Cigna AUTHORIZATION LETTER

Prior Authorization Determination

Cigna Health Insurance
Prior Authorization Department
[Address]
[Phone]

Date: [Authorization Date]

AUTHORIZATION DETERMINATION

Authorization Number:	[AUTH-XXXXXXXXXX]
Member Name:	■■■■■■■ ■■■■■■■■
Member ID:	[MEMBER ID]
Date of Birth:	XX/XX/XXXX
Requesting Provider:	[Provider Name, MD]
Provider NPI:	[NPI Number]

Service Authorized

Procedure:	[Imaging Procedure Name]
CPT Code(s):	[CPT Codes]
Diagnosis Code(s):	[ICD-10 Codes]
Service Date(s):	[Authorized Date Range]
Number of Services:	[Quantity]

DETERMINATION: APPROVED

This authorization has been approved based on the clinical information provided and medical necessity criteria. The authorized service(s) must be provided by an in-network provider within the approved timeframe.

Important Notes:

• Authorization valid for dates specified above
• Services must be medically necessary
• Provider must be in-network
• Authorization does not guarantee payment
• Subject to benefit verification at time of service

For questions, contact Cigna Prior Authorization Department.
Reference authorization number on all correspondence.