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: Provider_Intake_Form_MA/PA@healthspring.com Fax: (855) 285-0663

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