Complaint form

Personal information

First name	
Last name	
Are you an existing Cigna Healthcare member	☐ Yes ☐ No *(select applicable box)*
Cigna Healthcare member ID (for existing member)	
Policy holder (optional)	
Phone number	

Complaint details

Type of complaint:	Choose an item
Claim ID: *(If your complaint is related to claim)*	
Approval ID: *(If your complaint is related to pre-approval)*	
How would you like to be contacted about your complaint? Provide contact details.	☐ Email
	☐ Telephone
Background: *Please provide the background and details of your complaint in the box below. These details may include dates that things have happened on, who you have spoken to about this issue already, and what action has been taken so far.*	

Please submit any documents relevant to your complaint by email (e.g. medical reports, lab results, email communication), after clicking on the submit button below.

Note: when you submit this compliant, we will contact you within two (2) working days to acknowledge your complaint and share a complaint reference number.

We aim to deliver appropriate solution within fourteen (14) working days from the receipt of your complaint.

When you submit an appeal, your appeal will be acknowledged and a written answer will be provided within two (2) working days.

Submit