Provider Update Form

To update your demographic information, please complete this form or visit our online form at CignaForHCP.com.
Please note: this form is for updating information only. Claims should not be mailed or faxed to Network Operations

Fax To:	**Mail To:**
Network Operations 860.687.7257	Network Operations CIGNA Behavioral Health 11095 Viking Dr, Ste 350 Eden Prairie, MN 55344

Name:_____

Email Address: _____

Provider ID # (if known) _____

Mailing Address (Only 1 mailing address – for administrative correspondence, including authorization letters)

_____

Street Address/PO Suite City State Zip Code

I am currently seeing patients at the following location(s): (cannot be a PO Box)

Street _____Suite____ Street _____Suite_____

City/State _____Zip_____ City/State _____Zip_____

Telephone # _____ Telephone # _____

I'm no longer seeing patients at the following location(s):

Street _____Suite____ Street _____Suite_____

City/State _____Zip_____ City/State _____Zip_____

I want claim payments to be sent to the following location(s):

Street _____Suite____ Street _____Suite_____

City/State _____Zip_____ City/State _____Zip_____

Tax ID # _____ Tax ID # _____

Tax ID Legal Name _____ Tax ID Legal Name _____

I no longer want claim payments to be sent to the following location(s):

Street _____Suite _____ Street _____Suite _____

Street _____Suite _____ Street _____Suite _____

I am no longer using the following tax ID numbers:

_____ _____ _____ _____