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).

Provider Information:			
Provider Name			
NPI		**TIN**	
Contact Person		**Contact Number**	

Claim Information:			
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:	☐ Denied for Non-covered Benefit ☐ Denied for Timely Filing	☐ Denied for No Auth ☐ 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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