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***
Are you enrolled in Medicaid? ☐ **Yes** ☐ **No**

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 Serviced: _____ **Medicare Star Rating (if applicable):** _____

Location 2
Address: _____ **City:** _____ **State:** ____ **Zip Code:** _____
Phone: (_____) _____ **Fax:** (_____) _____ **County Located:** _____
Office Hours: _____
Counties Serviced: _____ **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: NewEnglandMarketProviderCommunications@cigna.com Fax: (860) 902-0097

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SUBMIT FORM RESET FORM