



Cigna-HealthSpring CarePlan (Medicare-Medicaid Plan) Claims Appeal Form

Providers must request Claims Appeal within 60 days from the date of the Explanation of Payment (EOP).

<u>Provider Information:</u>			
Provider Name			
NPI		TIN	
Contact Person		Contact Number	

<u>Claim Information:</u>			
Member Name		Medicaid or Medicare ID	
Number of Claims		Number of Pages Sent	
Claim ID	Date(s) of Service	Authorization Number	
Reason for Appeal/Denial:	<input type="checkbox"/> Denied for Non-covered Benefit		<input type="checkbox"/> Denied for No Auth
	<input type="checkbox"/> Denied for Timely Filing		<input type="checkbox"/> Other

Explanation for Appeal:

Please attach any additional information and any supporting documentation. Indicate an authorization number, if applicable. Please be advised that corrected claims are not appeals.

Submit Claims Appeal Form:

Fax	1-877-809-0783
Mail	Cigna-HealthSpring CarePlan Attn: Appeals and Complaints Department PO Box 211088, Bedford, TX 76095
Electronic Appeals	visit our HSConnect provider portal via our website at careplantx.com

For assistance, please call Provider Services at 1-877-653-0331.

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