Instructions for submitting a prior authorization form in Vermont

For Health Care Providers

To submit a prior authorization form electronically in Vermont, providers must register for access to the Cigna Healthcare online prior authorization tool.

To initiate registration for the tool, send an email to PMAC@Cigna.com. Include the following information:

- Provider or facility name
- Mailing address
- Email address
- Contact's name
- Contact's phone number

If you prefer to submit a prior authorization form via fax, please send it to **866.873.8279**.

To contact the Cigna Healthcare Coverage Review team, please call the phone number listed on the back of the customer's Cigna Healthcare ID card or **800.Cigna24 (800.244.6224)**.

All Cigna Healthcare products and services are provided exclusively by or through operating subsidiaries of The Cigna Group, including Cigna Health and Life Insurance Company (CHLIC), Connecticut General Life Insurance Company, Evernorth Behavioral Health, Inc., Evernorth Care Solutions, Inc., Express Scripts, Inc., or their affiliates.

VERMONT
DEPARTMENT OF FINANCIAL REGULATION

Pre-Service ☐ Post-Service ☐ | Elective ☐ Non-Elective ☐ | Urgent ☐ Non-Urgent ☑

Uniform Medical Prior Authorization Form

Important: Please read your insurer's (for individuals with commercial insurance) or Vermont Medicaid's (for Medicaid beneficiaries) specific instructions for completing this form.

Patient/Member Information *(* Required Field)*

*First Name Michael	Middle Initial	*Last Name Reynolds	
*Health Insurance ID# MCR123456	*DOB 14/03/80	Gender Identity Yes	
*Address		Apt.#	
*City	*State	*Zip	*Tel. 773-555-2390

Referring/Requesting Provider Information *(* Required)*	**Rendering/Attending Provider Information** *(* Required)*
*First Name Emily *Last Name Carter	*First Name *Last Name
*NPI/TIN# 1679574832 *Specialty Orthopedic Su	*NPI/TIN# *Specialty
*Address Suite	*Address Suite
*City *State	*City *State
*Tel. 312-555-9901 Fax# 312-555-9	*Tel. Fax#

*Office Contact/Person Completing Form

*Telephone No. | Fax No.

Required Clinical Information (* Required Field)

*Date of Request 05/11/25 | *Is this request for Out-of-Network Services? Y ☐ N ☐

*Type of Service Requested *(check all that apply)*

Services:		Therapies:
Medical Admit ☐	Obstetrics ☐	Occupational Therapy ☐
Mental Health/SUD ☐	Immunotherapy Treatment ☐	Physical Therapy ☑
Oncology ☐	Surgery (including Oral Surgery) ☐	Speech Therapy ☐
Acupuncture ☐	Transplant ☐	Applied Behavior Analysis ☐
	Chiropractic ☐	

Testing/Imaging:
Diagnostic Imaging ☐
Diagnostic Medical Test ☐

Other:
DME ☑ SNF ☐ Home Health ☐ Vision/Glasses ☐
Home Infusion ☐ Other *(please specify)* ☐

*Date Diagnosed:

*Place of Service: Telehealth/Audio Only ☐
Inpatient ☐ Outpatient ☑ Office ☐ Other *(please specify)* ☐

*Proposed Dates of Service: From 10/11/25 To 12/01/26	*Facility Where Service Will be Performed:
*Proposed Number of Inpatient Treatment Days	*Proposed Number of Outpatient Treatment Visits
*Primary Diagnosis Tear of medial meniscus, right knee	*Primary Diagnosis Code S83.241A
*Secondary Diagnosis Difficulty in walking, not elsewhere classified	*Secondary Diagnosis Code R26.2
*Name of Proposed Procedure Physical Therapy Evaluation	*CPT/HCPCS or Revenue Code 97161
*Requested Durable Medical Equipment (DME)	
*DME CPT/HCPCS Code	*DME Duration 4 weeks
*DME Purchase Price $	*DME Monthly Rental Price $

Additional Clinical Information Attached: ☑ **No. of pages:**

Revised October 20, 2023