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:

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

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 Serviced: _____

Location 2

Address: _____ **City:** _____ **State:** ____ **Zip Code:** _____

Phone: (_____) _____ **Fax:** (_____) _____

Office Hours: _____

Counties Serviced: _____

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: kansascityprovider@healthspring.com Fax (855) 248-8138

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SUBMIT FORM

RESET FORM