A

PHYSICIAN INFORMATION

Physician/Office Staff - Please validate the information below and make any applicable changes.

PHYSICIAN LAST NAME		**FIRST NAME**		**MI**	**Degree**
SSN	**TIN**	**DATE OF BIRTH**	**NAME OF GROUP**		
STREET (Primary office address, for directory purposes) **(For directory purposes please provide additional office addresses on separate page complete with office hour information)**					**SUITE**
CITY	**COUNTY**		**STATE** **ZIP CODE**		**OFFICE PHONE #**
STREET (Application mailing address, if different than above)			**ATTN TO:**		**SUITE**
CITY			**STATE** **ZIP CODE**		
EMAIL ADDRESS		**FAX #**			

How will the provider be completing the rendering provider (HCFA 1500 box 31) and billing provider (Box 33) information?

Rendering provider's name (CMS 1500, box 31)**:**	**Billing Name (Group name if appropriate) and address, for claim purposes** (CMS 1500, box 33):
Credentialing Contact Name:	**Caller Name:** **Caller Contact Number:**

CAQH ID#	**CIGNA Provider ID**	**Provider DEA#**
☐ **OFFICE HOURS FULL TIME 24 HOURS OR GREATER (PCP's Only)**	☐ **OFFICE HOURS PART TIME LESS THAN 24 HOURS (PCP's only)**	
HOSPITAL AFFILIATION **1.**	**2.**	
SPECIALTY:	**1.** **2.** **3.** **Please check one of the following roles:** ☐ **PCP** ☐ **SPEC** ☐ **OB/GYN** ☐ **HOSPITAL BASED** ☐ **HOSPITALIST**	

☐ **New, Solo Practice Contract**	☐ **Provider Joining An Existing Contracted Group**	☐ **Existing Great West Provider**	
☐ **New, Group Practice Contract** **____ # Of Providers**	☐ **Contracted Provider Adding A New TIN and/or Practice Location** (Not Changing Existing Information)	☐ **Contracted Provider Terminating One TIN or Practice and Joining a Different Group TIN or Practice**	☐ **Contracted Provider Terminating From One TIN or Practice and Forming A Solo TIN or Practice**
COMMENTS:			

Check all that apply:

My signature below indicates that I have verified the above information to be accurate.

_____

Physician/Office Staff Signature **Date**

COMPLETED BY _____ FOR CIGNA PURPOSES ONLY **DATE OF REQUEST** **01/17/2014**
CIGNA REPRESENTATIVE

County: Zip Code: Market Verified ☐

☐ U ☐ S ☐ A ☐ E **FT** ☐