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Request for Health Care Professional Payment Review

CIGNA

Step 1: Contact CIGNA's Customer Service Department at the toll-free number listed on the back of the CIGNA participant ID card to review any adverse determinations/payment reductions. If a Customer Service representative is unable to change the initial decision, you will be advised at that time of your right to request an appeal.

Step 2: Complete and mail this form and/or appeal letter along with all supporting documentation to the address identified in Step 3 on this form. Your appeal should be submitted within 180 days for Level 1 appeals and 60 days for Level 2. Please allow 30 days for processing your appeal.

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Requests for review should include:

1. This completed form and/or an appeal letter requesting an appeal review and indicating the reason(s) why you believe the adverse determination is incorrect and should be changed. If submitting a letter, please include all information requested on this form.
2. Include a copy of the original claim and the Explanation of Payment (EOP) or Explanation of Benefits (EOB), if applicable.
3. For reviews involving a previous clinical denial, such as denied hospital days, level of care, medical necessity or services denied for no prior authorization, supporting documentation should include a narrative describing the situation, an operative report and medical records, as applicable.

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PLEASE COMPLETE:

Are you a contracted with CIGNA? Yes ☐ No☐ Tax ID# contracted

Have services been rendered? Yes☐ No☐ If no, and these services require prior authorization, we will resolve your appeal request for benefit coverage as expeditiously as possible within 15 calendar days.

Is this a second level appeal review request? Yes☐ No☐

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Please check the issue that best describes your appeal. The initial decision was related to:

- ☐ Mutually exclusive, incidental or bundling procedure code denial
- ☐ Your CIGNA contract and the Fee Schedule or reimbursement terms
- ☐ Modifier reimbursement. List modifier(s): _____
- ☐ Inpatient Facility denial (level of care, length of stay, delayed treatment day)
- ☐ Experimental/Investigational procedure
- ☐ Medical necessity of the service
- ☐ Timely claim filing (without proof)
- ☐ Pre-certification/Authorization not obtained

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- ☐ Request for in-network benefits
- ☐ Benefit plan exclusion or limitation
- ☐ Benefit plan administration (i.e. copy, deductible, etc)
- ☐ Maximum Reimbursable Amount

- ☐ Corrected bill (addition or correction of modifier, CPT code or charge amount)
- ☐ Other (please indicate): _____

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CIGNA Subscriber Name: _____ **Subscriber ID#:** _____

Employer Name: _____ **Account Number (from CIGNA ID card):** _____

Patient Name: _____ **Date of Birth:** _____ **State of Residence:** _____

test_text_3

Date(s) of Service: _____ **Procedure/Type of Service:** _____

Claim Number/Document Control Number, if payment related appeal: _____

Indicate below where appeal correspondence should be directed:

Health Care Provider: (Practitioner/Facility Name):

_____

test_text_2

Street/PO Box: _____ **City:** _____ **State:** _____ **Zip:** _____

Referring Health Care Professional Name (if applicable): _____

Step 3: Mail the completed Request for Health Care Professional Review form or letter of appeal **along with all supporting documentation** to the address listed below:

CIGNA Appeals Unit
P.O. Box 5225
Scranton, PA 18505-5225

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If a decision is made to change the initial decision and issue additional payment, you may be notified of the payment adjustment through an Explanation of Payment (EOP) or Explanation of Benefits (EOB). If a decision is made to uphold our initial decision, you will be notified in writing.