# Medical-Network Adequacy Provision (NAP) Exception Request Form

CLEAR FORM

This form should be completed by a clinician who has knowledge of the Cigna Customer's current clinical presentation and treatment history. Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information.

Note: This form is ONLY for **Medical-Network Exception** requests. For other program network exception requests, i.e. behavioral, specialty drugs, etc., please call the number on the back of the customer's ID card for direction.

- For **Evernorth Behavioral**, access Outpatient Behavioral network Exception Request Form.
- For **Medicare**, please contact Member Services at 1-800-627-7534.
- For **Pharmacy, Dialysis, or Extended Care Facility (ECF)**, please contact Cigna's Prior Authorization department at 1-800-266-6224.

**TIPS FOR COMPLETING THIS FORM:**

- Our regular business hours are Monday – Friday, from 8:00 a.m. – 4:30 p.m. Eastern Time.
- To help expedite this request, please complete sections as specifically and as clearly as possible.
- Omissions, generalities, and illegibility may result in this request being returned for additional information or clarification.
- Typed responses are preferred

* Please note that Cigna assumes no responsibility for the protection of electronically transmitted information prior to its actual receipt of that information. It is your responsibility to take any steps necessary to protect documents prior to receipt by Cigna.

Please save this form to your computer, complete & save the form using Adobe Acrobat Reader DC, then fax to: **NAP Medical 833-213-9222**

For any questions, please contact Cigna's Prior Authorization department at 1-800-244-6224.

All fields are required.

| Patient Information | | |
|---|---|---|
| **Cigna ID Number:** _____ | **Date of Birth:** _____ | |
| **Customer Name:** | | |
| **Street Address:** | | |
| **City:** | **State:** | **Zip Code:** |
| **County:** | **Phone Number:** ( ) | |

## Provider Information

**Servicing Health Care (HCP) Provider Name:**

**Specialty:**

**Tax ID Number:** | **NPI Number:**

**Office Information:**

**Address where services will be rendered:**

| **City:** | **State:** | **Zip Code:** |
|---|---|---|
| **County:** | **Phone Number:** ( ) | **Fax Number:** ( ) |

**Are you requesting a Network Adequacy for this Provider?** ☐ Yes ☐ No

☐ **If Yes selected above, is your practice the only practice that can perform the service at this facility?** ☐ Yes ☐ No

## Facility Information

**Facility Name:**

**Street Address:**

| **City:** | **State:** | **Zip Code:** |
|---|---|---|
| **County:** | **Phone Number:** ( ) | **Fax Number:** ( ) |

**Tax ID Number:**

**Are you requesting a Network Adequacy for this Facility?** ☐ Yes ☐ No

## Service Information

**Reason for Request:**

Please specify the specialized experience, training or certification in a particular clinical area or patient population the requesting provider possesses that would support the need for an in network exception request.

Please attach any letter of Medical necessity and/or associated clinical information.

## Service Information (Continued)

**Past Medical History:**

**Primary Diagnosis Code** *(this should be the primary reason for the procedure/visit)*: _____

**Primary Diagnosis Description:**

_____

**Secondary Diagnosis Code:** _____

**Secondary Diagnosis Description:**

_____

**For maternity patients, include the Estimated Due Date:** _____

**For inpatient procedures, include scheduled date of admission:** _____

**Service Requested**

| | | |
|---|---|---|
| **Procedure Name:** | **CPT Code(s):** | **# of Units:** |
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**Is this a request for a Co-Surgeon** ☐ Yes ☐ No **Is this a request for an Assistant Surgeon?** ☐ Yes ☐ No

If service are complimentary to a primary surgery (i.e. Anesthesia and Intraoperative Neuromonitoring), please provide Provider Name, Address, and Tax ID of primary surgeon in the Additional Information section below.

**Additional information:**

**Where will this service be performed?**

☐ Home ☐ Hospital - In patient ☐ Hospital - Out patient ☐ Other *(please specify)*: _____

☐ Outpatient-Ambulatory Surgical Center ☐ Outpatient-HCP's office ☐ Physician's office –Visit only

## Authorization

Contact name and phone number for single case negotiation:

Contact Name: _____

Phone Number: ( ) _____

| | |
|---|---|
| Print HCP signer's name: _____ | HCP Signature _____ |
| Name of person completing the form: _____ | Date: _____ |

CLICK TO PRINT