

PHYSICIAN NOMINATION FORM
CIGNA HEALTHCARE NETWORK

Note: Please fax form to the Attention of Tim Johnson at Fax Number: (860-687-4396)

Employee Name: _____

Employer Name: _____

I would like the following doctor to be contacted for participation in the CIGNA Open Access Plus network.

Physician Name

Office Manager's Name

Phone Number

Address

City

State

Zip Code

Primary Specialty

Primary Admitting Hospital

I have contacted my physician regarding joining the CIGNA Open Access Plus Network.

____ YES

____ NO

I understand the existing network in my area may not be accepting new physicians at this time. Also, I understand there is no guarantee that the doctor I have nominated to participate in the network will meet the credentialing requirements. Even if my doctor qualifies, he or she may choose not to participate.

Employee Signature

Date