

FACILITY/ANCILLARY 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:

FACILITY/ANCILLARY INFORMATION

Corporate Name:		Operating (DBA) name:	
NPI #	Tax ID #	Medicare #	Medicaid #
Are you accredited <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list the accrediting entity:			
Network Participation you seek: <input type="checkbox"/> Medicare <i>Note: Providers must be enrolled in Medicare in an approved status</i>			

SERVICE LOCATIONS

*(Only list locations where you actively practice. *If you have more than 2 locations, please include an excel listing of all locations)*

Location	Address:	City:	State:	Zip Code:
1	Phone #	Fax #	County Located:	
Office Hours:				
Counties Served:			Medicare Star Rating (if applicable):	
Location	Address:	City:	State:	Zip Code:
2	Phone #	Fax #	County Located:	
Office Hours:				
Counties Served:			Medicare Star Rating (if applicable):	

SERVICE AREAS COVERED

AL GA NC SC FL MS TN AR MO KS MD DC DE PA IL IN TX

FACILITY/ANCILLARY SPECIFICATIONS

<input type="checkbox"/> Hospital: <input type="checkbox"/> Acute Inpatient <input type="checkbox"/> Long Term Care <input type="checkbox"/> Transplant Program: <input type="checkbox"/> Kidney <input type="checkbox"/> Heart <input type="checkbox"/> Pancreas <input type="checkbox"/> Liver <input type="checkbox"/> Lung <input type="checkbox"/> Critical Care Services – Intensive Care Units (ICU) <input type="checkbox"/> Cancer Center <input type="checkbox"/> Cardiac Catheterization Services <input type="checkbox"/> Cardiac Program: <input type="checkbox"/> Surgery <input type="checkbox"/> Monitoring <input type="checkbox"/> Testing <input type="checkbox"/> Mammography Center <input type="checkbox"/> Outpatient/Ambulatory Surgery Center (ASC) <input type="checkbox"/> Rehab Facility: <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Diagnostic: <input type="checkbox"/> Testing <input type="checkbox"/> Radiology <input type="checkbox"/> Therapy: <input type="checkbox"/> Physical <input type="checkbox"/> Occupational <input type="checkbox"/> Speech Language <input type="checkbox"/> Respiratory <input type="checkbox"/> Ambulance/ Transportation Service <input type="checkbox"/> Skilled Nursing Facility: <input type="checkbox"/> Vent <input type="checkbox"/> Onsite Dialysis Behavioral Health services, please go to CignaforHCP.com	<input type="checkbox"/> Endoscopy Center <input type="checkbox"/> Federally Qualified Health Center <input type="checkbox"/> Radiology <input type="checkbox"/> Sleep Clinic <input type="checkbox"/> Infusion Therapy Services <input type="checkbox"/> Dialysis Center <input type="checkbox"/> Durable Medical Equipment <input type="checkbox"/> Orthotics <input type="checkbox"/> Prosthetics <input type="checkbox"/> Home Health Agency <input type="checkbox"/> Hearing Aid Provider <input type="checkbox"/> Urgent Care Center <input type="checkbox"/> Laboratory Services <input type="checkbox"/> Other:
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BILLING INFORMATION

(This information should match your W-9)

Address:	City:	State:	Zip Code:
Phone #	Fax #	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: GeorgiaProvider@healthspring.com Fax: (877) 788-2721