CIGNA 3 STAR QUALITY BARIATRIC CENTER APPLICATION

Please Type or Print Legibly

Section One – General Information

❑ Hospital (Type)____________________________ ❑ Other (Type) ____________________________

________________________________ Facility Name

Cigna Participating Provider ❑ Yes ❑ No
Accreditation: ❑ ACS ❑ SRC

________________________________ Cigna Provider ID Number

________________ State License Number

__________ Exp. Date

Facility Address	Credentialing Address
Street, Suite	Street, Suite
City, State, ZIP	City, State, ZIP
Main Telephone Number	Credentialing Telephone Number
Fax Number	Fax Number

________________________________ Chief Administrator (Name & Title)

________________ Telephone Number

________________________________ Contact Person (Name & Title)

________________ Telephone Number

________________________________ Email Address

Section 2 – Bariatric Surgery Outcome Measures

Outcomes for the preceding 12 months for open and laparoscopic procedures performed in this facility only:

Measure	Gastric Bypass	Gastric Banding	Gastric Sleeve
Total # of cases			
* Overall mortality rate **(< 1%)**	__.__ __%	__.__ __%	__.__ __%
Inpatient mortality rate during initial Bariatric surgery hospital stay	__.__ __%	__.__ __%	__.__ __%
60 day mortality rate post initial Bariatric surgery	__.__ __%	__.__ __%	__.__ __%
90 day mortality rate post initial Bariatric surgery	__.__ __%	__.__ __%	__.__ __%
* Overall re-operation rate for Bariatric surgery complications **(<10%)**	__.__ __%	__.__ __%	__.__ __%
* Re-operation rate within 30 days of initial Bariatric surgery **(< 2.5%)**	__.__ __%	__.__ __%	__.__ __%
Transfer to another facility rate during initial Bariatric surgical hospital stay	__.__ __%	__.__ __%	__.__ __%
* Overall readmission rate within 30 days post initial Bariatric surgery for anastomotic leak, subphrenic abscess, splenic injury, pulmonary embolism or wound infection **(< 5%)**	__.__ __%	__.__ __%	__.__ __%

* Used in designation decision making. **If the facility's rates <u>do not meet</u> thresholds indicated in bold, include explanation of these rates.**

Section 3 – Bariatric Surgeons

Name and Degree: ______________________________ ____________ __________ __________
Cigna Participating Provider ❑ Yes ❑ No Tax ID Number: Date of Birth: UPIN Number:

Name and Degree: ______________________________ ____________ __________ __________
Cigna Participating Provider ❑ Yes ❑ No Tax ID Number: Date of Birth: UPIN Number:

Name and Degree: ______________________________ ____________ __________ __________
Cigna Participating Provider ❑ Yes ❑ No Tax ID Number: Date of Birth: UPIN Number:

Name and Degree: ______________________________ ____________ __________ __________
Cigna Participating Provider ❑ Yes ❑ No Tax ID Number: Date of Birth: UPIN Number:

Name and Degree: ______________________________ ____________ __________ __________
Cigna Participating Provider ❑ Yes ❑ No Tax ID Number: Date of Birth: UPIN Number:

Name and Degree: ______________________________ ____________ __________ __________
Cigna Participating Provider ❑ Yes ❑ No Tax ID Number: Date of Birth: UPIN Number:

Section 4 - Attestation

All information provided on this application or in connection with this application is complete and accurate to the best of the facility's knowledge. The facility understands that this application does not entitle the facility to participation in Cigna's networks. It is further understood that if the facility is accepted as a Cigna 3 Star Quality Bariatric Center, it shall provide an update to this information when requested by Cigna. The facility further agrees to notify Cigna within 30 days of any changes to the information provided on the application.

____ ____________________
Signature of Chief Administrator or Authorized Designee Date

____
Print Name of Chief Administrator or Authorized Designee

____
Facility Name

____
Address

____
City, State, ZIP Code

Cigna Contact Person

Please send this application and a <u>current copy of the hospital's State License</u> to:

Cigna
Bariatric Surgery Certification Program
2 College Park Drive 2nd Floor
Hooksett, NH 03106
Fax: 860-731-3468
Email: BariatricSurgeryCertificationProgram@Cigna.com