

# FACILITY/ANCILLARY NETWORK INTEREST PROFILE FORM

Required fields denoted with an asterisk (\*). Incomplete forms will be returned to contact mailing address.

## General Information

Applying for Cigna-HealthSpring\*:  MMP  STAR+PLUS Date: \_\_\_\_\_

Operating/DBA Name\*: \_\_\_\_\_

Multiple Locations:  Yes  No If yes, please attach additional location information

NPI\*: \_\_\_\_\_ TIN\*: \_\_\_\_\_ Medicare #: \_\_\_\_\_ Medicaid #: \_\_\_\_\_

Contact Person\*: \_\_\_\_\_ Contact Phone\*: \_\_\_\_\_

Contact Email\*: \_\_\_\_\_ Contact Fax\*: \_\_\_\_\_

Contact Mailing Address\*: \_\_\_\_\_

City, State, and Zip\*: \_\_\_\_\_

## Provider Specifications

Please check the type of service(s) you provider\*:

<input type="checkbox"/> Acute Hospital	<input type="checkbox"/> DME	<input type="checkbox"/> Othotics/Prosthetics
<input type="checkbox"/> Adult Day Care	<input type="checkbox"/> Emergency Response	<input type="checkbox"/> Pediatric Day Care
<input type="checkbox"/> Adult Foster Care	<input type="checkbox"/> Habilitation Services	<input type="checkbox"/> Personal Assistant Services
<input type="checkbox"/> Ambulatory Surgery Center	<input type="checkbox"/> Home Delivered Meals	<input type="checkbox"/> PT/OT/ST
<input type="checkbox"/> Assisted Living Facility	<input type="checkbox"/> Home Health	<input type="checkbox"/> Protective Supervision
<input type="checkbox"/> Behavioral Health	<input type="checkbox"/> Home Modifications	<input type="checkbox"/> Respite Services
<input type="checkbox"/> Consumer Direct Agency	<input type="checkbox"/> Hospice Services	<input type="checkbox"/> SNF (sub-acute, non-custodial)
<input type="checkbox"/> Diagnostics (list services below)	<input type="checkbox"/> Infusion	<input type="checkbox"/> Transitional Assistance Services
<input type="checkbox"/> Dialysis	<input type="checkbox"/> Nursing Facility (custodial/residential)	<input type="checkbox"/> Urgent Care
<input type="checkbox"/> Other: _____		

Are you accredited?  Yes  No If yes, list the accrediting entity: \_\_\_\_\_

Do you carry general and professional liability insurance? If so, how much? General: \_\_\_\_\_ Liability: \_\_\_\_\_

**Providers must be a licensed Medicaid approved provider to be considered for our STAR+PLUS and/or STAR+PLUS MMP products**

Geographic coverage of services\*:

<input type="checkbox"/> Hidalgo SA	<input type="checkbox"/> Webb	<input type="checkbox"/> Cass	<input type="checkbox"/> Hopkins	<input type="checkbox"/> Red River	<input type="checkbox"/> Upshur	<input type="checkbox"/> Tarrant
<input type="checkbox"/> Cameron	<input type="checkbox"/> Willacy	<input type="checkbox"/> Delta	<input type="checkbox"/> Lamar	<input type="checkbox"/> Rusk	<input type="checkbox"/> Van Zandt	<input type="checkbox"/> Wise
<input type="checkbox"/> Duval	<input type="checkbox"/> Zapata	<input type="checkbox"/> Fannin	<input type="checkbox"/> Marion	<input type="checkbox"/> Sabine	<input type="checkbox"/> Wood	
<input type="checkbox"/> Hidalgo	<b>Northeast SA</b>	<input type="checkbox"/> Franklin	<input type="checkbox"/> Montague	<input type="checkbox"/> San Augustine	<b>Tarrant SA</b>	
<input type="checkbox"/> Jim Hogg	<input type="checkbox"/> Anderson	<input type="checkbox"/> Grayson	<input type="checkbox"/> Morris	<input type="checkbox"/> Shelby	<input type="checkbox"/> Denton	
<input type="checkbox"/> Maverick	<input type="checkbox"/> Angelina	<input type="checkbox"/> Gregg	<input type="checkbox"/> Nacogdoches	<input type="checkbox"/> Smith	<input type="checkbox"/> Hood	
<input type="checkbox"/> McMullen	<input type="checkbox"/> Bowie	<input type="checkbox"/> Harrison	<input type="checkbox"/> Panola	<input type="checkbox"/> Titus	<input type="checkbox"/> Johnson	
<input type="checkbox"/> Starr	<input type="checkbox"/> Camp	<input type="checkbox"/> Henderson	<input type="checkbox"/> Rains	<input type="checkbox"/> Trinity	<input type="checkbox"/> Parker	

Languages spoken:  Arabic  Chinese-Cantonese  Chinese-Mandarin  Hindi  Sign Language

Spanish  Vietnamese  Other: \_\_\_\_\_

The Cigna-HealthSpring Network Interest Committee will review your request and send notification to you once the committee renders a decision. Determinations based on network need and current availability of services. All providers are subject to Cigna-HealthSpring Credentialing requirements and applicable state and federal guidelines as set forth in the Cigna-HealthSpring participating provider agreement. **PLEASE NOTE:** Requesting, obtaining, or submitting a profile form does not guarantee or imply that Cigna-HealthSpring will accept your participation in the Cigna-HealthSpring network, nor does it entitle you to payment of any services rendered to a Cigna-HealthSpring member prior to your receiving written confirmation of an effective date and meeting any and all applicable authorization requirements.

Highway 121, Ste 210 – Bedford, TX 76021 Phone: 1-877-653-0331 Fax: 1-877-440-7260  
 Email: [STARPLUSproviderrelations@healthspring.com](mailto:STARPLUSproviderrelations@healthspring.com) Website: <http://starplus.cignahealthspring.com>

All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation, including HealthSpring Life & Health Insurance Company, Inc. The Cigna name, logos, and other Cigna marks are owned by Cigna Intellectual property, Inc.

