Medicare Advantage Contracted Post Service Appeal and Claim Dispute Form

CLEAR FORM

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:

- ☐ Observation or Inpatient Medical
- ☐ Medical Necessity (MN) Denial
- ☐ No Prior Authorization
- ☐ Date of Service on claim does not match authorization
- ☐ Member not effective on date of service
- ☐ Service or Item not covered
- ☐ Exceeds benefit limit
- ☐ Quantity billed exceeds amount authorized
- ☐ Service provided before authorization was effective
- ☐ Service not covered by Medicare
- ☐ Not a covered benefit
- ☐ Member in Hospice
- ☐ Lack of Medical Records
- ☐ Duplicate Claim
  - If the Original Claim was denied for any of the above reasons for Appeal, please check this box and the original denial reason listed.
- ☐ Post Service Claim Audit or Payment Recovery for any of the listed reasons.

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

Claim Disputes/Reconsideration

Reason for Dispute/Reconsideration:

- ☐ Coordination of Benefits
- ☐ Invalid or Missing Modifier
- ☐ NPI/TIN mismatch
- ☐ Invalid DX/CPT codes
- ☐ Claim was not paid in accordance with contract allowable
- ☐ Not within the scope of contract
- ☐ MUE (medically unnecessary edits)
- ☐ Request for additional information
  - Include copy of letter/request received
  - Provide missing or incomplete information
    - Coding dispute
    - Timely filling
  - Remittance Advice (RA), Explanation of Benefits (EOB), or other documentation of filing original claim.
- ☐ Bundled Service
- ☐ Claim Timely filing Denials
- ☐ Additional information required
- ☐ Itemized bill required
- ☐ Duplicate Claim
  - 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.
- ☐ Post Service Claim Audit or Payment Recovery for any of the listed reasons.

Submit Disputes to: Cigna Medicare Services
Attn: Medicare Claims Department
Non Contracted Provider Payment Disputes
PO Box 20002
Nashville, TN 37202

Fax #: 615-401-4642

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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.

CLICK TO PRINT