



Complete the top section of this form completely and legibly. Check the box that most closely describes your appeal or reconsideration reason. Be sure to include any supporting documentation, as indicated below. Requests received without required information cannot be processed.

### Request for Appeal or Reconsideration

Please complete each box

Member Name (Last, First MI) LAST, FIRST MI	Claim number	Provider Name/Contact name
Member HealthSpring ID#	Provider NPI	Provider's contact phone number with area code (   )   -
Member Date of Birth MM/DD/YYYY	Date of Service MM/DD/YYYY	Provider's contact email address

#### Reason for Appeal:

- ☐ Medical Necessity
- ☐ Notification/Precertification
  - Include Precertification/Prior Authorization number
- ☐ Referral Denial

#### Reason for Reconsideration:

- ☐ Payment Issue
- ☐ Duplicate Claim
- ☐ Retraction of Payment
- ☐ Request for Medical Records
  - Include copy of letter/request received
- ☐ Request for Additional Information
  - Include copy of letter/request received
  - Provide missing or incomplete information
- ☐ Coding Dispute
- ☐ Timely Filing
  - RA, EOB, or other documentation of filing original claim
- ☐ Coordination of Benefits

**Note:** If you have multiple reconsideration requests for the same provider and payment issue, please indicate this in the notes below and include a list of the following: Member ID#, Claim #, and Date of Service. If the issue requires supporting documentation as noted above, it must be included for each individual claim.

<b>Submit Appeals to:</b> Cigna-HealthSpring Attn: Appeals Unit PO Box 24087 Nashville, TN 37202 Phone: 1-800-511-6943 Fax: 1-800-931-0149 Secure Email: FAX- SOL@healthspring.com	<b>Submit Reconsiderations to:</b> Cigna-HealthSpring Attn: Reconsiderations PO Box 20002 Nashville, TN 37202 Phone: 1-800-230-6138 Fax: 1-615-401-4642
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If no additional documentation is required for your appeal or reconsideration request, fax in only this completed coversheet. You may use the space below to briefly describe your reason for appeal or reconsideration.


#### Definitions:

**Payment Issue:** Was not paid in accordance with the negotiated terms

**Coordination of Benefits:** Could not fully be processed until information from another insurer has been received

**Duplicate Claim:** The original reason for denial was due to a duplicate claim

**Medical Necessity:** Medical clinical review

**Pre-Certification/ Notification of Prior-Authorization or Reduced Payment:** Failure to notify or pre-authorize services or exceeding authorized limits

**Payer Policy Clinical:** Incorrectly reimbursed because of the payers payment policy

**Referral Denial:** Invalid or missing primary care physician (PCP) referral

**Request for additional information:** Missing or incomplete information \*reply via sender \*

**Request for Medical Records:** Please include copy of letter/request received

**Retraction of Payment:** Retraction of full or partial payment

**Timely Filing:** The claim whose original reason for denial was untimely filing