CIGNA HealthCare/Healthcare Provider Billing Dispute Resolution Instructions and Form

The Billing Dispute Resolution Process is available to resolve disputes over the application of coding and payment rules and methodologies to patient-specific, factual situations.

Please Note:

- **If this dispute pertains to services rendered on or before 05/27/2005, you should submit a "CIGNA HealthCare Retained Claims Form," if appropriate.**
- **You must include the appropriate filing fee with this form.**

Instructions – Please be sure that your submission meets the requirements set forth below.

A. Date of Service

You must be able to answer "Yes" to this question.

Is the date of service after 05/27/2005? Yes_____ No_____

B. Exhaustion of Internal Appeals

You must be able to answer "Yes" to one of the two questions listed below.

1. Has CIGNA HealthCare notified you that the internal appeals process has been exhausted?
Yes_____ No_____

OR

2. Has CIGNA HealthCare failed to communicate a notice of decision within 45 calendar days from CIGNA HealthCare's receipt of all documentation needed to complete your internal appeal? Yes____ No_____

C. Amount in Dispute

The amount in dispute (the additional amount you believe CIGNA HealthCare should have paid) for the single or multiple claims involving the same or similar issues must be more than $500.

1. Is the amount of the single or multiple claim(s) involving the same or similar issues in dispute more than $500?
Yes_____ No_____

2. If you answered "No" to question C1, have you previously filed and deferred consideration of similar claims within one (1) year and if so, does the filing of this claim result in an aggregate amount of greater than $500?
Yes_____ No_____

3. If you answered "No" to question C2, would you like this request to be deferred? (Note: The filing fee is payable with your first submission.)
Yes_____ No_____

Healthcare providers, healthcare provider groups and healthcare provider organizations must exhaust CIGNA HealthCare's internal appeals process before submitting a Billing Dispute for external review. Healthcare providers, healthcare provider groups and healthcare provider organizations are deemed by implication to have exhausted **(implied exhaustion)** CIGNA HealthCare's internal appeals process if CIGNA HealthCare does not communicate a notice of decision within 45 calendar days from the receipt of all documentation needed to complete the internal appeal.

DEADLINE: Eligible billing disputes must be submitted on this form within **90 calendar days** of exhaustion (or implied exhaustion) of CIGNA HealthCare's internal appeals process.

All supporting documentation that the healthcare provider, healthcare provider group, or healthcare provider organization wishes to be considered by the Billing Dispute Administrator must be attached to this form. CIGNA HealthCare is not obligated to submit to the Billing Dispute Administrator any documents that you previously submitted to CIGNA HealthCare or that were submitted or considered in the internal review. Examples of supporting documentation you may attach include Explanation of Payment(s), the final appeal denial letter, and additional clinical information. The Billing Dispute Administrator may request additional documentation from you. Any such additional documentation must be submitted within **30 calendar days** of the Billing Dispute Administrator's request.

CIGNA HealthCare/Healthcare Provider Billing Dispute Resolution Form

PLEASE SEND THIS COMPLETED FORM, ALL SUPPORTING DOCUMENTATION AND THE FILING FEE TO THE BILLING DISPUTE ADMINISTRATOR:

HAYES Plus, Inc.
157 S. Broad Street
Suite 400
Lansdale, PA 19446
Phone: 215.855.0615
Fax: 215.855.5318

Healthcare Provider Information

Treating Healthcare Provider Name (as submitted on claim)		Tax Identification Number (as submitted on claim)
Billing Address (Street, City, State, ZIP)		
Telephone Number Office ( ) ext.		Fax Number Office ( )
Contact Name	Contact Phone Number	Contact E-mail

Codes/Modifiers Disputed

A specific code set must be identified; a minimum of two codes must be entered below.

CPT® Code (*primary):*	**CPT Code®** *(secondary)*	*(and/or)* **Modifier**

Claim Information

If your billing dispute contains multiple claims for the same code set, please attach a separate sheet noting the healthcare provider's name, member's name, member's ID, date of service and claim number.

Member Name	Member ID Number	Member Group Number (optional)
Member Address (Street, City, State, ZIP)		

Request for Healthcare Provider Billing Dispute External Review

Date of Service:	Claim Number (indicated on CIGNA HealthCare's Explanation of Payment)
Amount in dispute (the amount you believe you are entitled to receive in this dispute): $	Filing fee: (Please check one) _____ $50.00 Claim amount between $500.00 and $1,000.00 _____ $50.00 +5% of amount of dispute which exceeds $1000.00 _____ No amount is enclosed because this claim is an aggregate of a deferred claim for which a filing fee has previously been paid. Amount enclosed: _____ Make check payable to **Hayes Plus, Inc.**
The decision of Hayes Plus, Inc. is final and binding on CIGNA HealthCare and the healthcare provider, healthcare provider group, or healthcare provider organization only with respect to the specific case under review by Hayes Plus, Inc. Participating healthcare providers may access CIGNA HealthCare's provider website (www.cignaforhcp.com) or Hayes Plus' website (www.hayesinc.com) for further information.	
Comments:	
I hereby acknowledge the terms of the Billing Dispute External Review Process and further certify the accuracy of the material and information submitted with the request: Signature of Healthcare Provider: Date:	

Please attach supporting documentation: Explanation of Payment (EOP), final appeal denial letter, additional clinical information, etc.