

Provider Dispute Resolution Request



INSTRUCTIONS

- Please complete the below form. Fields with an asterisk (*) are required.
- Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME.
- Provide additional information to support the description of the dispute. Do not include a copy of a claim that was previously processed.
- Multiple "LIKE" claims are for the same provider and dispute but different members and dates of service.
- For routine follow-up, please use the Claims Follow-Up Form instead of the Provider Dispute Resolution Form.
- Mail the completed form to: California Provider Dispute Resolution Request

Cigna Network
P.O. Box 188011
Chattanooga, TN 37422

GWH - Cigna Network
P.O. Box 668
Kennett, MO 63857

| | | | |
|---|------------------------|---|----------------------------|
| *Provider NPI | | Provider Tax ID | |
| *Provider Name | | | |
| Provider Address | | | |
| PROVIDER TYPE: <input type="checkbox"/> MD <input type="checkbox"/> Mental Health Professional <input type="checkbox"/> Mental Health Institutional <input type="checkbox"/> Hospital <input type="checkbox"/> ASC <input type="checkbox"/> SNF <input type="checkbox"/> DME <input type="checkbox"/> Rehab <input type="checkbox"/> Home Health <input type="checkbox"/> Ambulance <input type="checkbox"/> Other (please specify type): _____ | | | |
| CLAIM INFORMATION: <input type="checkbox"/> Single <input type="checkbox"/> Multiple "LIKE" Claims (Complete attached spreadsheet) Number of Claims: _____ | | | |
| *Patient Last Name | | (First) | (MI) Date of Birth |
| *Health Plan ID Number | Patient Account Number | Original Claim ID Number (If multiple claims, use attached spreadsheet) | |
| *Service Dates: (Required for Claim, Billing and Reimbursement of Overpayment Disputes) | | Original Claim Amount Billed | Original Claim Amount Paid |
| From: _____ To: _____ | | | |
| DISPUTE TYPE: <input type="checkbox"/> Claim <input type="checkbox"/> Seeking Resolution of a Billing Determination <input type="checkbox"/> Appeal of Medical Necessity / Utilization Management Decision <input type="checkbox"/> Contract Dispute <input type="checkbox"/> Disputing Request for Reimbursement of Overpayment <input type="checkbox"/> Other: _____ | | | |
| *DESCRIPTION OF DISPUTE: | | | |
| EXPECTED OUTCOME: | | | |
| Contact Name (Please Print) | | Title | Phone Number |
| Signature | | Date | Fax Number |

CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED (Please do not staple)

| | |
|-------------------------------------|---------------------|
| For Health Plan/RBO Use Only | |
| TRACKING NUMBER: _____ | PROV ID # _____ |
| CONTRACTED ____ | NON-CONTRACTED ____ |

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