Shop for Plans

- **Shop for your own coverage**

- Medical
- Dental
- Other Supplemental
- (Cancer Treatment, Hospital Indemnity, and more)

- **Plans through your employer**

- Learn about the medical, dental, pharmacy, behavioral, and voluntary benefits your employer may offer.
- Explore coverage through work

- **Learn**

- How to Buy Health Insurance
- Types of Dental Insurance
- Open Enrollment vs. Special Enrollment
- See all topics

- **Looking for Medicare coverage?**

- Shop for Medicare plans

Shop for Plans

Shop for Plans

- Medical
- Dental
- Other Supplemental
- Explore coverage through work
- How to Buy Health Insurance
- Types of Dental Insurance
- Open Enrollment vs. Special Enrollment
- See all topics
- Shop for Medicare plans

- Member Guide
- Find a Doctor

How to File an Appeal or Grievance

Know how to voice your concerns or complaints.

Are you a member?

Activate your myCigna account for access to all plan details and live, 24/7 support.

Activate your account nowWhy activate your account?

Log in to your myCigna account

Loading...

At Cigna Healthcare[SM], we want you to be satisfied with your health care plan. In support of this goal, we have put a process in place to address your concerns and complaints. Cigna Healthcare also has a three-step process to appeal or request review of coverage decisions.

1. Call Customer Service at the number on your ID card.
2. If customer service is unable to resolve your concern, ask the representative how to appeal.
3. If you are not satisfied, we will provide information on other options that may be available.

If your benefit plan is through your employer, an additional external independent review of coverage decisions involving issues of medical necessity or experimental treatment may be available. You will be notified in writing as to what type of review is available to you.

To file an appeal or grievance:

Go to Customer Forms

Or, if you're a myCigna user, log in to myCigna and go to the Forms Center

Learn about appeals for Medicare plans

How to request an appeal if you have a plan through your employer

The appeal process you must follow is determined by the benefits plan your employer has chosen and follows state and federal rules specific to your benefits plan. If you request review of a coverage decision, you will receive a document outlining the appeal process. You can also refer to your Group Service Agreement, Group Insurance Certificate or other benefits-plan document or call customer service for additional information.

Following is a general description of the internal single level appeal process for coverage decisions.

1. To begin the process, **call customer service at the telephone number on your ID card** within 180 calendar days of the date of the initial payment or denial notice
    - Explain why you believe the initial decision should be reconsidered
    - Along with your written appeal request (or promptly after you request an appeal by phone) include any documentation that supports your argument. State Requirements may differ from this process.
2. Your request will be reviewed by someone who was not involved in the initial decision and has the authority to take corrective action if necessary
    - Decisions will be based upon the terms of your benefits plan
    - A physician will be involved in any review related to medical necessity
    - If your situation requires urgent care, the review and response will be expedited
3. You will be notified in writing of the appeal decision within 30 calendar days for Pre Service and Post Service Medical Necessity appeals, and within 60 days for Post Service Administrative appeals.

Independent external reviews

If you are still not satisfied following completion of the internal appeals process, you or your representative may have the option to submit the dispute for resolution (which is binding upon Cigna Healthcare and the plan) by an independent external reviewer

for appeals that involve medical judgment. Other options may be available to you depending on the type of plan your employer has chosen.

If the appeal involves a coverage decision based on issues of medical necessity or experimental treatment, you may be able to request independent review by an external review organization. If external review is available to you, you will be provided with instructions, after the final internal appeal, on how to request this review. The decision of the external reviewer is binding upon Cigna Healthcare or your employer, but not upon you.

If you are covered under a health insurance policy or a health plan offered by a health maintenance organization (HMO), the state insurance department or other government agency may be able to assist you in resolving your dispute. If your benefits plan is self-insured by your employer, your employer may have elected not to offer external review. Check with your employer or in your summary plan description for more options.

In most cases, you must complete the Cigna Healthcare internal appeal process described above before pursuing arbitration or legal action. You may also want to consider taking advantage of the independent external review that may be available. To learn more about the appeal process, call customer service at the number on your ID card.

Visit our Knowledge Center to learn more about:

How Health Insurance Works

What is Managed Care?

What is Prior Authorization?

View all articles

Member Guide Quick Links

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I want to...

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- File a claim
- View my claims and EOBs
- Check coverage under my plan
- See prescription drug list
- Find an in-network doctor, dentist, or facility
- Find a form
- Find 1095-B tax form information
- View the Cigna Healthcare Glossary
- Contact Cigna Healthcare

Audiences

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Manage Your Account

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