



MEDICARE ADVANTAGE FACILITY/ANCILLARY NETWORK INTEREST FORM

NOTE: Cigna will review your request and send notification to you once a decision has been rendered. Determinations are based on network need and current availability of services. All providers are subject to Cigna credentialing requirements and applicable state and federal guidelines.

Submission of Interest Form Does Not Guarantee Acceptance by the Plan

OFFICE CONTACT INFORMATION

(Cigna will use this information for any questions, concerns or responses regarding this form)

Date: _____ Name: _____ Email: _____
Phone: (____) _____ Fax: (____) _____
Address: _____ City: _____ State: _____ Zip Code: _____

FACILITY/ANCILLARY INFORMATION

Corporate Name : _____ Operating (DBA) name: _____
NPI#: _____ Tax ID#: _____ Medicare #: _____ Medicaid #: _____
Are you accredited Yes No If yes, list the accrediting entity: _____
Network Participation you seek: Medicare **Note: Providers must be enrolled in Medicare in an approved status**

SERVICE LOCATIONS

(Only list locations where you actively practice. *If you have more than 2 locations, please attach additional location information)

Location 1 Address: _____ City: _____ State: _____ Zip Code: _____
Phone: (____) _____ Fax: (____) _____ County Located: _____

Office Hours: _____
Counties Served: _____ Medicare Star Rating (if applicable): _____

Location 2 Address: _____ City: _____ State: _____ Zip Code: _____
Phone: (____) _____ Fax: (____) _____ County Located: _____

Office Hours: _____
Counties Served: _____ Medicare Star Rating (if applicable): _____

SERVICE AREAS COVERED

AL AR CO DC DE FL GA IL KS MD MO MS NC NJ PA SC TN TX

FACILITY/ANCILLARY SPECIFICATIONS

- | | |
|--|--|
| <input type="checkbox"/> Hospital: <input type="checkbox"/> Acute Inpatient <input type="checkbox"/> Long Term Care
<input type="checkbox"/> Transplant Program: <input type="checkbox"/> Kidney <input type="checkbox"/> Heart <input type="checkbox"/> Pancreas <input type="checkbox"/> Liver <input type="checkbox"/> Lung
<input type="checkbox"/> Critical Care Services – Intensive Care Units (ICU)
<input type="checkbox"/> Cancer Center
<input type="checkbox"/> Cardiac Catheterization Services
<input type="checkbox"/> Cardiac Program: <input type="checkbox"/> Surgery <input type="checkbox"/> Monitoring <input type="checkbox"/> Testing
<input type="checkbox"/> Mammography Center
<input type="checkbox"/> Outpatient/Ambulatory Surgery Center (ASC)
<input type="checkbox"/> Rehab Facility: <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient
<input type="checkbox"/> Diagnostic: <input type="checkbox"/> Testing <input type="checkbox"/> Radiology
<input type="checkbox"/> Therapy: <input type="checkbox"/> Physical <input type="checkbox"/> Occupational <input type="checkbox"/> Speech Language <input type="checkbox"/> Respiratory
<input type="checkbox"/> Ambulance/ Transportation Service
<input type="checkbox"/> Skilled Nursing Facility: <input type="checkbox"/> Vent <input type="checkbox"/> Onsite Dialysis
Behavioral Health services, please go to CignaforHCP.com | <input type="checkbox"/> Endoscopy Center
<input type="checkbox"/> Federally Qualified Health Center
<input type="checkbox"/> Radiology
<input type="checkbox"/> Sleep Clinic
<input type="checkbox"/> Infusion Therapy Services
<input type="checkbox"/> Dialysis Center
<input type="checkbox"/> Durable Medical Equipment
<input type="checkbox"/> Orthotics
<input type="checkbox"/> Prosthetics
<input type="checkbox"/> Home Health Agency
<input type="checkbox"/> Hearing Aid Provider
<input type="checkbox"/> Urgent Care Center
<input type="checkbox"/> Laboratory Services
<input type="checkbox"/> Other: _____ |
|--|--|

BILLING INFORMATION

(This information should match your W-9)

Address: _____ City: _____ State: _____ Zip Code: _____
Phone: (____) _____ Fax: (____) _____ Tax ID: _____

This form can be downloaded, printed and sent by email or fax. You may also complete it electronically and return via email. Please note that it can take up to 60 days to receive a response to your Network Interest Form. If this form is returned without all required questions answered, the form will not be processed.

Email: centralfloridaproviders@healthspring.com Fax: (855) 879-4993

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