

CIGNA HealthCare

PHYSICIAN NOMINATION FORM

CIGNA HEALTHCARE OPEN ACCESS PLUS PLAN

For employees of The Town & BOE of Manchester

Employee Name: _____

Company/Location: _____

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

Physician's Name

Phone Number

Address (street, city, state, zip)

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 completed forms to:

Michelle Bridges-Smith
CIGNA
Fax: 860-226-2333