

Complete all areas of this form and attach the appropriate documentation as well as a signed letter stating the reason why you are filing a payment dispute. Detailed descriptions of information required to process a provider dispute are located in the [CareLink Provider Payment Dispute Policy](#).

Note: Send corrected claims to the address on the back of the member's identification card. Corrected claims should not be sent to the address on this form. CMS-1500 claims must be stamped corrected claim. All UB-04 claims must have a Type of Bill to reflect a corrected/changed claim. Reference the [Claims Submission Policy](#) for additional information.

Today's date: _____

CareLink Subscriber/Member Name:	
Subscriber Identification Number:	
Member Name:	
Date of Birth:	
Date(s) of Service:	
Procedure/Type of Service:	
Phone Number:	
Claim Number:	
Provider ID# (Internal Use Only)	

Disputes should be mailed to the following address:

- CIGNA HealthCare Inc.
 National Appeals Unit
 P.O. Box 188011
 Chattanooga, TN 37422

The following is a list of required documentation
(check and submit all that apply):

- Invoice Attached
- Office Notes Attached
- Operative Notes Attached
- Proof of Timely Filing
- Radiology/Pathology Report(s)
- SOA/EOB with Claim Circled
- Typed Letter of Medical Necessity Explaining Why the Service was Necessary