

Cigna HealthCare of Arizona, Inc.
Cigna Behavioral Health, Inc.
Cigna Dental Health Plan of Arizona, Inc.
Cigna Health and Life Insurance Company
Connecticut General Life Insurance Company

Appeals Process Information Packet

CAREFULLY READ THE INFORMATION IN THIS PACKET AND KEEP IT FOR FUTURE REFERENCE. IT HAS IMPORTANT INFORMATION ABOUT HOW TO APPEAL DECISIONS WE MAKE ABOUT YOUR HEALTH CARE.

I. Introduction: Getting Information About the Health Care Appeals Process; Help in Filing an Appeal: Standardized Forms and Consumer Assistance From the Department of Insurance

We will send you a copy of this information packet when you first receive your policy, and within 5 business days after we receive your request for an appeal. When your insurance coverage is renewed, we will also send you a separate statement to remind you that you can request another copy of this packet. We will also send a copy of this packet to you or your treating provider at any time upon request. Just call our customer services number at 1.800.244.6224 to ask.

At the back of this packet, you will find forms you can use for your appeal. The Department of Insurance and Financial Institutions (“the Department”) developed these forms to help people who want to file a health care appeal. You are not required to use them. We cannot reject your appeal if you do not use them. If you need help in filing an appeal, or you have questions about the appeals process, you may call the Department’s Consumer Assistance Office at 602.364.2499 or 1.800.325.2548 or call our customer service number.

Either you or your treating provider can file an appeal on your behalf. If you decide to appeal our decision to deny authorization for a service, you should tell your treating provider so the provider can help you with the information you need to present your case. When we do not authorize or approve a service or pay for a claim, we must notify you of your right to appeal that decision. Your notice may come directly from us, or through your treating provider. You **can** appeal the following decisions: (1) we do not approve a service that you or your treating provider has requested; (2) we do not pay for a service that you have already received; (3) we do not authorize a service or pay for a claim because we say that it is not “medically necessary”; (4) we do not authorize a service or pay for a claim because we say that it is not covered under your insurance policy, and you believe it is covered; (5) we do not notify you, within 10 business days of receiving your request, whether or not we will authorize a requested service; and (6) we do not authorize a referral to a specialist. In addition, Individual Plan applicants may appeal a decision regarding initial eligibility. You **cannot** appeal the following decisions: (1) you disagree with our decision as to the amount of “usual and customary charges”; (2) you disagree with how we are coordinating benefits when you have health insurance with more than one insurer; (3) you disagree with how we have applied or will apply your claims or services to your plan deductible; (4) you disagree with the amount of coinsurance or copayments that you paid or to be paid; (5) you disagree with our decision to issue or not issue a policy to you (except for Individual Plan applicants who may appeal a dispute regarding initial eligibility decisions); (6) you are dissatisfied with any rate increases you may receive under your insurance policy; (7) you believe we have violated any other parts of the Arizona Insurance Code. If you disagree with a decision that is not appealable according to this list, you may still file a complaint with the Department of Insurance and Financial Institutions, Consumer Affairs Division, 100 North 15th Avenue, Suite 261 Phoenix, AZ 85007-2630.

All participants may inquire about their benefits at any time by contacting Cigna HealthCare Customer Services as described below. You may request that the Plan review its decisions involving a request for service or denial of a claim. In general, the following levels involving benefit information and appeal processes, all discussed below, are available to all participants. At any time during the expedited review, Level 1, or Level 2 appeal processes the Plan may request an External Independent Review.

- Expedited Review
- Level 1 & Level 2 Appeals
- External Independent Review

Note For Participants In Individual Medical Plans: The Interim Final Rules relating to internal claims and appeals and external review processes under the federal Patient Protection And Affordable

Care Act (PPACA) requires that Individual Plans follow a single level appeal process. Participants in the Individual Plans will only be required to complete one level of internal review before pursuing an external review.

II. Appeal Process

A. Expedited Review Level 1 and Level 2 (pursuant to A.R.S. §20-2534-expedited medical review)

**Please note that Dental Appeals are not eligible for expedited review.*

1. Eligibility

- a. **Request for a service not yet provided:** For a service that has not already been provided, you may obtain an Expedited Review, if:
- You have coverage with us;
 - Your request for a service has been denied and
 - Your treating provider certifies in writing and provides supporting documentation that the time required to process your request through the Level 1 and Level 2 Appeal process is likely to cause a significant negative change in your medical condition. At the end of this packet is a form that your provider may use for this purpose. Your provider could also send a letter or make up a form with similar information.
 - *To initiate an Expedited Review, contact your Customer Service Representative and send certification and supporting documentation to the address indicated below. Your Customer Services Representative will immediately refer your Expedited Review request to the Appeals Processor.*
- b. **Request for payment of denied claim:**
You may not obtain Expedited Review of a denied claim. Instead, you may initiate the Level 1 Appeals process (See Section II. B.) by calling a Customer Services Representative at Customer Services.

Expedited Review

Medical Appeals

Appeals Processor,
National Appeals Organization
Cigna HealthCare
P.O. Box 188011
Chattanooga, TN 37422

Behavioral Appeals

Cigna Behavioral Health
Central Appeals Unit
P.O. Box 188064
Chattanooga, TN 37422

Phone: 1.800.244.6224

Fax: 1.800.286.6797

Phone: 1.800.241.4057 ext. 7962009

Fax: 1.877.815.4827

2. Decision Process – Expedited Review Level 1

Within one (1) business day of receipt of your request and the accompanying certification and the supporting documentation, the Plan will make an Expedited Review decision and mail a notice of that decision to you and your treating provider.

a. Denial upheld:

- If the Plan upholds its denial of the requested service, in addition to the written notice the Plan will inform you, your representative, and/or treating provider by telephone. The written notice of the decision will include the criteria used and the clinical reasons for that decision, any references to supporting documentation, a statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of Relevant Information as defined, a statement describing any voluntary appeal procedures offered by us and your right to bring an action under ERISA section 502(a), and upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination.
- *If the Plan upholds the denial of the requested service, you may request further review as an Expedited Level 2 Appeal.* After you receive our Level 1 denial, your treating provider **must immediately** send us a written request (to the same person and address listed above for Level 1) to tell us you are appealing to Level 2. To help your appeal, your provider should also send us any more information (that the provider hasn't already sent us) to show why you need the requested service.

b. Denial reversed:

- If the Plan reverses its prior denial of a service, *you will be notified and the requested service will be authorized.* The notice of the decision will include the criteria used and the clinical reasons for that decision and any references to supporting documentation.

3. Decision Process – Expedited Review Level 2

Within one (1) business day of receipt of your request and the accompanying certification and the supporting documentation, the Plan will make an Expedited Review decision and mail a notice of that decision to you and your treating provider.

a. Denial upheld:

- If the Plan upholds its denial of the requested service, in addition to the written notice the Plan will inform you, your representative, and/or treating provider by telephone. The written notice of the decision will include the criteria used and the clinical reasons for that decision, any references to supporting documentation, a statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of Relevant Information as defined, a statement describing any voluntary appeal procedures offered by us and your right to bring an action under ERISA section 502(a), and upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination.
- *If the Plan upholds the denial of the requested service, you will receive written notice of the option to proceed to External, Independent Review (See Section II. D).*

b. Denial reversed:

If the Plan reverses its prior denial of a service, *you will be notified and the requested service will be authorized.* The notice of the decision will include the criteria used and the clinical reasons for that decision and any references to supporting documentation.

B. LEVEL 1 APPEAL (pursuant to A.R.S. §20-2535-informal reconsideration)

1. Eligibility

If you were unable to resolve your concern during your discussion with the Customer Service Representative at Customer Services you may request review of the Plan’s decision as a Level 1 Appeal of your denied request for a service or claim if:

- You have coverage with us;
- We denied your request for covered service or claim;
- You do not qualify for an expedited appeal; and
- You or your treating provider asks for a Level 1 Appeal within 2 years of the date we first deny the requested service or claim by calling, writing, or faxing your request for review as indicated below.

Medical Appeals

Appeals Processor,
National Appeals Organization
Cigna HealthCare
P.O. Box 188011
Chattanooga, TN 37422

Phone: 1.800.244.6224

Fax: 1.877.815.4827

Behavioral Appeals

Cigna Behavioral Health
Central Appeals Unit
P.O. Box 188064
Chattanooga, TN 37422

Phone: 1.800.241.4057 ext. 7962009

Fax: 1.877.815.4827

Dental HMO Appeals

Appeals Coordinator,
National Appeals Unit
Cigna Dental
P.O. Box 188047
Chattanooga, TN 37422-8047

Phone: 1.800.244.6224

Fax: 1.866.870.3842

Dental PPO Appeals

Appeals Coordinator,
National Appeals Unit
Cigna Dental
P.O. Box 188044
Chattanooga, TN 37422-8044

Phone: 1.800.244.6224

Fax: 1.866.870.3842

2. Deadlines Applicable to the Level 1 Appeal Process

Within 5 business days after receiving your request for review at the Complaint level, the Plan will mail you and your treating provider:

- a notice indicating that your request was received and
- a copy of the Information Packet (only sent to treating provider upon request).

3. Decision Process

The Plan will make a decision and mail a notice of that decision to you and your treating provider within fifteen (15) calendar days after we receive an appeal for a pre-service or concurrent coverage determination, and within thirty (30) calendar days after we receive an appeal for a post-service coverage determination. If more time or information is needed to make the pre-service or concurrent determination, we will notify you in writing to request an extension of up to fifteen calendar days and to specify any additional information needed to complete the review.

- a. **Denial upheld:**
If the Plan upholds denial of the requested service or the denied claim, the notice of that decision will include the criteria used and the clinical reasons for that decision, any references to supporting documentation, a statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of Relevant Information as defined and upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination. You may request further review as a Level 2 Appeal. (See Section II.C.).
- b. **Denial reversed**
If the Plan agrees that the requested service should be provided or that the claims should have been paid, the Plan will authorize the service or pay the claim. The notice of that decision will include the criteria used and the clinical reasons for that decision and any references to supporting documentation.

C. LEVEL 2 APPEAL (pursuant to A.R.S. §20-2536-formal appeal)

1. Eligibility

- a. If the Plan denies:
 - your request for a service not already provided after review as a Level 1 Appeal or
 - a claim for a service that has already been provided after review as a Level 1 Appeal
 you may submit an oral or a written request for review as a Level 2 Appeal. If you submit a written request, please send to the address indicated below:
- b. Please send your review request within sixty (60) days of the last denial for a service that has not yet been provided (pre-service) and within two (2) years of the last denial for a claim for a service that has already been provided (post-service).
- c. Along with your oral or written request for review as a Level 2 Appeal, you or your treating provider are required to submit to the Plan in writing any material justification or documentation to support your request for the service not already provided or payment for a service already provided.
- d. The Level 2 appeal will be reviewed by an individual(s) who was not involved in any previous decision on the issue and who is not a subordinate of a previous decision maker.

Medical and Behavioral Appeals

Level 2 Coordinator
National Appeals Organization
Cigna HealthCare
P.O. Box 188011
Chattanooga, TN 37422

Phone: 1.800.244.6224

Fax: 1.800.286.6797

Dental HMO Appeals

Appeals Coordinator,
National Appeals Unit
Cigna Dental
P.O. Box 188047
Chattanooga, TN 37422-8047

Phone: 1.800.244.6224

Fax: 1.866.870.3842

Dental PPO Appeals

Appeals Coordinator,
National Appeals Unit
Cigna Dental
P.O. Box 188044
Chattanooga, TN 37422-8044

Phone: 1.800.244.6224

Fax: 1.866.870.3842

2. Deadlines Applicable to the Level 2 Appeal Process

Within 5 business days after receiving your request for review as a Level 2 Appeal the Plan will send you and your treating provider a notice indicating that your request was received.

3. Decision Process

For pre-service and concurrent care coverage determinations the review will be completed within fifteen (15) calendar days and for post-service claims, the review and written notification of the decision will be completed within thirty (30) calendar days from the date the Plan receives your Level 2 Appeal request. The Plan will mail a notice of the decision to you and your treating provider. If more time or information is needed to make the pre-service or concurrent determination, we will notify you in writing to request an extension of up to fifteen (15) calendar days and to specify any additional information needed to complete the review.

a. Denial upheld

If the Plan upholds its denial of the requested service or claim for a service that has already been provided, you will receive:

- written notice which includes the criteria used and the clinical reasons for that decision, any references to supporting documentation, a statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies

Relevant Information as defined, a statement describing any voluntary appeal procedures offered by the Plan and your right to bring an action under ERISA section 502(a), and upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination; and

- *written notice of the option to proceed to External, Independent Review.*

b. Denial reversed

If the Plan agrees that the requested service should be provided or that the claims should have been paid, the *Plan will authorize the service or pay the claim.* Written notice which includes the criteria used and the clinical reasons for that decision and any references to supporting documentation.

D. External, Independent Review (pursuant to A.R.S. §20-2537-external appeal)

1. Eligibility

Under Arizona law, you may seek an Expedited or Standard External, Independent Review only after seeking any available Expedited Review, Level 1 Appeal, and Level 2 Appeal. *Your request for Expedited or Standard External Independent Review should be submitted in writing to the address indicated below:*

Medical and Behavioral Appeals

Level 2 Coordinator
National Appeals Organization
Cigna HealthCare
P.O. Box 188011
Chattanooga, TN 37422

Phone: 1.800.244.6224
Fax: 1.800.286.6797

Dental HMO Appeals

Appeals Coordinator,
National Appeals Unit
Cigna Dental
P.O. Box 188047
Chattanooga, TN 37422-8047

Phone: 1.800.244.6224
Fax: 1.866.870.3842

Dental PPO Appeals

Appeals Coordinator,
National Appeals Unit
Cigna Dental
P.O. Box 188044
Chattanooga, TN 37422-8044

Phone: 1.800.244.6224
Fax: 1.866.870.3842

2. Deadlines applicable to the Standard External Independent Review Process

After receiving written notice from the Plan that your Level 2 Appeal has been denied, you have 4 months to submit a written request for External, Independent Review, including any material justification or documentation to support your request for the service or payment of a claim. Neither you nor your treating provider is responsible for the cost of any external independent review.

a. Medical Necessity Issues

These are cases where we have decided not to authorize a service because we think the services you (or your treating provider) are asking for, are not medically necessary to treat your problem. For medical necessity cases, the independent reviewer is a provider retained by an outside independent review organization (“IRO”), that is procured by the Arizona Insurance Department, and not connected with our company. The IRO provider must be a provider who typically manages the condition under review. If your appeal for External, Independent Review involves an issue of medical necessity:

- Within 5 business days of receipt of your request for External Independent Review, the Plan will:
 - (1) mail a written acknowledgment of the request to the Director of Insurance, you, and your treating provider of your request for Standard External, Independent Review, and
 - (2) send the Director of Insurance: the request for review; your certificate of coverage; all medical records and supporting documentation used to render our decision; a summary of the applicable issues including a statement of our decision; the criteria used and clinical reasons for our decision; and the relevant portions of our utilization review guidelines. We must also include the name and credentials of the health care provider who reviewed and upheld the denial at the earlier appeal levels.
- Within 5 days of receiving our information, the Insurance Director must send all the submitted information to an external independent review organization (the “IRO”).

- Within 21 days of receiving the information the IRO must make a decision and send the decision to the Insurance Director.
- Within 5 business days of receiving the IRO's decision, the Insurance Director must mail a notice of the decision to us, you, and your treating provider.

If the IRO decides that we should provide the service or pay the claim, we must authorize the service or pay the claim. If the IRO agrees with our decision to deny the service or payment, the appeal is over. Your only further option is to pursue your claim in Superior Court.

b. Coverage Issues

These are cases where we have denied coverage because we believe the requested service is not covered under your certificate of coverage. For contract coverage cases, the Arizona Insurance Department is the independent reviewer. If your appeal for Standard External, Independent Review involves an issue of service or benefit coverage or a denied claim:

- Within 5 business days of receiving your request for Standard External Independent Review, the Plan will:
 - (1) mail a written acknowledgment of your request to the Insurance Director, you, and your treating provider; and
 - (2) send the Director of Insurance: the request for review, your certificate of coverage, all medical records and supporting documentation used to render our decision, a summary of the applicable issues including a statement of our decision, the criteria used and any clinical reasons for our decision and the relevant portions of our utilization review guidelines.
- Within 15 business days of receiving this information, the Insurance Director must determine if the service or claim is covered, issue a decision, and send notice to us, you, and your treating provider. If the Director decides that we should provide the service or pay the claim we must do so.

The Insurance Director is sometimes unable to determine issues of coverage. If this occurs, the Insurance Director will forward your case to an IRO. The IRO will have 21 days to make a decision and send it to the Insurance Director. The Insurance Director will have 5 business days after receiving the IRO's decision to send the decision to us, you, and your treating provider. If you disagree with the Insurance Director's final decision on a contract coverage issue, you may request a hearing with the Office of Administrative Hearings ("OAH"). If we disagree with the Director's final decision, we may also request a hearing before OAH. A hearing must be requested within 30 days of receiving the Director's decision. OAH will schedule and complete a hearing for appeals from standard external independent review coverage decisions.

3. Deadlines Applicable to the Expedited External, Independent Review Process

After receiving written notice from the Plan that your Expedited Level 2 Appeal has been denied, you have **only 5 business days** to send us your **written** request for Expedited External Independent Review. Neither you nor your treating provider is responsible for the cost of any external independent review.

a. Medical Necessity Issues

These are cases where we have decided not to authorize a service because we think the services you (or your treating provider) are asking for, are not medically necessary to treat your problem. For medical necessity cases, the independent reviewer is a provider retained by an outside independent review organization ("IRO"), that is procured by the Arizona Insurance Department, and not connected with our company. The IRO provider must be a provider who typically manages the condition under review. If your appeal for Expedited External Independent Review involves an issue of medical necessity:

- Within 1 business day of receiving your request for Expedited External Independent Review, the Plan will:
 - (1) mail a written acknowledgment of the request to the Director of Insurance, you, and your treating provider; and

- (2) send the Director of Insurance: the request for review; your certificate of coverage; all medical records and supporting documentation used to render our decision; a summary of the applicable issues including a statement of our decision; the criteria used and clinical reasons for our decision; and the relevant portions of our utilization review guidelines. We must also include the name and credentials of the health care provider who reviewed and upheld the denial at the earlier appeal level.
- Within 2 business days of receiving our information, the Insurance Director must send all the submitted information to an external independent reviewer organization (the “IRO”).
- Within 72 hours of receiving the information the IRO must make a decision and send the decision to the Insurance Director.
- Within 1 business day of receiving the IRO’s decision, the Insurance Director must mail a notice of the decision to us, you, and your treating provider.

If the IRO decides that we should provide the service, we must authorize the service. If the IRO agrees with our decision to deny the service, the appeal is over. Your only further option is to pursue your claim in Superior Court.

b. Coverage Issues

These are cases where we have denied coverage because we believe the requested service is not covered under your evidence of coverage. For contract coverage cases, the Arizona Insurance Department is the independent reviewer. If your appeal for Expedited External Independent Review involves a contract coverage issue:

- Within 1 business day of receiving your request for Expedited External Independent Review, the Plan will:
 - (1) mail a written acknowledgment of your request to the Insurance Director, you, and your treating provider; and
 - (2) send the Director of Insurance: the request for review, your certificate of coverage, all medical records and supporting documentation used to render our decision, a summary of the applicable issues including a statement of our decision, the criteria used and any clinical reasons for our decision and the relevant portions of our utilization review guidelines.
- Within 2 business days of receiving this information, the Insurance Director must determine if the service or claim is covered, issue a decision, and send notice to us, you, and your treating provider.

The Insurance Director is sometimes unable to determine issues of coverage. If this occurs, the Insurance Director will forward your case to an IRO. The IRO will have 72 hours to make a decision and send it to the Insurance Director. The Insurance Director will have 1 business day after receiving the IRO’s decision to send the decision to us, you, and your treating provider.

If you disagree with the Insurance Director’s final decision on a contract coverage issue, you may request a hearing with the Office of Administrative Hearings (“OAH”). If we disagree with the Director’s final decision, we may also request a hearing before OAH. A hearing must be requested within 30 days of receiving the Director’s decision. OAH must promptly schedule and complete a hearing for appeals from expedited external independent review coverage decisions.

III. Obtaining Medical Records

A. Requesting Medical Records

Arizona law permits you to ask for a copy of your medical records. A.R.S. §12-2293. Medical records requests must be in writing. Requests must specify who you want to receive the records. The health care provider who has the requested records will provide you or the specified person with a copy of the records.

B. Designated Decision Maker

If you have a designated health care decision maker, that person must send a written request for access to or copies of your medical records. The medical records must be provided to your health care decision maker or a person designated in writing by the health care decision maker unless you limit access to your medical records only to you or your health care decision maker.

C. Confidentiality

Medical records disclosed under A.R.S. §12-2293 remain confidential. If you participate in the appeal process, the relevant portions of your medical records may be disclosed only to people authorized to participate in the review process for the medical condition under review. These people may not disclose your medical information to any other people.

D. Relevant Information

Is any document, record, or other information that was (a) relied upon in making the benefit determination; (b) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; (c) demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or (d) constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

IV. Documentation for an Appeal

If you decide to file an appeal, you must give us any material justification or documentation for the appeal at the time the appeal is filed. If you gather new information during the course of your appeal, you should give it to us as soon as you get it. **At all levels of the process discussed above, you also should give the appropriate Plan contact (see Section IV) your address and phone number.**

V. The Role of the Director of Insurance and Financial Institutions

Arizona law (A.R.S. §20-2533(F)) requires "any participant who files a complaint with the Department relating to an adverse decision to pursue the review process prescribed" by law. This means, that for appealable decisions, you must pursue the health care appeals process before the Insurance and Financial Institutions Director can investigate a complaint you may have against our company based on the decision at issue in the appeal.

The appeal process requires the Director to:

- Oversee the appeals process;
- Review decisions of insurers;
- Maintain copies of each utilization review plan submitted by insurers;
- Receive, process, and act on requests from insurers for External, Independent Review of claim;
- Enforce the decisions of insurers;
- Report to the Legislature;
- Send when necessary, a record of the proceedings of an appeal to Superior Court or to the Office of Administrative Hearings; and
- Issue a final administrative decision on coverage issues, including notice of right to request a hearing as applicable.

VI. Confidentiality

If you participate in the review process, the relevant portions of your medical records may be disclosed only to people authorized to participate in the review process for the medical condition under review. These people may not disclose such medical information to any other people.

VII. Receipt of Documents

Any written notice, acknowledgment, request, decision or other written document required to be mailed during the process discussed in this information packet is deemed received by the person to whom the document is properly addressed on the fifth business day after being mailed. "Properly addressed" means your last known address.

VIII. Complaints to the Department of Insurance and Financial Institutions

The Director of Insurance and Financial Institutions is required by law to require any participant who files a complaint with the Arizona Department of Insurance and Financial Institutions relating to an adverse decision to first pursue the review process established by the Arizona Legislature and the Plan as described above.

HEALTH CARE APPEAL REQUEST FORM

Medical Appeals and Behavioral Level 2 Appeals:

Cigna HealthCare
National Appeals Organization
P.O. Box 188011
Chattanooga, TN 37422

Behavioral Level 1 Appeals:

Cigna Behavioral Health
Central Appeals Unit
P.O. Box 188064
Chattanooga, TN 37422

Dental HMO Appeals:

Cigna Dental
National Appeals Unit
Appeals Coordinator
P.O. Box 188047
Chattanooga, TN 37422-8047

Dental PPO Appeals:

Cigna Dental
National Appeals Unit
Appeals Coordinator
P.O. Box 188044
Chattanooga, TN 37422-8044

Level 1 Appeals Fax:
1.877.815.4827
Level 2 Appeals Fax:
1.800.286.6797

Fax: 1.877.815.4827

Fax: 1.866.870.3842

Fax: 1.866.870.3842

You may use this form to tell your insurer you want to appeal a denial decision.

Insured Member's Name: _____ Member ID #: _____

Name of representative pursuing appeal, if different from above: _____

Mailing Address: _____ Phone #: _____

City: _____ State: _____ Zip Code: _____

Type of Denial: Denied Claim Denied Service Not Yet Received

Name of Insurer that denied the claim/service: _____

If you are appealing your insurer's decision to deny a service you have not yet received, will a 30 to 60 day delay in receiving the service likely cause a significant negative change in your health?
If your answer is "Yes," you may be entitled to an expedited appeal. Your treating provider must sign and send a certification and documentation supporting the need for an expedited appeal.

What decision are you appealing? _____

(Explain what you want your insurer to authorize or pay for.)

Explain why you believe the claim or service should be covered:

(Attach additional sheets of paper, if needed.)

If you have questions about the appeals process or need help to prepare your appeal, you may call the Department of Insurance and Financial Institutions Consumer Assistance number (602) 364-2499 or 1-(800) 325-2548 or Cigna HealthCare at 1-(800) _____

Make sure to attach everything that shows why you believe your insurer should cover your claim or authorize a service, including: Medical Records, Supporting documentation (letter from your doctor, brochures, notes, receipts, etc.) ** Also attach the certification from your treating provider if you are seeking expedited review.

Signature of Insured or Authorized Representative

Date

PROVIDER CERTIFICATION FORM FOR EXPEDITED MEDICAL REVIEWS

(You and your provider may use this form when requesting an expedited appeal.)

Medical Appeals:

Cigna HealthCare
National Appeals Organization
P.O. Box 188011
Chattanooga, TN 37422

Behavioral Appeals

Cigna Behavioral Health
Central Appeals Unit
P.O. Box 188064
Chattanooga, TN 37422

Fax: 1.800.286.6797

Fax: 1.877.815.4827

A patient who is denied authorization for a covered service is entitled to an expedited appeal if the treating provider certifies and provides supporting documentation that the time period for the standard appeal process (about 60 days) "is likely to cause a significant negative change in the patient's medical condition at issue."

PROVIDER INFORMATION

| | | |
|-----------------------------------|-------------|----------------|
| Treating Physician/Provider _____ | | |
| Phone # _____ | Fax # _____ | |
| Address _____ | | |
| City _____ | State _____ | Zip Code _____ |

PATIENT INFORMATION

| | | |
|----------------------|-------------|------------------|
| Patient's Name _____ | | Member ID# _____ |
| Phone # _____ | | |
| Address _____ | | |
| City _____ | State _____ | Zip Code _____ |

INSURER INFORMATION

| | | |
|--------------------|-------------|----------------|
| Insurer Name _____ | | |
| Phone # _____ | Fax # _____ | |
| Address _____ | | |
| City _____ | State _____ | Zip Code _____ |

- Is the appeal for a service that the patient has already received? Yes No

If "Yes" the patient must pursue the standard appeals process and cannot use the expedited appeals process.

If "No" continue with this form.

- What service denial is the patient appealing? _____
- Explain why you believe the patient needs the requested service and why the time for the standard appeal process will harm the patient. _____

Attach additional sheets if needed, and include:

- Medical records; and
- Supporting documentation

If you have questions about the appeals process or need help regarding this certification, you may call the Department of Insurance and Financial Institutions Consumer Assistance number (602) 364-2499 or 1-(800) 325-2548. You may also call Cigna HealthCare at 1 (800) 244-6224.

I certify, as the patient's treating provider, that delaying the patient's care for the time period needed for the informal reconsideration and formal appeal processes (about 60 days) is likely to cause a significant negative change in the patient's medical condition at issue.

Provider's Signature _____

Date _____