APPLICATION FOR PROVIDER FACILITIES

You should complete this form to apply to be a registered provider to Cigna HealthCare.
This application must be completed fully using block capitals.

1. PROVIDER DETAILS

This section should be completed with the details of the consultant/provider who is applying to be registered with Cigna HealthCare.

Title (Mr, Mrs, Dr, etc.):					
Full name:					
Gender (please tick the box that applies):		Female:		Male:	
Correspondence address: (Please provide the address which is detailed on the consultant/provider invoice)					
Postcode:					
Email address:					
Website address:					
Telephone number:					

2. SECRETARY DETAILS

This section should be completed with the details of the secretary to the consultant/provider who is applying to be registered with Cigna HealthCare.

Title (Mr, Mrs, Dr, etc.):	
Full name:	
Telephone number:	
Email address:	

3. SPECIALTY

Is the consultant/provider a specialist or anaesthetist? (please tick the box that applies)	Consultant specialist:		Consultant anaesthetist:	
What is the consultant's/provider's speciality?				

If the consultant/provider has any sub-specialities please list them here:		1.	
2.		3.	
4.		5.	

Please provide details of the consultant/provider's clinical areas of interest.

4. REGISTRATION

Please provide the consultant's/provider's GMC membership number:							
If other, please specify:							

5. FEE SCHEDULE USED

Will you adhere to Cigna's fee schedule? You can view this at **www.cigna.co.uk/healthcare-providers/fee-schedule/index.html**							Yes:		No:
If no, please tick which fee schedule the consultant or provider works to:									
Aviva:		BUPA:		WPA:		PruHealth:			
AXA:		SimplyHealth:		If other, please specify:					

6. WHICH HOSPITALS DOES THE CONSULTANT/PROVIDER HAVE PRACTICING PRIVILEGES AT?

Please provide names and addresses.

	Hospital name	Hospital address
1.		
2.		
3.		
4.		
5.		

7. PROVIDER BANKING DETAILS

Please provide details of the bank account which Cigna HealthCare should make payment to.

Invoices are normally paid by Direct Credit to your Bank Account and we send a separate remittance advice.	
Sort code:	
Bank account number:	
Name of payee:	

8. REMITTANCE ADVICES

We will send all remittance advices by email. If you DO NOT wish to receive electronic remittance advices please complete the details below.				
Would you like the remittance advices to be sent to the correspondence email/postal address given in Section 1? (If no, please provide details below)	Yes:		No:	
Full name:				
Address:				
Postcode:				
Email:				

9. CONSENT

Do you give your consent for your details to be included on our website to help our members find a practitioner?	Yes:		No:	

10. DECLARATION

Signed:	
Date:	
Name (BLOCK CAPITALS):	

Please return the completed form to Cigna HealthCare, 1 Knowe Road, Greenock, Inverclyde, PA15 4RJ, or by email Provider.affairs@cigna.com or by fax 01475 788448.

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