



40245

# Cigna Out of Network Therapy Provider Fax Request Form



**PLEASE USE THIS FORM FOR Cigna MEMBERS**

Please fax to OrthoNet at: (888) 779-8365 Fax Date: \_\_\_\_\_ # of Pages Faxed: \_\_\_\_\_

## THERAPY PROVIDER INFORMATION

Facility Name

Street Address

City

State

Zip

Telephone Number

(    )   -

Return Fax Number

(    )   -

National Provider Identifier (NPI)

Provider Tax ID Number

Facility NPI Number     Individual NPI Number

## PATIENT INFORMATION

First Name

Alpha Prefix

Member ID Number

Last Name

Date of Birth

/  /

Month      Day      Year

## REQUEST INFORMATION

Request for Out of Network Therapy Visits Pre-Certification.

Service Type

- Physical Therapy  
 Occupational Therapy

Initial Evaluation Date

/  /

Month      Day      Year

Diagnosis Code (ICD-9 or ICD-10 Format)

**Instructions:** 1. Use this form when requesting prior authorization of therapy services for Cigna members.

2. Please complete and Fax this request form along with all supporting clinical documentation to OrthoNet at 1-888-779-8365.

(This completed form should be page 1 of the Fax.)

3. Please ensure that this form is a DIRECT COPY from the MASTER.

4. Please PRINT, in black ink, one character per box for ALL requested information and completely fill in each circle for selection where applicable.

5. For assistance in completing this form, please call OrthoNet Provider Services Toll Free at (866) 874-0727.

**NOTE:** The information transmitted is intended only for the person or entity to which it is addressed and may contain CONFIDENTIAL material. If you receive this material / information in error, please contact the sender and delete or destroy the material / information.



For Internal Office Use Only

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