



Cigna
HealthSpringSM

Provider Change of Information

Provider Name: _____

Provider UPIN (if applicable): _____

Provider NPI: _____

Provider Information

SECTION I: NEW PHYSICAL ADDRESS (Primary Location ONLY):

Street Address:
City, State, Zip Code:
Telephone Number:
Fax Number:

SECTION II: MULTIPLE LOCATIONS: Please submit *ALL* locations as a separate attachment.

SECTION III: PANEL STATUS (if applicable): Indicate by selecting the appropriate box.

- ☐ Accepting New and Existing Patients
- ☐ Accepting Existing Patients Only
- ☐ Closed to all Patients (New and Existing)

**** An effective date should be entered if your selection is a change to your current status.

Effective Date: _____

Group Information

SECTION IV: GROUP CHANGES (multiple changes should be listed on a separate attachment)

Group NPI: _____

Group Tax ID: _____

- ☐ Addition (Please include a copy of the W-9)
- ☐ Deletion

**** Effective Date (required for all additions and deletions): _____

SECTION V: NEW REMITTANCE ADDRESS

Street Address:
City, State, Zip Code:
Telephone Number:
Fax Number:

Please provide (applicable) changes for all locations and fax to (205) 444-4243 or email: Albusinesssupport@healthspring.com