APPLICATION FOR GMC REGISTERED PROVIDER

You should complete this form to apply to be a registered provider to Cigna HealthCare. Please note by applying to be a registered provider you agree to adhere to the Cigna Fee Schedule.

All sections marked with * are mandatory, your application will not be successful if these sections are not fully completed and signed by the applicant at the bottom of the form. The form must be completed fully using BLOCK CAPITALS. When you have completed the form you can return it to us either via email to provider.affairs@cigna.com , fax to 01475 788448 or post to Provider Affairs, Cigna HealthCare Benefits, 1 Knowe Road, Greenock, Scotland PA15 4RJ.

1. PROVIDER DETAILS				
Title (Mr, Mrs, Dr, etc.)*				
Full name*				
Gender*	Female		Male	
Correspondence address 1*				
Correspondence address 2				
Correspondence town/city*				
Correspondence postcode*				
Email address*				
Telephone number*				
Website address				
GMC number*				
Any other details				

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

3. SPECIALTY				
Is the consultant a:*	Specialist		Anaesthetist	
Consultant specialty*				
Sub specialty				
Clinical areas of interest				

4. BILLING				
Please advise of any electronic billing practice				
Healthcode	Yes:		No:	
Other (if NO above)				

5. PRACTICING PRIVILEGES AT HOSPITALS AND/OR CLINICS

Please advise us of any facilities (private or NHS) the consultant has practicing privileges at*

Facility name*	Facility address*

6. 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	

7. 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	

8. WEBSITE CONSENT

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

10. DECLARATION

By signing this form you are agreeing to adhere to the Cigna Fee Schedule when treating a Cigna member. If you do not sign this declaration this application will not be considered and your application for accreditation at Cigna will be unsuccessful, resulting in Cigna members being directed to an alternative consultant. Below is a link to the Cigna fee schedule web pages:
https://www.cigna.co.uk/healthcare-providers/fee-schedule/search.aspx

Signature*	
Date*	

***Mandatory Field**

Together, all the way.℠