



**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:

**PRACTITIONER INFORMATION**

First Name:	Last Name:	MI:	Degree:
NPI #	Medicare #	Medicaid #	CAQH #
Desired Role:      PCP <input type="checkbox"/> Specialist <input type="checkbox"/> Allied Health <input type="checkbox"/> Hospital based <input type="checkbox"/>			
<b>Behavioral Health providers, please go to <a href="http://CignaforHCP.com">CignaforHCP.com</a></b>			
Preferred Specialty 1:		Are you board certified in this specialty? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Preferred Specialty 2:		Are you board certified in this specialty? <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> No    If Yes, list hospital(s):			
If No, list alternate admitting arrangements:			
Are you still in Residency? <input type="checkbox"/> Yes <input type="checkbox"/> No    If Yes, expected Residency completion date: <i>Applications will not be accepted prior to 30 days of residency completion</i>			
Network Participation you seek: <input type="checkbox"/> Medicare <i>Note: Providers must be enrolled in Medicare in an approved status</i>			
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 Served:				
Location 2	Address:	City:	State:	Zip Code:
	Phone #	Fax #		
Office Hours:				
Counties Served:				

**GROUP INFORMATION**

Are you joining an existing group that is currently on plan with Cigna-Healthspring? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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: [GeorgiaProvider@healthspring.com](mailto:GeorgiaProvider@healthspring.com)

Fax: (877) 788-2721