APPLICATION TO REGISTER AS A CIGNA PROVIDER (FACILITY)

You should complete this form to apply to be a registered provider (facility) to Cigna HealthCare. This application should be completed in full or may be rejected.

1. PROVIDER DETAILS	
Full name*	
Correspondence address 1*	
Correspondence address 2	
Correspondence town/city*	
Correspondence postcode*	
Email address*	
Telephone number*	
Website address	

2. DAILY CONTACT DETAILS	
Title (Mr, Mrs, Dr, etc.)	
Full name	
Telephone number	
Email address	

3. SPECIALTY	
Does the facility specialise in particular fields?	
A	
B	
C	
D	
E	

4. REGISTRATION	
CQC Number	
Any other details	

5. BILLING				
Healthcode	Yes:	◯	No:	◯
Other (if NO above)				

6. COMMERCIALS

Please note that any application will not be complete until the Commercial Manager has agreed to any pricing proposals. Please attach your Insured Tariffs.

Renewal date	
Commercial Manager	
Email address	
Telephone number	

7. BANKING DETAILS

Please note:
Payments will ONLY be paid by Direct Credit (BACS) to your bank account and a separate remittance advice will be sent.

Bank name*	
Sort code*	
Account number*	
IBAN number	

8. REMITTANCE ADVICE

Remittances will be sent via Healthcode if you are invoicing us via that method. Otherwise they will be sent to the email address in section 1 unless specified differently below.

Alternative email	

9. WEB CONSENT

I hereby give consent for our details to be included on Cigna's website (Please tick) ☐

10. DECLARATION

Signature*	
Print name*	
Date*	
Position*	

***Mandatory Field**

Together, all the way.℠

Cigna®

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