



MEDICARE ADVANTAGE MEDICAL PRACTITIONER 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: _____

PRACTITIONER INFORMATION

First: _____ Last: _____ MI: _____ Degree: _____
NPI #: _____ Medicare #: _____ Medicaid #: _____ CAQH #: _____

Desired Role:

- | | |
|--|--|
| <input type="checkbox"/> Primary Care | <input type="checkbox"/> Specialty Care |
| <input type="checkbox"/> In-Office Laboratory (must have CLIA certification) | <input type="checkbox"/> DME (accredited and enrolled with Medicare as DME Provider) |
| <input type="checkbox"/> Radiology (accredited and enrolled with Medicare) | <input type="checkbox"/> Nurse Practitioners and/or Physician Assistants |
| <input type="checkbox"/> Therapy Services -PT/OT/Speech Pathology
(Appropriately licensed and enrolled with Medicare) | |

Behavioral Health providers, please go to CignaforHCP.com

Preferred Specialty 1: _____

Are you board certified in this specialty? Yes No

Preferred Specialty 2: _____

Are you board certified in this specialty? Yes No

If your specialty is (Other) please list specialty: _____

If NP or PA, name of supervising physician: _____ **NPI of supervising physician:** _____

Do you have admitting privileges Yes No **If Yes, list hospital(s):** _____

If No, list alternate admitting arrangements: _____

Are you in Residency? Yes No

Applications will not be accepted prior to 30 days of residency completion

Network Participation you seek: HMO and PPO HMO Only PPO Only

Note: Providers must be enrolled in Medicare in an approved status

What lab(s) do you use: _____

PRACTICE 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: (____) _____

Office Hours: _____

Counties Served: _____

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

Office Hours: _____

Counties Served: _____

GROUP INFORMATION

Are you joining an existing group that is currently on par with Cigna Medicare? Yes No Solo Provider

Group Name: _____ **Group NPI:** _____

BILLING INFORMATION

(This information should match your W-9)

Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____
Phone: (____) _____ **Fax:** (____) _____ **NPI:** _____ **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: ILProviderData@healthspring.com Fax: (866) 234-6649

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