Medical Payment Appeal Form

To appeal a denied request for payment of a medical service/item, please complete the following and either fax it to 1-866-567-2474 or mail it to the address on the next page.

Please Note: If your request will be received by Cigna more than 60 calendar days after the date of the denial, you must provide a reason why the 60-calendar day timely filing limit should be extended. You may attach any letter and/or documentation to this form that supports your appeal request.

I am requesting an appeal of the adverse organization determination dated _______________ because:

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THIS APPEAL IS BEING FILED BY: *Select one of the following.*

1. ____ **Me, the Cigna customer.** *Complete and sign below.*

Customer's Name (please print): ______________________ Customer's Signature: ______________________ Date (mm/dd/yyyy): ______________	Customer's Address: ______________________ ______________________ ______________________ Customer's Phone #: ______________
Cigna Customer ID#: ______________________	Customer's Medicare Number: ______________________

2. ____ **A representative appointed by me, the Cigna customer.**
If using this form to appoint a representative, the customer must complete and sign Section 1 above. The representative must complete and sign all applicable sections on the next page. Otherwise, you must provide another document showing this person is legally authorized to act on your behalf.

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Appointment of Representative: I appoint this individual: ______________________________ to act as my representative in connection with my claim or asserted right under Title XVIII of the Social Security Act (the "Act") and related provisions of Title XI of the Act. I authorize this individual to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with my appeal, wholly of in my stead. I understand that personal medical information related to my appeal may be disclosed to the representative indicated below.

Acceptance of Appointment: I, _______________________, hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the Department of Health and Human Services; that I am not, as a current or former employee of the United States, disqualified from acting as the party's representative; and that I recognize that any fee may be subject to review and approval by the Secretary.

I am a/an ____

(*Professional status or relationship to the party, e.g. Attorney, Relative*)

Representative's Signature:	Representative's Address:
___________________________	___________________________ ___________________________
Date (mm/dd/yyyy): ________________	Representative's Phone #: ________________

This section must be completed if the representative is required to, or chooses to waive their fee for representation. (Note that providers or suppliers that are representing a beneficiary and furnished the items or services may not charge a fee for representation and must complete this section.)

I waive my right to charge and collect a fee for representing ______________________________ before the Secretary of the department of Health and Human Services.

Representative's Signature: ______________________________ Date: ________________

Please attach a copy of the Notice of Denial of Payment and send to:

Cigna Medicare Services / Attn: Medicare Appeal Dept. / PO Box 29030 / Phoenix, AZ 85038
Or to our secure fax: **1-866-567-2474**

If you need help completing this form, have questions about this process, or want to file an expedited appeal over the phone, you may call 1-800-973-2580 (Option 2), 7 days a week, 8 am – 8 pm (hours apply Monday – Friday, February 15 – September 30). TTY users should call 711.

This information is available for free in other languages. Please call our customer service number at 1-800-627-7534 (TTY 711), 7 days a week, 8 am – 8 pm, hours apply Monday – Friday, February 15 – September 30. Esta información está disponible de forma gratuita en otros idiomas. Favor de contactar a nuestro Departamento de servicio al cliente llamando al 1-800-627-7534 (TTY 711), 7 días de la semana, 8 am – 8 pm Del 15 de febrero al 30 de septiembre, llame de lunes a viernes.

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