OUT-OF-NETWORK REFERRAL DISCLOSURE FORM

For Providers

October 2015

This form is designed to help ensure that your patients with Cigna coverage have the necessary information to make an informed decision about their medical benefits and care. It must be completed by the referring physician (and not delegated) each time a referral is made to a non-participating provider, facility, or other health care entity. It is not necessary to complete the form in emergency situations, or if we determine there are no alternative participating providers, facilities, or other health care entities that can render the requested covered services. A copy of the completed form should be given to the patient, and the original should be placed in his or her medical file. Use of this form is subject to periodic audit to determine compliance with this administrative requirement.

Patient name: _____

Referral for: _____
(Describe service)

☐ I offered the above-named patient the option of a referral to a participating provider or facility.

☐ Yes ☐ No

If yes, which participating provider or facility was recommended? ***Note: At least one Cigna-contracted provider or facility must be specified by name below, or this form will be considered incomplete.***

_____

If no, please explain why a network-participating provider or facility was not ***clinically*** acceptable:

_____

_____

_____

☐ The patient will be referred to:

_____
(Name of the non-participating provider or health care facility)

Physician disclosure of financial interest

☐ I do not have any financial interest in the non-participating provider or health care facility listed above.

☐ I have a financial interest in, or may benefit by, making this referral to the non-participating provider or health care facility listed above (see details below).

_____

_____

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Cigna®

Cigna customer out-of-network informed consent

You have a referral to a doctor or a health care facility that does not participate in Cigna's network. We call this a non-participating doctor or facility. You can save money, and get the most from your health care benefits, if you use a participating doctor or health care facility instead.

You will pay more if you visit a non-participating doctor or health care facility, because we will process your claim with a lower benefit. Please be aware that if you do not have out-of-network coverage, your claim may be denied. This means that you will be responsible for any charges not covered by your plan, up to and including the full billed amount.

To find out whether you have out-of-network benefits, you should review your benefit plan or call the number on your Cigna ID card. To find a participating doctor or facility, go to the Cigna Health Care Professional Directory at Cigna.com > Find a Doctor, or call 1.800.88Cigna (882.4462).

Please take note of this important information below about fee forgiving or waiver of charges
Some non-participating doctors and health care facilities may offer to adjust the amount you pay to use their services. They may tell you that they'll accept payment based on what Cigna pays for participating providers. If you accept this arrangement, you may need to pay for services you receive out-of-pocket and be responsible for submitting the claim to Cigna, which we may or may not accept.

Additionally, please note that "fee-forgiving" on any particular claim, or any portion of it, may be considered fraud, and cause a doctor or facility to face civil and criminal liability. If a non-participating doctor or health care facility offers to waive or forgive any part of its charges, please notify the Cigna Special Investigations Unit hotline at 1.800.667.7145.

Customer's decision

☐ **I have reviewed the information provided above and understand that:**

- I have the choice of using a doctor or health care facility that participates, or does not participate in, Cigna's network.
- If I choose to use a doctor or health care facility that does not participate in Cigna's network, Cigna may not cover the services if my plan does not have out-of-network benefits.
- If my plan has out-of-network benefits, I understand that by using my out-of-network benefits I may have higher out-of-pocket costs that I will be responsible to pay.

☐ **I wish to use a non-participating doctor or health care facility, and I understand what this means for possible benefit approval**.

☐ I acknowledge that I have a right to a copy of this form.

_____ _____
Customer signature Date

_____
Please print name

Physician endorsement

☐ I have reviewed this form with my patient prior to treatment for which the referral is being made. The patient has acknowledged the information contained in this form, and was offered a copy for his or her records.

_____ _____
Physician signature Date

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