

# PROVIDER NETWORK CHANGE FORM



If you currently receive services from a Primary Care Physician (PCP) in the Arizona Provider network and wish to receive services from a PCP in the CIGNA Medical Group network **(at a lower monthly premium rate)** you must complete this form.

If you wish to select the CIGNA Medical Group (CMG) provider network and begin paying the **lower monthly premium rate** beginning the first of the month, fill out this form and mail it to CIGNA HealthCare of Arizona, Inc. in the enclosed return envelope. Benefit coverage is the same for the CIGNA Medical Group and Arizona Provider networks. **However, the monthly premium rates for the CIGNA Medical Group are lower.** And, membership in the CMG network still allows you to receive services from Obstetrics/Gynecology (OB/GYN) providers in the Arizona Provider network, while paying the **lower CMG network premiums.**

### Enrolling in the CIGNA Medical Group network

To enroll in the CIGNA Medical Group network, select a CMG PCP by logging on to [www.cigna.com](http://www.cigna.com), clicking the Provider Directory link on the left panel and following the prompts. Be sure to select "AZ-CIGNA Medical Group" when asked to "Select Healthplan network." Your PCP selection must be from the CIGNA Medical Group network, though you may still receive services from an Arizona Provider network OB/GYN physician. Complete and sign this form and mail it in the enclosed return envelope.

In order for your reduced premium rate to take effect as soon as possible, please provide the information requested below immediately. Forms received on or before the 5<sup>th</sup> of the month will be effective on the first day of the following month. For example, the effective date of coverage for a form received on October 5th would be November 1<sup>st</sup>. However, the effective date for a form received on or after October 6<sup>th</sup> would be December 1<sup>st</sup>.

### Policyholder Information

Last Name:	First Name:	Middle Initial:
CIGNA ID#:	Daytime Phone:	
Address:	City, State:	Zip:
Current PCP's Name/ID #:	New PCP's Name/ID #:	

	Name (Last, First, MI)	Current PCP's Name/ID#	New PCP's Name/ID #
Spouse			
Dependents			

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*Primary Policyholder*

**CIGNA HEALTHCARE**  
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