Cigna authorization intake fax cover sheet

Cigna fax number: 866.873.8279

Sender name: _____

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PRIOR AUTHORIZATION FORM

Fax #: 866.873.8279 - *Please allow 24-48 hours for acknowledgement of pending review.*
Complete this form in its entirety and attach clinical to support medical necessity.

Patient information

Patient's name _____ **Cigna ID#** _____

Patient's address _____

Date of birth _____ **Phone number** _____

Requesting healthcare professional's information (HCP)

Requesting HCP name _____

Address _____

City/State _____ **Tax ID/NPI** _____

Office contact name _____ **Phone** _____

Fax _____

Servicing healthcare professional information

Servicing HCP name _____

Address _____

City/State _____ **Tax ID/NPI#** _____

Service information

Inpatient ____ **Outpatient** ____ **DME** ____ **Other** _____

Date of service _____

Diagnosis description _____

Diagnosis code(s) _____ _____ _____ _____ _____ _____

Procedure description _____

Procedure code	Modifier	Units (specify per extremity)

Visits (if applicable, specify frequency and duration) _____

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