PRIOR AUTHORIZATION REQUEST FORM **Alabama/Georgia/MS/NC/SC**

Fill out the form completely below. Incomplete/illegible forms will not be processed and will be returned to your fax number on file.

Request Type	Standard Request ☐ (Our goal for completion of standard requests is (5-7) days) (**Retro** Requests are subject to medical review.	Expedited Request ☐ (Please read and sign **below** if this is an expedited request) (**Expedited** Requests may take up to (72) hours)

TODAY'S DATE:	**Fax Completed Form and ALL SUPPORTIVE DOCUMENTATION TO:** **205-444-4263/(800)872-8685**

Required Provider Information

Member Name:	Member ID #:	Member DOB:
PCP:	PCP UPIN:	
Provider of Service:	**UPIN # / TIN:**	
Ordering Physician:	**UPIN:**	
Phone:	**Fax:**	
Facility / Place of Service:		

Required Clinical Information

DOS:	**Please use the Cigna-HealthSpring DME form for DURABLE MEDICAL EQUIPMENT Requests.**

☐ Inpatient Elective Medical ☐ Elective Surgical ☐

☐ Outpatient Transport ☐ DME ☐ Surgery ☐ Rehab ☐ (PT, OT, ST) Radiology ☐ Wound care ☐

Diagnosis:	ICD-9 Code(s):
Service / Procedure(s):	CPT Procedure Code(s):
	Quantity Requested:

***Please attach any RELEVANT CLINICAL INFORMATION or office notes for review including pertinent history, symptoms, diagnostics, labs, treatment plan, etc.**

REMINDER: Routine Response Time: Our goal for completion of standard requests is **(5-7) days.** If a response has **not** been received at that time, please contact the Cigna HealthSpring Health Services Prior Authorization Department to confirm your request was received at **(205)423-1222 or (800) 962-3016. Retro Requests** may take longer to process and are subject to medical review.

- Requests will only be fully processed once **ALL** necessary information has been received.
- The Health Services department will return the decision via fax or phone within **(1) business day** of the date of the determination.

DENIALS:

If the determination is to deny the service requested, in addition to a fax or call, a letter noting the denial and appeal information will be mailed within **(1) business days** of the date of the determination.

Fax Completed Form and ALL SUPPORTIVE DOCUMENTATION TO: (205)444-4263

Please Read if Expedited Request: By signing below, I certify that applying the standard 72-hour review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function. **SIGNATURE:** _____