your requested service. Within the same business day, we must call and tell you and your treating provider and mail you our decision in writing. The written decision must explain the reasons for our decision and tell you the documents on which we based our decision.

If we deny your request: You may immediately appeal to Level 2.
If we grant your request: We will authorize the service and the appeal is over.
If we refer your case to Level 3: We may decide to skip Level 1 and Level 2 and send your case straight to an independent reviewer at Level 3.

Level 2: Expedited Appeal

Your request: If we deny your request at Level 1, you may request an Expedited Appeal. After you receive our Level 1 denial, your treating provider must immediately send us a written request (to the same person and address listed above under Level 1) to tell us you are appealing to Level 2. To help your appeal, your provider should also send us any more information (that the provider hasn’t already sent us) to show why you need the requested service.

If we deny your request: You may immediately appeal to Level 3.
If we grant your request: We will authorize the service and the appeal is over.
If we refer your case to Level 3: We may decide to skip Level 1 and Level 2 and send your case straight to an independent reviewer at Level 3.

Level 3: Expedited External, Independent Review

Your request: You may appeal to Level 3 only after you have appealed through Levels 1 and 2. You have only 5 business days after you receive our Level 2 decision to send us your written request for Expedited External Independent Review. Send your request and any more supporting information to:

Medical Appeals
Appeals Processor,
National Appeals Organization Cigna HealthCare
P.O. Box 188011
Chattanooga, TN 37422
Phone: 1.800.244.6224
Fax: 1.800.286.6797

Behavioral Health Appeals
Cigna Behavioral Health
Central Appeals Unit
P.O. Box 188064
Chattanooga, TN 37422
Phone: 1.800.241.4057 ext. 7962009
Fax: 1.877.815.4827

Neither you nor your treating provider is responsible for the cost of any external independent review.

The process: There are two types of Level 3 appeals, depending on the issues in your case:

(1) Medical necessity
These are cases where we have decided not to authorize a service because we think the services you (or your treating provider) are asking for, are not medically necessary to treat your problem. For medical necessity cases, the independent review is a provider retained by an outside independent review organization (“IRO”), that is procured by the Arizona Department of Insurance and Financial Institutions, and not connected with our company. The IRO reviewer must be a provider who typically manages the condition under review.

(2) Contract coverage
These are cases where we have denied coverage because we believe the requested service is not covered under your insurance policy. For contract coverage cases, the Arizona Department of Insurance and Financial Institutions is the independent reviewer.

Medical Necessity Cases

Within 1 business day of receiving your request, we must:

1. Send a written acknowledgement of the request to the Director of the Department of Insurance and Financial Institutions (“Director”) you, and your treating provider.
2. Send the Director: the request for review; your policy, evidence of coverage or similar document; all medical records and supporting documentation used to render our decision; a summary of the applicable issues including a statement of our decision;
the criteria used and the clinical reasons for our decision; and the relevant portions of our utilization review guidelines. We must also include the name and credentials of the health care provider who reviewed and upheld the denial at the earlier appeal levels.

Within 2 business days of receiving your information, the Director must send all the submitted information to an external independent reviewer organization (the “IRO”).

Within 72 hours of receiving the information the IRO must make a decision and send the decision to the Director.

Within 1 business day of receiving the IRO’s decision, the Director must send a notice of the decision to us, you, and your treating provider.

**The decision (medical necessity):** If the IRO decides that we should provide the service, we must authorize the service. If the IRO agrees with our decision to deny the service, the appeal is over. Your only further option is to pursue your claim in Superior Court.

**Contract Coverage Cases**

Within 1 business day of receiving your request, we must:

1. Send a written acknowledgement of your request to the Director, you, and your treating provider.
2. Send the Director: the request for review, your policy, evidence of coverage or similar document, all medical records and supporting documentation used to render our decision, a summary of the applicable issues including a statement of our decision, the criteria used and any clinical reasons for our decision and the relevant portions of our utilization review guidelines.

Within 2 business days of receiving this information, the Director must determine if the service or claim is covered, issue a decision, and send a notice to us, you, and your treating provider.

**Referral to the IRO for contract coverage cases:** The Director is sometimes unable to determine issues of coverage. If this occurs, the Director will forward your case to an IRO. The IRO will have 72 hours to make a decision and send it to the Director. The Director will have 1 business day after receiving the IRO’s decision to send the decision to us, you, and your treating provider.

**The decision (contract coverage):** If you disagree with Director’s final decision on a contract coverage issue, you may request a hearing with the Office of Administrative Hearings (“OAH”). If we disagree with the Director’s final decision, we may also request a hearing before OAH. A hearing must be requested within 30 days of receiving the Director’s decision. OAH must promptly schedule and complete a hearing for appeals from expedited Level 3 decisions.
STANDARD APPEAL PROCESS FOR NON-URGENT SERVICES AND DENIED CLAIMS

Level 1. Informal Reconsideration

Your request: You may obtain Informal Reconsideration of your denied request for a service [or claim] if:

- You have coverage with us,
- We denied your request for a covered service [for claim],
- You do not qualify for an expedited appeal, and
- You or your treating provider asks for Informal Reconsideration within 2 years of the date we first deny the requested service [or claim] by calling, or sending your request to:

<table>
<thead>
<tr>
<th>Medical Appeals</th>
<th>Behavioral Health Appeals</th>
<th>Dental HMO Appeals</th>
<th>Dental PPO Appeals</th>
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<tbody>
<tr>
<td>Appeals Processor</td>
<td>Cigna Behavioral Health Appeals</td>
<td>Appeals Coordinator</td>
<td>Appeals Coordinator</td>
</tr>
<tr>
<td>National Appeals Organization</td>
<td>Central Appeals Unit</td>
<td>National Appeals Unit</td>
<td>National Appeals Unit</td>
</tr>
<tr>
<td>Cigna Healthcare</td>
<td>P.O. Box 188064</td>
<td>Cigna Dental</td>
<td>Cigna Dental</td>
</tr>
<tr>
<td>P.O. Box 188011</td>
<td>Chattanooga, TN 37422</td>
<td>P.O. Box 188047</td>
<td>P.O. Box 188044</td>
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<td>Chattanooga, TN 37422</td>
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<td>Chattanooga, TN 37422</td>
<td>Chattanooga, TN 37422</td>
</tr>
<tr>
<td>Phone: 1.800.244.6224</td>
<td>Phone: 1.800.241.4057 ext.7962009</td>
<td>Phone: 1.800.244.6224</td>
<td>Phone: 1.800.244.6224</td>
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<tr>
<td>Fax: 1.877.815.4827</td>
<td>Fax: 1.877.815.4827</td>
<td>Fax: 1.866.87.3842</td>
<td>Fax: 1.866.8780.3842</td>
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</table>

Claim for a covered service already provided but not paid for: You may not obtain Informal Reconsideration of your denied request for the payment of a covered service. Instead, you may start the review process by seeking Formal Appeal.

Our acknowledgement: We have 5 business days after we receive your request for Informal Reconsideration (“the receipt date”) to send you and your treating provider a notice that we got your request.

Our decision: We have 30 days after the receipt date to decide whether we should change our decision and authorize your requested service [or pay your claim]. Within that same 30 days, we must send you and your treating provider our written decision. The written decision must explain the reasons for our decision and tell you the documents on which we based our decision.

If we deny your request: You have 60 days to appeal to Level 2. If we grant your request: The decision will authorize the service [or pay the claim] and the appeal is over.
If we refer your case to Level 3: We may decide to skip Level 1 and Level 2 and send your case straight to an independent reviewer at Level 3.

Level 2. Formal Appeal

Your request: You may request Formal Appeal if: (1) we deny your request at Level 1, or (2) you have an unpaid claim, and we did not provide a Level 1 review. After you receive our Level 1 denial, you or your treating provider must send us a written request within 60 days to tell us you are appealing to Level 2. If we did not provide a Level 1 review of your denied claim, you have 2 years from our first denial notice to request Formal Appeal. To help us make a decision on your appeal, you or your provider should also send us any more information (that you haven’t already sent to us) to show why we should authorize the requested service or pay the claim. Send your appeal request and information to:

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<td>Phone: 1.800.244.6224</td>
<td>Phone: 1.800.244.6224</td>
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<tr>
<td>Fax:  1.800.286.6797</td>
<td>Fax:  1.866.870.3842</td>
<td>Fax:  1.866.870.3842</td>
</tr>
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Our Acknowledgement: We have 5 business days after we receive your request for Formal Appeal (‘the receipt date”) to send you and your treating provider a notice that we got your request.

Our decision: For a denied service that you have not yet received, we have 30 days after the receipt date to decide whether we should change our decision and authorize your requested service. For denied claims, we have 60 days to decide whether we should change our decision and pay your claim. We will send you and your treating provider our decision in writing. The written decision must explain the reasons for our decision and tell you the documents on which we based our decision.

If we deny your request: You have four months to appeal to Level 3.
If we grant your request: We will authorize the service or pay the claim and the appeal is over.
If we refer your case to Level 3: We may decide to skip Level 1 and Level 2 and send your case straight to an independent reviewer at Level 3.
Level 3: External Independent Review

Your request: You may appeal to Level 3 only after you have appealed through Levels 1 and 2. You have four months after you receive our Level 2 decision to send us your written request for External Independent Review. Send your request and any more supporting information to:

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</table>

Neither you nor your treating provider is responsible for the cost of any external independent review.

The process: There are two types of Level 3 appeals, depending on the issues in your case:

1. Medical necessity
   These are cases where we have decided not to authorize a service because we think the services you (or your treating provider) are asking for, are not medically necessary to treat your problem. For medical necessity cases, the independent review is a provider retained by an outside independent review organization (“IRO”), that is procured by the Arizona Department of Insurance and Financial Institutions, and not connected with our company. The IRO reviewer must be a provider who typically manages the condition under review.

2. Contract coverage
   These are cases where we have denied coverage because we believe the requested service is not covered under your insurance policy. For contract coverage cases, the Arizona Department of Insurance and Financial Institutions is the independent reviewer.

Medical Necessity Cases

Within 5 business days of receiving your request, we must:

3. Send a written acknowledgement of the request to the Director, you, and your treating provider.
4. Send the Director: the request for review; your policy, evidence of coverage or similar document; all medical records and supporting documentation used to render our decision; a summary of the applicable issues including a statement of our decision;
the criteria used and the clinical reasons for our decision; and the relevant portions of our utilization review guidelines. We must also include the name and credentials of the health care provider who reviewed and upheld the denial at the earlier appeal levels.

Within 5 business days of receiving our information, the Director must send all the submitted information to an external independent reviewer organization (the “IRO”).

Within 21 days of receiving the information the IRO must make a decision and send the decision to the Director.

Within 5 business days of receiving the IRO’s decision, the Director must send a notice of the decision to us, you, and your treating provider.

**The decision (medical necessity):** If the IRO decides that we should provide the service, we must authorize the service. If the IRO agrees with our decision to deny the service, the appeal is over. Your only further option is to pursue your claim in Superior Court.

**Contract Coverage Cases**

Within 5 business days of receiving your request, we must:

3. Send a written acknowledgement of your request to the Director, you, and your treating provider.
4. Send the Director: the request for review, your policy, evidence of coverage or similar document, all medical records and supporting documentation used to render our decision, a summary of the applicable issues including a statement of our decision, the criteria used and any clinical reasons for our decision and the relevant portions of our utilization review guidelines.

Within 15 business days of receiving this information, the Director must determine if the service or claim is covered, issue a decision, and send a notice to us, you, and your treating provider.

**Referral to the IRO for contract coverage cases:** The Director is sometimes unable to determine issues of coverage. If this occurs, the Director will forward your case to an IRO. The IRO will have 21 days to make a decision and send it to the Director. The Director will have 5 business days after receiving the IRO’s decision to send the decision to us, you, and your treating provider.

**The decision (contract coverage):** If you disagree with Director’s final decision on a contract coverage issue, you may request a hearing with the Office of Administrative Hearings (“OAH”). If we disagree with the Director’s final decision, we may also request a hearing before OAH. A hearing must be requested within 30 days of receiving the coverage issue determination. OAH has rules that govern the conduct of their hearing proceedings.
Obtaining Medical Records

Arizona Law (A.R.S. §12-2293) permits you to ask for a copy of your medical records. Your request must be in writing and must specify who you want to receive the records. The health care provider who has your records will provide you or the person you specified with a copy of your records.

**Designated Decision-Maker:** If you have a designated health care decision-maker, that person must send a written request for access to or copies of your medical records. The medical records must be provided to your health care decision-maker, or a person designated in writing by your health care decision-maker unless you limit access to your medical records only to yourself or your health care decision-maker.

**Confidentiality:** Medical records disclosed under A.R.S. §12-2293 remain confidential. If you participate in the appeal process, the relevant portions of your medical records may be disclosed only to people authorized to participate in the review process for the medical condition under review. These people may not disclose your medical information to any other people.

**Documentation for an Appeal**

If you decide to file an appeal, you must give us any material justification or documentation for the appeal at the time the appeal is filed. If you gather new information during the course of your appeal, you should give it to us as soon as you get it. You must also give us the address and phone number where you can be contacted. If the appeal is already at Level 3, you should also send the information to the Department.

**The Role of the Department of Insurance and Financial Institutions**

Arizona law (A.R.S. §20-2533(F)) requires “any member who files a complaint with the Department relating to an adverse decision to pursue the review process prescribed” by law. This means, that for appealable decisions, you must pursue the health care appeals process before the Director can investigate a complaint you may have against our company based on the decision at issue in the appeal.

The appeal process requires the Director to:

1. Oversee the appeals process.
2. Maintain copies of each utilization review plan submitted by insurers.
3. Receive, process, and act on requests from insurers for External, Independent Review.
4. Enforce the decisions of insurers.
5. Review decisions of insurers.
6. Send, when necessary, a record of the proceedings of an appeal to Superior Court or to the Office of Administrative Hearings (OAH).
7. Issue a final administrative decision on coverage issues, including notice of right to request a hearing at OAH.

**Receipt of Documents**

Any written notice, acknowledgment, request, decision or other written document that is sent by mail is deemed received by the person to whom the document is properly addressed on the fifth business day after mailing. “Properly addressed” means your last known mailing address.
HEALTH CARE APPEAL REQUEST FORM

You may use this form to tell your insurer you want to appeal a denial decision.

[processor title, processor department, mailing address, phone number, fax number]

Insured Member’s Name: _______________________________
Member ID #: __________________________________________________________________
Name of representative pursuing appeal, if different from above: __________________________________________________________
Mailing Address: __________________________________________________________
Phone #: __________________________________________________________________
City: ______________________________  State: ______________________________
Zip Code: __________________________
Type of Denial: ☐ Denied Claim  ☐ Denied Service Not Yet Received
Name of Insurer that denied the claim/service:

If you are appealing your insurer’s decision to deny a service you have not yet received, will a 30 to 60 day delay in receiving the service likely cause a significant negative change in your health?

If your answer is “Yes,” you may be entitled to an expedited appeal. Your treating provider must sign and send a certification and documentation supporting the need for an expedited appeal.

What decision are you appealing? __________________________________________________________

(Explain what you want your insurer to authorize or pay for.)

Explain why you believe the claim or service should be covered:

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

(Attach additional sheets of paper, if needed.)

If you have questions about the appeals process or need help to prepare your appeal, you may call the Department of Insurance Consumer Assistance number (602) 364-2499 or 1-(800) 325-2548 or Cigna HealthCare at the number on the back of your ID card.
Make sure to attach everything that shows why you believe your insurer should cover your claim or authorize a service, including: Medical Records, Supporting documentation (letter from your doctor, brochures, notes, receipts, etc.) **Also attach the certification from your treating provider if you are seeking expedited review.

___________________________________________   ____________________
Signature of Insured or Authorized Representative   Date
PROVIDER CERTIFICATION FORM FOR EXPEDITED MEDICAL REVIEWS

(You and your provider may use this form when requesting an expedited appeal.)

[provider title, provider department, mailing address, phone number, fax number]

A patient who is denied authorization for a covered service is entitled to an expedited appeal if the treating provider certifies and provides supporting documentation that the time period for the standard appeal process (about 60 days) “is likely to cause a significant negative change in the patient’s medical condition at issue.”

PROVIDER INFORMATION

<table>
<thead>
<tr>
<th>Treating Physician/Provider</th>
<th>Phone # _____________________________</th>
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<tbody>
<tr>
<td></td>
<td>Fax # _______________________________</td>
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<td></td>
<td>Address</td>
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<td></td>
<td>City ________________________________  State __________</td>
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<tr>
<td></td>
<td>____________________________________ Zip Code __________</td>
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</tbody>
</table>

PATIENT INFORMATION

<table>
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<tr>
<th>Patient’s Name ____________________________</th>
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<tr>
<td>Member ID# _______________________________</td>
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<td>Phone # _________________________________</td>
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<tr>
<td>Address</td>
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<tr>
<td>City _______________________________  State __________</td>
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<tr>
<td>Zip Code _________________________________</td>
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INSURER INFORMATION

<table>
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<tr>
<th>Insurer Name</th>
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<tr>
<td>Phone # __________________________</td>
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<tr>
<td>Fax # ____________________________</td>
</tr>
<tr>
<td>Address</td>
</tr>
<tr>
<td>City _______________________________  State __________</td>
</tr>
<tr>
<td>____________________________ Zip Code __________</td>
</tr>
</tbody>
</table>

- Is the appeal for a service that the patient has already received? 
  
  □ Yes □ No

If “Yes” the patient must pursue the standard appeals process and cannot use the expedited appeals process.

If “No” continue with this form.

- What service denial is the patient appealing? ____________________________

- Explain why you believe the patient needs the requested service and why the time for the standard appeal process will harm the patient. ____________________________
Attach additional sheets if needed, and include:

- Medical records; and
- Supporting documentation

If you have questions about the appeals process or need help regarding this certification, you may call the Department of Insurance Consumer Assistance number (602) 364-2499 or 1-(800) 325-2548. You may also call Cigna HealthCare at the number on the back of your ID card.

I certify, as the patient’s treating provider, that delaying the patient’s care for the time period needed for the informal reconsideration and formal appeal processes (about 60 days) is likely to cause a significant negative change in the patient’s medical condition at issue.

Provider’s Signature _______________________________  Date ___________________