CIGNA Medicare Services®

CIGNA Medicare RX® (PDP)
Post Service Payment Determination Appeal Form
To request an appeal of an adverse coverage determination related to a treatment not yet received, please complete the following and either mail to the address below or fax to 866-945-4631.

____ I am requesting a standard appeal of the adverse coverage determination dated _____ because: (Please use the space below to provide your reasons for appealing. You may attach any letter and documentation to this form that supports your appeal request. If your request will be received after 60 calendar days from the above coverage determination date, please attach reasons that you wish to have an extension to the 60 calendar day timely filing limit.)

THIS APPEAL IS BEING FILED BY: (PLEASE SELECT ONE OF THE FOLLOWING)

1. ____ Me, the CIGNA Medicare RX (PDP) Enrollee.

2. ____ A Representative appointed by me, the CIGNA Medicare RX (PDP) Enrollee. Please complete statement below.

I am authorizing_____ to act as my representative in connection with my claim. I authorize this individual to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with my appeal. I understand that personal medical information related to my appeal may be disclosed to the representative.

Representatives, other than treating practitioners or other prescribers must complete and sign below.

I, _____, hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the Department of Health and Human Services; that I am not, as a current or former employee of the United States, disqualified from acting as a beneficiary's representative; and that I recognize that any fee may be subject to review and approval by the Secretary; and that I recognize that any fee may be subject to review and approval by the Secretary.

I am a/an _____
(PROFESSIONAL STATUS OR RELATIONSHIP TO THE PARTY, E.G. ATTORNEY, RELATIVE, ETC.)

Representatives must complete and sign below.

Representative's Signature: _____ Date: _____(MM/DD/YYYY)	Representative's Phone # :_____ Representative's Address: (Street, City, State, Zip Code) _____ _____

In order for CIGNA to process this appeal the Enrollee Must Sign Below

Enrollee's Name: (please print) _____ ID Number (from CIGNA Medicare RX (PDP ID Card): _____ Enrollee's HICN No.:_____ Enrollee Phone Number:_____	Enrollee's Address (Street, City, State, Zip): _____ _____ _____ Enrollee's signature: _____ Date:_____

Please attach a copy of your CIGNA Medicare Rx (PDP) EXPLANATION OF BENEFITS (EOB) to this form and send to:

Fax: 866-945-4631, or
CIGNA Pharmacy Services
Attention: Medicare Rx (PDP) Appeals
PO Box 42005
Phoenix, AZ 85080-2005