

CIGNA CERTIFIED HOSPITAL FOR BARIATRIC SURGERY APPLICATION



Please Type or Print Legibly

Section One – General Information

Hospital (Type) _____ Other (Type) _____

Facility Name _____ CIGNA Participating Provider Yes No
 Accreditation: 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 procedures performed in this facility only:

Measure	Gastric Bypass Procedures Open and Laparoscopic	Gastric Banding Procedures Open and Laparoscopic
Total # of cases		
* Overall mortality rate	__ . __ __ %	__ . __ __ %
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	__ . __ __ %	__ . __ __ %
* Re-operation rate within 30 days of initial Bariatric surgery	__ . __ __ %	__ . __ __ %
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	__ . __ __ %	__ . __ __ %

* Used in designation decision making

Section 3 – Bariatric Surgeons

Name and Degree: _____	_____	_____	_____
CIGNA Participating Provider <input type="checkbox"/> Yes <input type="checkbox"/> No	Tax ID Number:	Date of Birth:	UPIN Number:
Name and Degree: _____	_____	_____	_____
CIGNA Participating Provider <input type="checkbox"/> Yes <input type="checkbox"/> No	Tax ID Number:	Date of Birth:	UPIN Number:
Name and Degree: _____	_____	_____	_____
CIGNA Participating Provider <input type="checkbox"/> Yes <input type="checkbox"/> No	Tax ID Number:	Date of Birth:	UPIN Number:
Name and Degree: _____	_____	_____	_____
CIGNA Participating Provider <input type="checkbox"/> Yes <input type="checkbox"/> No	Tax ID Number:	Date of Birth:	UPIN Number:
Name and Degree: _____	_____	_____	_____
CIGNA Participating Provider <input type="checkbox"/> Yes <input type="checkbox"/> 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 Certified Facility for Bariatric Surgery, 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: 347-821-5999
 Email: BariatricSurgeryCertificationProgram@Cigna.com