MEDICAL PRACTITIONER NETWORK INTEREST FORM

NOTE: Cigna-HealthSpring will review your request and send notification to you once a decision has been rendered. Determinations are based on network need and current availability of services. All providers are subject to Cigna-HealthSpring credentialing requirements and applicable state and federal guidelines.

Submission of Interest Form Does Not Guarantee Acceptance by the Plan

OFFICE CONTACT INFORMATION

(Cigna-HealthSpring will use this information for any questions, concerns or responses regarding this form)

Date:	Name:	Email:	
Phone:		Fax:	
Address:	City:	State:	Zip Code:

PRACTIONER INFORMATION

First Name:	Last Name:	MI:	Degree:
NPI #	Medicare #	Medicaid #	CAQH #

Desired Role: PCP ☐ Specialist ☐ Allied Health ☐ Hospital based ☐

Behavioral Health providers, please go to CignaforHCP.com

Preferred Specialty 1:	Are you board certified in this specialty? ☐ Yes ☐ No
Preferred Specialty 2:	Are you board certified in this specialty? ☐ Yes ☐ No

If your specialty is (Other) please list specialty:

If NP or PA, name of supervising physician:	NPI of supervising physician:

Do you have admitting privileges ☐ Yes ☐ No If Yes, list hospital(s):

If No, list alternate admitting arrangements:

Are you still in Residency? ☐ Yes ☐ No If Yes, expected Residency completion date:

Applications will not be accepted prior to 30 days of residency completion

Network Participation you seek: ☐ Medicare *Note: Providers must be enrolled in Medicare in an approved status*

What lab(s) do you use:

PRACTICE LOCATIONS

*(Only list locations where you actively practice. *If you have more than 2 locations, please attach additional location information)*

Location 1	Address:	City:	State:	Zip Code:
	Phone #	Fax #		
Office Hours:				
Counties Serviced:				
Location 2	Address:	City:	State:	Zip Code:
	Phone #	Fax #		
Office Hours:				
Counties Serviced:				

GROUP INFORMATION

Are you joining an existing group that is currently on plan with Cigna-Healthspring? ☐ Yes ☐ No ☐ Solo Provider

Group Name:	Group NPI:

BILLING INFORMATION

(This information should match your W-9)

Address:	City:	State:	Zip Code:
Phone #	Fax #	NPI:	Tax ID:

This form can be downloaded, printed and sent by email or fax. You may also complete it electronically and return via email. Please note that it can take up to 60 days to receive a response to your Network Interest Form. If this form is returned without all required questions answered, the form will not be processed

Email: TXGQProviderRelations@healthspring.com Fax: (832) 553-3418

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