MEDICARE ADVANTAGE APPEALS AND PAYMENT DISPUTES REQUEST FORM

CLEAR FORM

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

Request for appeal or payment disputes

Customer First Name: _____ MI: _____ Customer Last Name: _____

Customer ID Number: _____ Date of Birth: _____ Claim Number: _____ Date of Service: _____

Provider Name / Contact Name: _____

Provider NPI: _____ Provider Telephone Number: _____ Provider's Contact Email Address: _____

Appeals

Reason for appeal:

- ☐ Medical necessity
- ☐ Notification/precertification
  - Include precertification/prior authorization number
- ☐ Referral denial
- ☐ Payer policy

Submit appeals to:

Cigna Medicare Advantage Appeals
PO Box 188081
Chattanooga, TN 37422
Fax: 1-855-350-8671

Payment Disputes

Reason for payment dispute:

- ☐ 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
  - Remittance Advice (RA), Explanation of Benefits (EOB), or other documentation of filing original claim Coordination of Benefits

Submit payment dispute to:

Cigna Medicare Services
Attn: Medicare Claims Department
Provider Payment Disputes
25500 North Norterra Drive
Phoenix, AZ 85085
Fax: 1-860-731-3463

Note: If you have multiple payment dispute requests for the same health care professional and payment issue, please indicate this in the notes below and include a list of the following: Customer ID #, Claim #, and date of service. If the issue requires supporting documentation as noted above, it must be included for each individual claim. If no additional documentation is required for your appeal or payment dispute request, fax in only this completed coversheet. **You may use the space starting on the next page to briefly describe your reason for appeal or payment dispute.**

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

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