**Commercial Carrier Process to Request a Referral to a Specialist or NonPhysician Specialist**
(Accurate as of August 1, 2022. Please check the MIA website for up-to-date information.)

| | CIGNA |
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| **Consumer Contact Information** | |
| Website | cigna.com |
| Phone Number | 1 (800) 997-1654 |
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| **Requesting a Referral** | |
| Steps to request a non-panel (non-participating) provider specialist | 1. Contact Cigna's Customer Service Department at the toll-free number listed on the back of your ID card to request authorization of services, not based on personal preference or convenience for customer, for a non-participating health care professional at the in-network benefit level.<br>2. Staff will conduct research establishing the availability of like services with participating healthcare professionals with established mileage radius or equidistant to non-participating healthcare professionals.<br>3. The clinical staff will review the request for medical necessity and if medically appropriate, will approve. If request cannot be approved, it will be referred to the medical director for review and final disposition.<br>4. The medical director will review the request and all supporting clinical information to determine if it is medically necessary to utilize the non-participating health care professional.<br>5. Once a decision has been made, authorization determination is documented in the Utilization Management system of record and determination letters are issued in accordance with accreditation and regulatory requirements. |
| Review full referral request procedures | https://www.cigna.com/health-care-providers/coverage-and-claims/referrals/ |
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| **Carrier's timeline to grant or deny request** | 2 business days review time |

| **Grievance process to appeal denial of a request** | |
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| How to file a grievance | STEP 1:<br>Contact Cigna's Customer Service Department at the toll-free number listed on the back of your ID card to review any adverse coverage determinations/payment reductions. We may be able to resolve your issue quickly outside of the formal appeal process. If a Customer Service representative cannot change the initial coverage decision, he or she will advise you of your right to request an appeal.<br>STEP 2:<br>Complete and mail this form and/or appeal letter along with any supporting documentation to the address identified below. Complete and accurate preparation of your appeal will help us perform a timely and thorough review. In most cases your appeal should be submitted within 180 days, but your particular benefit plan may allow a longer period.<br>You will receive an appeal decision in writing.<br>REQUESTS FOR AN APPEAL SHOULD INCLUDE:<br>1. If you submit a letter without a copy of the Customer Appeal form, please specify in your letter this is a "Customer Appeal". Please include all the information that is requested on this form.<br>2. A copy of the original claim and explanation of payment (EOP), explanation of benefit (EOB), or initial adverse decision letter, if applicable.<br>3. Any documentation supporting your appeal. For adverse decisions based upon lack of medical necessity, additional documentation may include a statement from your healthcare professional or facility describing the service or treatment and any applicable medical records. |
| Number of days for final grievance decisions | 30 days from receipt of appeal request |
| | 72 Hours from the date the appeal was received |
| Review full grievance process | https://www.cigna.com/individuals-families/member-resources/appeals-grievances |