**MEMBER APPEAL FORM**

Cigna-HealthSpring has sent you this form in response to your request to file an appeal. We cannot review your appeal until you send us this completed form. Cigna-HealthSpring must receive your completed form by <30 days from the date on the denial letter>.

If you need help completing this form, call our Member Services Department at 1-877-653-0327. TTY users should call 7-1-1. We are open Monday to Friday, 8 a.m. to 5 p.m. Central Standard Time. You can also visit our service location at:

Cigna-HealthSpring
121 Airport Centre 1
2208 N. Highway 121 Suite 210
Bedford, Texas 76021

Once completed, please mail or fax this form to the following address:

Cigna-HealthSpring
Appeals and Complaints Department
P.O. Box 211088
Bedford, TX 76095

Fax: (877) 809-0783

Today's Date: _____ Member Name: _____

Member Medicaid ID Number: _____

Name of person completing form and their relationship to Member:

_____

Phone Number where you can be reached: _____

Please list the details of your appeal below:
Is your appeal about a HealthSpring issue or a provider issue?

_____

_____

_____

Provider name (if applicable): _____

Date(s) of service (if applicable): _____

Member or Authorized Representative Signature: _____