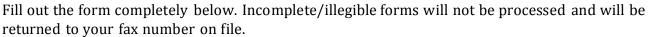
PRIOR AUTHORIZATION REQUEST FORM

Alabama/Georgia/MS/NC/SC 🎬



Request Type	Standard Request (Our goal for completion of standard requests is (5-7) days)		Expedited Request (Please read and sign <b>below</b> if this is an expedited request)			
	<b>Retro</b> Requests are subject to medical review.			(Expedited Requests ma	y 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 <sup>Transpo</sup>	ort DME	Surgery	Rehab	(PT, OT, ST) Radiolog	gy Wound care	
Diagnosis:		ICD-9 Code(s):				
Service / Procedure(s): C			CPT Procedure Code(s):			
		Quantity	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:** 

Authorization is for medical necessity only and not a guarantee of payment. Eligibility is determined at the time the claim is received and benefits are subject to the

limitations and exclusions of the member's plan.

Cigna – HealthSpring Prior Authorization Request Form: AL/GA/MS/NC/SC