Appeal Request

CIGNA

An appeal is a request to change a previous adverse decision made by CIGNA. You or your representative (including a physician on your behalf) may appeal the adverse decision related to your coverage.

Step 1: Contact CIGNA's Customer Service Department at the toll-free number listed on the back of your ID card to review any adverse coverage determinations/payment reductions. We may be able to resolve your issue quickly outside of the formal appeal process. If a Customer Service representative cannot change the initial coverage decision, he or she will advise you of your right to request an appeal.

Step 2: Complete and mail this form and/or appeal letter along with any supporting documentation to the address identified below. Complete and accurate preparation of your appeal will help us perform a timely and thorough review. In most cases your appeal should be submitted within 180 days, but your particular benefit plan may allow a longer period.

You will receive an appeal decision in writing.

Requests for an appeal should include:

1. This completed form and/or an appeal letter requesting a review and indicating the reason(s) why you believe the adverse decision is incorrect and should be changed. If you submit a letter, please include all the information that is requested on this form.
2. A copy of the original claim and explanation of payment (EOP), explanation of benefit (EOB), or initial adverse decision letter, if applicable.
3. Any documentation supporting your appeal. For adverse decisions based upon lack of medical necessity, additional documentation may include a statement from your healthcare professional or facility describing the service or treatment and any applicable medical records.

CIGNA Participant Name: _____ **Participant ID#:** _____

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

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

Health Care Professional or Facility Name: _____ **Date(s) of Service:** _____

Claim Number/Document Control Number: _____ **Procedure/Type of Service:** _____

Appeal is being filed by:

Participant ☐ **Primary Care Physician** ☐ **Specialist/Ancillary Physician** ☐ **Health Care Facility** ☐

Other Representative ☐ **(Indicate relationship to participant):** _____

Name of person filling out the form: _____

Signature: _____

Phone # (Home): _____ **(Business):** _____ **Date:** _____

Have you already received services? Yes ☐ **No** ☐ If no, and these services require prior authorization, we will resolve your appeal request for coverage as quickly as possible, within 15 calendar days.

Is this a second appeal? Yes☐ **No**☐

Please check off the selection that best describes your appeal:

- ☐ Request for in-network coverage
- ☐ Coverage Exclusion or Limitation
- ☐ Coverage Administration (i.e. copay, deductible, etc.)
- ☐ Maximum Reimbursable Amount
- ☐ Inpatient Facility Denial (Level of Care, Length of Stay)
- ☐ Mutually Exclusive, Incidental procedure code denials
- ☐ Additional reimbursement to your out of network healthcare professional for a procedure code modifier
- ☐ Experimental/Investigational Procedure
- ☐ Medical Necessity
- ☐ Timely Claim Filing
- ☐ Benefits reduced due to re-pricing of billed procedures (Viant, Beech Street, Multiplan, etc.)

Reason why you believe the adverse coverage decision was incorrect and what you feel the expected outcome should be. As a reminder, please attach any supporting documentation (for medical necessity –related denials, include medical records documentation from your health care professional or facility). _____

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Additional comments:

Mail the completed Appeal Request form or appeal letter along **with all supporting documentation** to:

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

Important: This address is intended only for appeals of coverage denials. Any other requests sent to this address will be forwarded to the appropriate CIGNA location, which may result in a delay in handling your request or processing your claim.