

**CIGNA 3 STAR QUALITY BARIATRIC CENTER
 RECREDENTIALING APPLICATION**



Please Type or Print Legibly

Section One – General Information

Hospital (Type) _____ Other (Type) _____	
Facility Name _____	Cigna Participating Provider Accreditation: Yes No ACS SRC
Cigna Provider ID Number _____	State License Number _____ Exp. Date _____
Facility Address	Credentialing Address
Street, Suite _____	Street, Suite _____
City, State, ZIP _____	City, State, ZIP _____
Main Telephone Number _____	Credentialing Telephone Number _____
Fax Number _____	Fax Number _____
Chief Administrator (Name & Title) _____	Telephone Number _____
Contact Person (Name & Title) _____	Telephone Number _____
Email Address _____	

Section 2 – Bariatric Surgery Outcome Measures

Outcomes for the preceding 12 months for open and laparoscopic procedures performed in this facility only:

Measure	Gastric Bypass	Gastric Banding	Gastric Sleeve
Total # of cases			
* Overall mortality rate (< 1%)	__ . __ __ %	__ . __ __ %	__ . __ __ %
Inpatient mortality rate during initial Bariatric surgery hospital stay	__ . __ __ %	__ . __ __ %	__ . __ __ %
60 day mortality rate post initial Bariatric surgery	__ . __ __ %	__ . __ __ %	__ . __ __ %
90 day mortality rate post initial Bariatric surgery	__ . __ __ %	__ . __ __ %	__ . __ __ %
* Overall re-operation rate for Bariatric surgery complications (<10%)	__ . __ __ %	__ . __ __ %	__ . __ __ %
* Re-operation rate within 30 days of initial Bariatric surgery (< 2.5%)	__ . __ __ %	__ . __ __ %	__ . __ __ %
Transfer to another facility rate during initial Bariatric surgical hospital stay	__ . __ __ %	__ . __ __ %	__ . __ __ %
* Overall readmission rate within 30 days post initial Bariatric surgery for anastomotic leak, subphrenic abscess, splenic injury, pulmonary embolism or wound infection (< 5%)	__ . __ __ %	__ . __ __ %	__ . __ __ %

* Used in designation decision making. **If the facility's rates do not meet thresholds indicated in bold, include explanation of these rates.**

Section 3 – Bariatric Surgeons

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Name and Degree: _____	_____	_____	_____
Cigna Participating Provider	Yes No	Tax ID Number:	Date of Birth: UPIN Number:
Name and Degree: _____	_____	_____	_____
Cigna Participating Provider	Yes No	Tax ID Number:	Date of Birth: UPIN Number:
Name and Degree: _____	_____	_____	_____
Cigna Participating Provider	Yes No	Tax ID Number:	Date of Birth: UPIN Number:
Name and Degree: _____	_____	_____	_____
Cigna Participating Provider	Yes No	Tax ID Number:	Date of Birth: UPIN Number:
Name and Degree: _____	_____	_____	_____
Cigna Participating Provider	Yes No	Tax ID Number:	Date of Birth: UPIN Number:

Section 4 - Attestation

All information provided on this application or in connection with this application is complete and accurate to the best of the facility's knowledge. The facility understands that this application does not entitle the facility to participation in Cigna's networks. It is further understood that if the facility is accepted as a Cigna 3 Star Quality Bariatric Center, it shall provide an update to this information when requested by Cigna. The facility further agrees to notify Cigna within 30 days of any changes to the information provided on the application.

_____ Signature of Chief Administrator or Authorized Designee	_____ Date
_____ Print Name of Chief Administrator or Authorized Designee	
_____ Facility Name	
_____ Address	
_____ City, State, ZIP Code	

Cigna Contact Person

Please send this application and a current copy of the hospital's State License to:
 Tracy LaBranche
 Senior Credentialing Coordinator
 Cigna
 2 College Park Drive
 Hooksett, NH 03106
 Fax: 860-731-3468
 Email: BariatricSurgeryCertificationProgram@Cigna.com