



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 CT DC DE FL GA IL KS MD MO MS NC NM NJ OH OK OR PA SC TN TX UT VT WA

FACILITY/ANCILLARY SPECIFICATIONS

- Hospital: Acute Inpatient Long Term Care
- Transplant Program: Kidney Heart Pancreas Liver Lung
- Critical Care Services – Intensive Care Units (ICU)
- Cancer Center
- Cardiac Catheterization Services
- Cardiac Program: Surgery Monitoring Testing
- Mammography Center
- Outpatient/Ambulatory Surgery Center (ASC)
- Rehab Facility: Inpatient Outpatient
- Diagnostic: Testing Radiology
- Therapy: Physical Occupational Speech Language Respiratory Massage
- Ambulance/ Transportation Service
- Skilled Nursing Facility: Vent Onsite Dialysis

Behavioral Health services, please go to CignaforHCP.com

- Endoscopy Center
- Federally Qualified Health Center
- Radiology
- Sleep Clinic
- Infusion Therapy Services
- Dialysis Center
- Durable Medical Equipment
- Orthotics
- Prosthetics
- Home Health Agency
- Hearing Aid Provider
- Urgent Care Center
- Laboratory Services
- 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: TXMAContracting@Cigna.com

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