

PRACTITIONER NETWORK INTEREST PROFILE FORM

Required fields denoted with an asterisk (*). Incomplete forms will be returned to contact mailing address. If you use CAQH, use this time to re-attest and update your credentialing documents.

Practitioner Information

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

Practitioner Name*:

Desired role*: PCP Specialist Hospitalist Behavioral Health

NPI*: TIN*: Medicare #: Medicaid #:

Contact Person*: Contact Phone*:

Contact Email*: Contact Fax*:

Contact Mailing Address*:

City, State, and Zip*:

Is practitioner still in residency? Yes No If yes, expected residency completion date:

APPLICATIONS WILL NOT BE ACCEPTED PRIOR TO 30 DAYS OF RESIDENCY COMPLETION

Primary Specialty*: Board Certified: Yes No

Secondary Specialty*: Board Certified: Yes No

Group Name*: Group NPI*:

Is practitioner joining an existing group of practitioners who is currently participating with Cigna-HealthSpring?

Yes No

County: CAQH #:

Practitioner's physical address*:

If physician, list hospital admitting privileges*:

If NP or PA, name of supervising physician*:

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.

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