CIGNA Medicare Select Plus Rx® (HMO)

A Medicare Advantage HMO Medical Plan with Part D Prescription Drug Coverage

Adverse Coverage Determination Pre-Service Appeal Form

To request an appeal of a denied prescription drug not yet received, please complete all applicable sections of this form and either fax it to 1-866-567-2474 or mail it to the address on the next page.
Please Note: If your request will be received by CIGNA more than 60-calendar days after the date of the denial, you must provide a reason why the 60-calendar day timely filing limit should be extended. You may attach any letter and/or documentation to this form that supports your appeal request.

____ I am requesting a standard appeal of the adverse coverage determination dated ________________
because: ____

____

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OR

____ I am requesting an expedited appeal of the adverse coverage determination dated ______________ because I am receiving urgent care and believe my health or ability to regain maximum function could be jeopardized by waiting seven (7) calendar days for a standard appeal decision.

THIS APPEAL IS BEING FILED BY: *Select one of the following.*

1. ____ **Me, the CIGNA Medicare Select Plus Rx enrollee.** *Complete and sign below.*

Enrollee's Name (please print): ______________________ Enrollee's Signature: ______________________ Date (mm/dd/yyyy): ______________	Enrollee's Address: ______________________ ______________________ ______________________ Enrollee's Phone #: ______________
CIGNA Member ID#: ______________________	Enrollee's Medicare Number: ______________________

2. ____ **Prescribing Physician or Other Prescriber.** *Check "No" or "Yes" below if you are requesting an appeal on behalf of your patient. Only the prescribing physician or other prescriber may sign this section.*

☐ No, my patient's health or ability to regain maximum function will not be seriously jeopardized if we wait to provide the prescribed drug until after this appeal is processed through the standard seven (7) calendar day process. Please utilize the standard appeal process.

☐ Yes, my patient's health or ability to regain maximum function will be seriously jeopardized if we wait to provide the prescribed drug until after this appeal is processed through the standard seven (7) calendar day process. Please utilize the expedited appeal process.

Prescriber's Name *(print)*: ________________________ NPI: ________________________

Prescriber's Signature: ____________________________ Phone#: ______________________

3. ____ **A representative appointed by me, the CIGNA Medicare Select Plus Rx enrollee.** *Complete and sign section 1 above and all applicable sections on the next page, or provide documentation of the authority of your representative (i.e. Power of Attorney).*

H0354_1962009a CMS Approved 12202010

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Appointment of Representative: I appoint this individual: ______________________________ to act as my representative in connection with my claim or asserted right under Title XVIII of the Social Security Ace (the "Act") and related provisions of Title XI of the Act. 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, wholly of in my stead. I understand that personal medical information related to my appeal may be disclosed to the representative indicated below.

Acceptance of Appointment: 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 the party's representative; 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.*)

Representative's Signature:	Representative's Address:
________________________________	________________________________ ________________________________
Date (mm/dd/yyyy): ________________	Representative's Phone #: ______________

This section must be completed if the representative is required to, or chooses to waive their fee for representation. (Note that providers or suppliers that are representing a beneficiary and furnished the items or services may not charge a fee for representation and must complete this section.)

I waive my right to charge and collect a fee for representing ______________________________ before the Secretary of the department of Health and Human Services.

Representative's Signature: ______________________________ Date: ________________

Please attach a copy of the Notice of Denial of Medicare Prescription Drug Coverage and send to:

Toll Free Fax: 1-866-567-2474 or
CIGNA Medicare Services
Attn: Medicare Appeal Department
11001 N Black Canyon Hwy
Phoenix, AZ 85029

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