Physician referral form

This form must be completed when referring patients to network-participating specialists aligned to the appropriate plan* for visits in the office setting. Please provide all information requested below. If all information is not provided, we will return this form to you and ask that you complete and return it within three business days.

PRIMARY CARE PROVIDER (PCP) INFORMATION	
PCP Address: <address>	
PCP Phone: <phone number>	PCP Fax Number: <fax number>
PCP TIN**: <TIN>	Requesting PCP: <requesting PCP>
PCP Office Contact Name: <contact name>	
If the requesting provider is not a PCP, please explain (e.g., Nurse Practitioner at office covering for PCP, etc.) <explanation>	
Diagnosis: <diagnosis>	
PATIENT INFORMATION	
Patient Name: <name>	Patient Cigna ID: <ID number>
Patient Date of Birth: <DOB>	
SPECIALIST INFORMATION	
Specialist Name: <name>	Specialty Type (e.g., cardiology, pulmonology): <specialty>
Specialist Address: <address>	
Specialist TIN (if available): <TIN>	

All referrals to specialists for an office visit must be submitted by fax, mail, or phone.

Fax: 866.873.8279

Mail: Cigna Healthcare, Attn: Precertification and Referral Department, 2nd Floor, 1640 Dallas Parkway, Plano, TX 75093

Phone: 866.494.2111 Choose the prompt for "specialist referral." You will be asked to provide all the information on this form.

When making referrals, please use the online directories at **Cigna.com/hcpdirectory** or **Cigna.com/ifp-providers** to find participating physicians, hospitals, and other health care providers. If you have questions, call Cigna Healthcare Customer Service at **866.494.2111**.

* Please check your patient's ID card for more guidance.

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