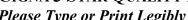
CIGNA 3 STAR QUALITY BARIATRIC CENTER APPLICATION Please Type or Print Legibly





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 N	Number		
Contact Person (Name & Title)	Telephone Number			
Email Address	_			
Section 2 – Bariatric S	urgery Outcom	e 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	%	%	%	

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Section 3 – Bariatric Surgeons

CIGNA 3 STAR QUALITY BARIATRIC CENTER APPLICATION Name and Degree: Cigna Participating Provider Yes No Tax ID Number: UPIN Number: Date of Birth: 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 Tax ID Number: ☐ No Date of Birth: **UPIN** Number: Name and Degree: ___ Cigna Participating Provider

Yes Tax ID Number: Date of Birth: □ No 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 current copy of the hospital's State License to:

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

Email: BariatricSurgeryCertificationProgram@Cigna.com

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