CIGNA HEALTH BENEFITS PROGRAM

PHYSICIAN NOMINATION FORM
CIGNA HEALTHCARE OPEN ACCESS PLUS PLAN
For Employees of City of Stamford

Employee Name: ____

Company/Department: ____

I would like the following doctor to be considered for participation in the OPEN ACCESS PLUS Network:

____
Physician's Name

____
Phone Number

____
Address

____
Specialty

I understand that this doctor's participation is subject to his or her desire to participate in the network and is subject to the CIGNA HealthCare credentialing criteria.

______________________________ ______________________
Employee Signature Date

Please return complete forms to:
Angela Diaz
CIGNA
Fax: 877.828.3849