SUPPORT FOR YOUR GLOBALLY MOBILE FAMILY.

Transition of Medical Management
Are you new to Cigna? Do you already have medical treatment planned?

Traveling abroad for work comes with enough for you and your family to think about. That's why we provide our Transition of Medical Management service – to provide you a smooth transition to your new medical coverage allowing you and your family to:

- Easily continue planned care that was previously authorized or care that is scheduled.
- Continue case management support that you or your family may already be receiving.

Here's how it works

By completing the attached form you can receive an updated Guarantee of Payment (GOP) or be contacted by a case manager to support your medical needs.

For Guarantee of Payment/Utilization Management

- During the transition to your new medical plan you and your family members may have been previously authorized for services under your prior medical plan.

For Case Management

- Case Management is designed to help you and your health care practitioner better manage complex acute care, as well as catastrophic situations and related costs. Cigna provides these services across the globe.

How to request Transition of Medical Management

- Complete the attached form
- Include with a copy of your Guarantee of Payment or Prior Authorization letter
- Submit both to:
  Cigna
  Attention: Medical Review
  PO Box 1550
  Wilmington, DE 19850-5050
  Fax 001.302.797.3150
  Toll-Free Fax 800.243.6998
  Email CGHBMedical@cigna.com

Together, all the way.®

Cigna®

Cigna Transition of Medical Management request form

Please provide as much of this information as possible, so that we can properly support your needs.

Check all that apply

❑ Guarantee of Payment/Prior Authorizattion Transition Request ❑ Case Management Transition Request

Use a separate form for each condition. Photocopies are acceptable. Attach additional information if needed.

Employer policy # 00863B	Employee date of enrollment in Cigna plan (mm/dd/yyyy)
Employee name	Employee Social Security # or alternate ID
Best phone number to contact you (mobile, home, work)	Email address
Mailing address:	

Patient's name	Patient's Social Security # or alternate ID	Patient's birth date (mm/dd/yyyy)	Relationship to employee ❑ Spouse ❑ Dependent ❑ Self

Guarantee of Payment/Utilization Management Authorization – Date of service _____ (mm/dd/yyyy)

– Copy from prior carrier attached? ❑ Yes ❑ No

Care Management requests, please provide as much information as possible:

– Condition that we can support you with: _____

– Have you had any specific complications from this condition? _____

– Any current medication you are taking for this condition: _____

– Any upcoming procedures you have for this condition: _____

Please complete the health care professional information request below if you have not attached a copy of the authorization.

Health care professional name		Health care professional phone #
Health care professional address		
Condition/reason/diagnosis		
Date(s) of admission (mm/dd/yyyy)	Date of surgery (mm/dd/yyyy)	Type of surgery
Treatment being received and expected duration		

Is this patient expected to be in the hospital when coverage with Cigna begins or during the next 90 days? ❑ Yes ❑ No

Please list any other continuing care needs that may qualify for Transition of Medical Management.

I hereby authorize the above health care professional to give Cigna or any affiliated Cigna company any and all information and medical records necessary to make an informed decision concerning my request for Transition of Medical Management under Cigna. I understand I am entitled to a copy of this authorization form.

Signature of patient, parent or guardian	Date (mm/dd/yyyy)