Cigna HealthSpring

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 ☐ Yes ☐ No If yes, list the accrediting entity:

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

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

☐Hospital: ☐Acute Inpatient ☐Long Term Care
☐Transplant Program: ☐Kidney ☐Heart ☐Pancreas ☐Liver ☐Lung
☐Critical Care Services – Intensive Care Units (ICU)
☐Cancer Center
☐Cardiac Catheterization Services
☐Cardiac Program: ☐Surgery ☐Monitoring ☐Testing
☐Mammography Center
☐Outpatient/Ambulatory Surgery Center (ASC)
☐Rehab Facility: ☐Inpatient ☐Outpatient
☐Diagnostic: ☐Testing ☐Radiology
☐Therapy: ☐Physical ☐Occupational ☐Speech Language ☐Respiratory
☐Ambulance/ Transportation Service
☐Skilled Nursing Facility: ☐Vent ☐Onsite Dialysis

☐Endoscopy Center
☐Federally Qualified Health Center
☐Radiology
☐Sleep Clinic
☐Infusion Therapy Services
☐Dialysis Center
☐Durable Medical Equipment
☐Orthotics
☐Prosthetics
☐Home Health Agency
☐Hearing Aid Provider
☐Urgent Care Center
☐Laboratory Services
☐Other:

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: ILProviderData@healthspring.com Fax: 1-866-234-6649

Submit Reset