CIGNA
A Business of Caring.

American Maritime Officers Medical Plan
Shared Administration Repricing Network

Provider Nomination Form

Once completed, please fax to: (800) 657-3073

Physician / Provider Nomination

Please use this area to provide us detailed information on any providers you would like for us to contact. **All fields must be completed.**

Physician/Provider Name: _____

Practice Name (if applicable): _____

Specialty (Type of Provider): _____

Street Address: _____

City, State Zip Code: _____

Phone Number: _____

Physician/Provider Name: _____

Practice Name (if applicable): _____

Specialty (Type of Provider): _____

Street Address: _____

City, State Zip Code: _____

Phone Number: _____

Physician/Provider Name: _____

Practice Name (if applicable): _____

Specialty (Type of Provider): _____

Street Address: _____

City, State Zip Code: _____

Phone Number: _____

How can we contact you to provide feedback on your nomination?

Your Name: _____

Your Address: _____

_____