

# PROVIDER NETWORK CHANGE FORM

If you currently receive services from a Primary Care Physician (PCP) in the CIGNA Medical Group network and wish to receive services from a PCP in the Arizona Provider network you must complete this side of the form.



**CIGNA HealthCare  
of Arizona**  
*A Business of Caring.*

If you wish to select a PCP from the Arizona Provider network, fill out this form and mail it to CIGNA HealthCare of Arizona, Inc. in the enclosed return envelope. Your completed form must be received by CIGNA HealthCare no later than March 1, 2005. Benefit coverage is the same for the CIGNA Medical Group and Arizona Provider networks. However, the **monthly premium rates for the Arizona Provider network are higher.**

## Enrolling in the Arizona Provider network

To enroll in the Arizona Provider network, select a PCP for you and one for each covered member of your family 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-Arizona" when asked to "Select Healthplan network." You may also obtain an Arizona Provider network Provider Directory by calling CIGNA HealthCare Member Services at 800.832.3211. All of your PCP selections must be from the Arizona Provider network. Complete and sign this form and mail it in the enclosed return envelope so that it is **received by CIGNA HealthCare no later than March 1, 2005** in order for this change to become effective by April 1, 2005.

This option is available to members residing in the Phoenix Service Area covering Maricopa County, the City of Apache Junction, and Pima, Pinal, Graham, Greenlee, Cochise and Santa Cruz counties in the Tucson Service Area.

## Primary 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<br>(Last, First, MI) | Current<br>PCP's Name/ID # | New<br>PCP's Name/ID # |
|------------|---------------------------|----------------------------|------------------------|
| Spouse     |                           |                            |                        |
| Dependents |                           |                            |                        |
|            |                           |                            |                        |

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

*Primary Policyholder*

CIGNA HEALTHCARE  
PO BOX 2010  
CONCORD, NH 03302  
FAX: 603.268.7578

