



# 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  NM  NJ  OH  OK  PA  SC  TN  TX  UT

## 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](http://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: [SFLMedicareproviders@cigna.com](mailto:SFLMedicareproviders@cigna.com) Fax: (860) 907-8964

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