

PROVIDER NOMINATION FORM

Cigna Healthcare
Attn: Dianna Coffman
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Fax 860.298.6442

PROVIDER OR CLINIC NAME: _____

PROVIDER SPECIALTY: _____

ADDRESS: _____

CITY / STATE: _____

ZIP CODE: _____

TELEPHONE: _____

YOUR NAME (optional): _____

Please note that we cannot approach or contract with all nominated providers. The following are a few examples of provider recruitment limitations:

- *Providers must meet all credentialing and quality guidelines as determined by Cigna.*
- *We may not be able to contract with a provider due to exclusivity provisions in another agreement or promises that we would not contract with every provider in their specialty in the service area.*
- *Providers must have admitting privileges to a Cigna contracted hospital.*
- *Providers must accept our standard fee schedule offered to other providers in their area.*