Successful Appeals

Request for Health Care Professional Payment Review

BEFORE PROCEEDING, NOTE THE FOLLOWING:

- Corrected claims should be submitted to the claim address on the back of the patient's Cigna identification card (ID card). If the claim in question has had no payments to date or you are submitting additional information for the initial review of payment, please forward to the address on the back of the patient's ID card.
- Fee schedule or reimbursement terms for multiple patients do not require individual appeals. Contact Cigna Customer Service at the toll-free number listed on the back on the patient's ID card for further assistance. If you are a contracted health care professional and you feel your contract is being inappropriately applied, please contact your Experience Manager or Experience Consultant at Cigna.

Step 1: Contact Cigna Customer Service at the toll-free number listed on the back of the patient's Cigna 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.

Step2: 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 and allow 60 days for processing your appeal, unless other timelines are required by state law.

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 claim payment is incorrect and should be changed. If submitting a letter, please include all information requested on this form. If only submitting a letter, please specify in the letter this is a Health Care Professional Appeal.
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.

PLEASE COMPLETE:

Are you contracted with Cigna? Yes☐ No☐
Tax identification number ______________________ National Provider Identifier (NPI) number _________________

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 and within the time permitted by applicable law.

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)
☐ Precertification or prior authorization not obtained
☐ Request for in-network benefits
☐ Benefit plan exclusion or limitation
☐ Maximum Reimbursable Amount
☐ Non participating anesthesiologist, radiologist, or pathologist requesting in-network benefits
☐ Other (please indicate) ____

Cigna Subscriber Name: ________________________________ **Subscriber ID#:** ___________________________

Employer Name: ________________________________ **Account Number (from Cigna ID card):** __________________________________

Patient Name: ____ **Date of Birth:** _________________**State of Residence:** ___________

Date(s) of Service: ____**Procedure/Type of Service:** _________________________________

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

Original Claim Amount Billed: ________________ **Original Claim Amount Paid:** _________________
Indicate below where appeal correspondence should be directed:

Health Care Provider (Practitioner/Facility Name): ____

Street/PO Box: ____________________________ **City:** ____________________ **State:** ___________ **Zip:** ___________

Telephone: _______________________________ **Fax:** ___________________________________

Referring Health Care Professional Name (if applicable): ____________________________________

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Step3: Refer to the patient's Cigna ID card to determine the appeal address to use below. Mail this completed form (Request for Health Care Professional Review) or a letter of appeal **along with all supporting documentation** to the address below:

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Successful Appeals

Cigna ID cards:	If the Cigna ID card indicates: GWH -Cigna or 'G' on the front of the card:
Cigna Appeals Unit PO Box 188011 Chattanooga, TN 37422	Cigna Appeals Unit P.O. Box 188062 Chattanooga, TN 37422-8062

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.

State the reason for the appeal and expected outcome below. Note: please attach supporting documentation.

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Name of Requestor/Title: ____ **Today's Date:** _______________

Phone #: __________________________**Fax #:** ___________________________

Signature: ____

☐ **Check if additional information is attached**

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Practitioner and Provider Complaint and Appeal Request

NOTE: Completion of this form is mandatory. To obtain a review submit this form as well as information that will support your appeal, which may include medical records, office notes, discharge summaries, lab records and/or member history (this is not an all-inclusive list) to the address listed on your Explanation of Benefits (EOB) or other correspondence received from Aetna.

Please provide the following information.
(This information may be found on the front of the member's ID card.)

Today's Date	Member's ID Number	Plan Type ☐ Medical ☐ Dental	Member's Group Number *(Optional)*

Member's First Name	Member's Last Name	Member's Birthdate *(MM/DD/YYYY)*

Provider Name	TIN/NPI	Provider Group *(if applicable)*
Contact Name and Title		
Contact Address *(Where appeal/complaint resolution should be sent)*		
Contact Phone	Contact Fax	Contact Email Address

To help Aetna review and respond to your request, please provide the following information.
(This information may be found on correspondence from Aetna.)
You may use this form to appeal multiple dates of service for the same member.

Claim ID Number (s)	Reference Number/Authorization Number	Service Date(s)
Initial Denial Notification Date(s)	Reconsideration Denial Notification Date(s)	
CPT/HCPC/Service Being Disputed		
Explanation of Your Request *(Please use additional pages if necessary.)*		

Note: If you are acting on the member's behalf and have a signed authorization from the member or you are appealing a preauthorization denial and the services have yet to be rendered, use the member complaint and appeal form.

You may mail your request to:

Aetna-Provider Resolution Team
PO Box 14020
Lexington, KY 40512

Or use our National Fax Number: 859-455-8650

GR-69140 (3-17) **CRTP**

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