Service Availability Form

Employer Name: Johns Hopkins University Applied Physics Laboratory

If a necessary medical service is not available in your GWH-Cigna OAP network, please complete this form and send it to:

Allegiance Benefit Plan Management
Attn: Claims-JHUAPL Team
PO Box 3018
Missoula, MT 59806

All fields required. Incomplete forms will not be honored.

Employee Name (Please Print) ____

Member ID number: ____

Patient Name: ____

Service Required: ____

Treatment Period: ____

Specialist Required: ____

Provider Name: ____

I, ____________________________________, hereby certify that I have checked the website directory www.askallegiance.com/apl to determine if an In-Network provider is available within 25 miles of my address for the service I need. After checking, I have determined that (check the situation that applies):

Must check one

___a specialist of the type I need is not part of the GWH-Cigna OAP network
OR
___an In-Network provider is more than 25 miles from the employee's residence

Employee signature__________________________________

Date____

Please note that you will need to send an updated form every 6 months.

Office Use Only
Date sent to Cigna ________ Cigna Verification that no provider in OAP ________Name of Cigna Rep___________________