Cigna Out-of-Network Disclosure Form

For Health Care Professionals in Texas

September 2014

The Cigna Out-of-Network Disclosure Form is designed to help ensure that patients with Cigna coverage have the necessary information to make an informed decision about their medical benefits and care. The form must be completed by the referring physician (and not delegated) each time a referral is made to a non-participating health care professional, facility, or other health care entity. **It is unnecessary to complete the form in emergency situations, or if Cigna determines there are no alternative Cigna-participating health care professionals that can provide the requested covered services.** A copy of the completed form should be given to the patient, and the original 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 an in-network referral.

☐ YES ☐ NO

If yes, which in-network health care professional or facility did you recommend?

_____

If no, please explain why an in-network health care professional or facility was not **CLINICALLY** acceptable:

_____
_____
_____

The patient will be referred to:_____
Name of the non-participating health care professional or facility

Physician Disclosure of Financial Interest

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

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

_____
_____
_____
_____
_____
_____

Cigna Customer Out-of-Network Informed Consent

You are being referred to a doctor or facility that does not participate in Cigna's network (an "out-of-network" provider). You can save money and get the most from your health care benefits if you use an in-network (participating) doctor or facility instead.

You will pay more if you visit an out-of-network doctor or health care facility because your claim will be processed with a lower benefit. Please be aware that if you do not have out-of-network coverage, your claim may be denied. This means 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, call the number on your Cigna ID card. To find a participating doctor or facility, go to Cigna.com > Find a Doctor or call 1.800.88Cigna.

Please take note of the important information below about fee forgiving or waiving of charges
Some out-of-network doctors and facilities may offer to adjust the amount you pay to use their services. They may state that they'll accept payment based on what Cigna pays for in-network providers. If you accept this arrangement, you may need to pay for the services you receive out-of-pocket and be responsible for submitting to Cigna the claim, 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 an out-of-network doctor or facility offers to waive or forgive any part of its charges, please notify the Cigna Special Investigations hotline at 1.800.667.7145.

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

- I have the choice of using a Cigna participating or non-participating doctor or facility.
- If I choose to use a doctor or 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 them I may have higher out-of-pocket costs that I will be responsible to pay.

☐ I wish to use a non-participating doctor or 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

_____
Print name

Health care professional:

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

_____ _____
Physician signature Date