To: Cigna LifeSOURCE Transplant Network
LifeSourceTransplantClaims@Cignahealthcare.com

Claim Submissions Coversheet
*Required fields

Donor Claims Included? Yes

From				
From	Facility Name:		# of Claims:	
	Address:		# of Pages:	
	City:		Date Submitted:	
	State:		Zip Code:	
	Billing Contact Name:			
	Billing Contact Phone:			
	Billing Contact Email:			

Payment	Facility Payment Information		Group Payment Information	
	Payee Facility Name:		Group Facility Name:	
	Payee Address:		Group Address:	
	Payee City:		Group City:	
	Payee State:		Group State:	
	Payee Zip Code:		Group Zip Code:	
	*Facility TIN:		Group TIN:	
	Facility NPI:		Group NPI:	

General Information				
	*Transplant Recipient First:		Transplant Recipient Number:	
	*Transplant Recipient Last		*Transplant Recipient DOB:	
	*Transplant Recipient Cigna ID:		Donor First:	
	Medical Record #:		Donor Last:	
	Transplant Recipient AMI:			
	*Type of Transplant:			
	Case Authorization Number:			

General Information					
	Start Date of Service:				
	End Date of Service:				
	Date of Transplant Event:				
	*Zone:	Zone 1	Zone 2	Zone 3	Zone 4
	Zone Authorization Number(s) (Recipient):				
	Zone Authorization Number(s) (Donor):				
	Total Hospital Charges:		Total Physician Charges:		
	*Total Billed Charges:		Expected Case Rate:		
	Expected Reimbursement:		Expected Outlier Reimbursement:		
	Comment: (any special instructions or comments)				