HealthFirst

Allegiance℠ by Cigna Healthcare

Network Service Availability Form

For Covered Persons on the High Value plan option only, services not able to be performed by a network provider are eligible for coverage only when pre-approved, or services will be denied. To have out of network services reviewed, please complete and return this form (all fields required) along with any supporting documentation. If services are to be rendered with, or at, an in-network provider, this form does not need to be completed.

Fax: 406-523-3111

Date: _____

Employee Name (Please Print): _____

Member ID number: _____

Patient Name: _____

Home Address: _____

Phone Number: _____

Referring Provider: _____

Provider TIN/NPI: _____

Treating Facility/Provider Info:
(Please provide name/phone/fax) _____

_____

Diagnosis: _____

CPT/ICD-10 Code(s): _____

Type of Service Required: _____

Type of Specialist Required: _____

Date(s) of Service: _____

***Referring Provider Office – Attach letter of medical necessity for referral**