

Medicare Advantage Arizona Contracted Provider Post Service Appeal and Claim Disputes



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

If your request is related to a pre-service denial please use this form: <https://www.cigna.com/medicare/resources/customer-forms>

Request for Appeal or Claim Disputes/Reconsiderations

Customer First Name:	MI:	Customer Last Name:	Date of Birth:	Customer ID Number:
Claim Number:	Line Item Number:	Date(s) of Service:		
Provider Name / Contact Name:		Provider NPI:	Phone Number:	Fax Number:

Contracted Provider Appeals

Reason for appeal:

<input type="checkbox"/> Observation or Inpatient Medical	<input type="checkbox"/> Service not covered by Medicare
<input type="checkbox"/> Medical Necessity (MN) Denial	<input type="checkbox"/> Not a covered benefit
<input type="checkbox"/> No Prior Authorization	<input type="checkbox"/> Member in Hospice
<input type="checkbox"/> Date of Service on claim does not match authorization	<input type="checkbox"/> Lack of Medical Records
<input type="checkbox"/> Member not effective on date of service	<input type="checkbox"/> Duplicate Claim
<input type="checkbox"/> Service or Item not covered	<ul style="list-style-type: none"> If the Original Claim was denied for any of the above reasons for Appeal, please check this box and the original denial reason listed.
<input type="checkbox"/> Exceeds benefit limit	
<input type="checkbox"/> Quantity billed exceeds amount authorized	<input type="checkbox"/> Post Service Claim Audit or Payment Recovery for any of the listed reasons.
<input type="checkbox"/> Service provided before authorization was effective	

Submit appeals to: Cigna Medicare Advantage Appeals **Fax #: 855-699-8985**
PO Box 188085
Chattanooga, TN 37422

Claim Disputes/Reconsideration

Reason for Dispute/Reconsideration:

<input type="checkbox"/> Coordination of Benefits	<input type="checkbox"/> Bundled Service
<input type="checkbox"/> Invalid or Missing Modifier	<input type="checkbox"/> Claim Timely filing Denials
<input type="checkbox"/> NPI/TIN mismatch	<input type="checkbox"/> Additional information required
<input type="checkbox"/> Invalid DX/CPT codes	<input type="checkbox"/> Itemized bill required
<input type="checkbox"/> Claim was not paid in accordance with contract allowable	<input type="checkbox"/> Duplicate Claim
<input type="checkbox"/> Not within the scope of contract	<ul style="list-style-type: none"> If the Original Claim was denied for any of the listed reasons for Dispute/Reconsideration, please check this box and the original denial reason listed.
<input type="checkbox"/> MUE (medically unnecessary edits)	
<input type="checkbox"/> Request for additional information	<input type="checkbox"/> Post Service Claim Audit or Payment Recovery for any of the listed reasons.
<ul style="list-style-type: none"> Include copy of letter/request received Provide missing or incomplete information <ul style="list-style-type: none"> Coding dispute Timely filling Remittance Advice (RA), Explanation of Benefits (EOB), or other documentation of filing original claim. 	

Submit Disputes to: Cigna **Fax #: 800-731-3463**
Attn: Provider Payment Disputes
P.O. Box 38639
Phoenix, AZ 85069

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Note: If you have multiple reconsideration 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 reconsideration request, fax in only this completed coversheet

You may use the space below to clearly describe your reason for appeal or claim dispute/reconsideration.

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