



# 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"/> Part B Drugs  |
| <input type="checkbox"/> Radiology (accredited and enrolled with Medicare)   | <input type="checkbox"/> DME (accredited and enrolled with Medicare as DME Provider) |
| <input type="checkbox"/> Therapy Services -PT/OT/Speech Pathology<br>(Appropriately licensed and enrolled with Medicare) | <input type="checkbox"/> Nurse Practitioners and/or Physician Assistants             |

**Behavioral Health providers, please go to [CignaforHCP.com](http://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:**  Medicare  HMO  PPO  Group Products

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

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

**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: [NewEnglandMarketProviderCommunications@cigna.com](mailto:NewEnglandMarketProviderCommunications@cigna.com) Fax: (860) 902-0097

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