

Out-of-Network Referral Disclosure Form*

For providers and their patients with Cigna Healthcare-administered plans

This form is designed to help ensure that your patients with Cigna Healthcare 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 nonparticipating 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. Give a copy of the completed form to the patient and place the original in their 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 participating provider or facility did you recommend? **Note: At least one Cigna Healthcare-contracted provider or facility must be specified by name or this form will be considered incomplete.**

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

The patient will be referred to the following nonparticipating health care provider or facility:

Physician disclosure of financial interest

- I do not have any financial interest in the nonparticipating provider or facility to which the patient is being referred.
- I have a financial interest in making this referral to the nonparticipating provider or facility to which the patient is being referred.

* See separate form for out-of-network referrals for providers and facilities in Texas.

Cigna Healthcare customer out-of-network informed consent

You have a referral to a provider or health care facility that does not participate in the Cigna Healthcare network. We call this a nonparticipating (out-of-network) provider or facility. You can save money and get the most from your health care benefits if you use a participating (in-network) provider or health care facility instead.

You will generally pay more if you visit a nonparticipating provider 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 if you have out-of-network benefits, review your benefit plan or call the customer service telephone number on the back of your Cigna Healthcare ID card. To find a participating provider or facility, go to the Cigna Healthcare Provider Directory at [Cigna.com](https://www.cigna.com) > Find a Doctor or call **800.88Cigna (882.4462)**.

Please take note of this important information about fee forgiving or waiver of charges.

Some nonparticipating providers and health care facilities may offer to "fee forgive" your charges by adjusting the amount you pay to use their services. They may tell you that they'll accept payment based on what Cigna Healthcare pays for participating providers. If you accept this arrangement, you may need to pay out-of-pocket for the services you receive and be responsible for submitting the claim to Cigna Healthcare, which we may or may not accept. The Cigna Healthcare policy prohibits fee forgiving or waivers of charges by providers using all contractual and legal options available.

Additionally, please note that "fee forgiving" on any particular claim or portion of it may be considered fraud and cause a provider or facility to face civil and criminal liability. If a nonparticipating provider or health care facility offers to waive or forgive any part of its charges, please notify the Cigna Healthcare Special Investigations Unit Hotline at **800.667.7145**.

Customer's decision

I have reviewed the information provided above and understand that:

- I have the choice of using a provider or health care facility that participates, or does not participate, in the Cigna Healthcare network.
- If I choose to use a provider or health care facility that does not participate in the Cigna Healthcare network, Cigna Healthcare may not cover the services if my plan does not cover out-of-network benefits.
- If my plan covers out-of-network benefits, I understand that I may have higher out-of-pocket costs that I will be responsible to pay if services are rendered by a nonparticipating provider or health care facility.
- I choose to use a nonparticipating provider or health care facility, and I understand what this means for possible benefit approval and costs.**
- I acknowledge that I have a right to a copy of this form.

Customer signature: _____ Date: _____

Please print name: _____

Physician's 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 their records.

Physician signature: _____ Date: _____