Hospital Coverage Agreement Form

Complete this form if you do not participate in a Cigna network-participating hospital, but have arrangements with a hospitalist group or physician that can admit your Cigna patients to a Cigna network-participating hospital in which they have active privileges. This physician or hospitalist group must participate in the Cigna network, and practice in the same or similar specialty field as you do.

Hospital coverage arrangement statement

I, _____ (the referring physician), practice in the specialty of _____. I confirm that if any of my patients should require admission to the hospital, they will be admitted

to _____ ,
(Cigna-participating hospital name)

by _____,
(Cigna-participating admitting hospitalist group or physician name)

who agrees to admit my patients and provide care appropriate to my specialty.

***Note**: The provider must have active privileges at the hospital noted above; temporary or pending privileges are not acceptable.*

Attestation

By signing below, I am attesting that:

1. The above information is correct and current.
2. The admitting hospitalist group or physician is aware of this arrangement.
3. I will notify Cigna of any change in my hospital coverage arrangement within 10 calendar days of the change.

Print name: _____
(Referring physician)

Signature: _____
(Referring physician)

Date: _____