



## BEHAVIORAL PROVIDER TERMINATION REQUEST FORM

This form may be used to initiate termination from the Cigna Behavioral Health provider network. Once completed, please save it to your computer and then email it to [BehavioralTerminations@Cigna.com](mailto:BehavioralTerminations@Cigna.com).

**Please note:** All terminations will be effective 65 days from the date of request to comply with the practitioner's contract (unless a date in excess of 65 days is requested). The following states require a 95-day termination notice: Maine, Maryland, Texas, and Virginia (unless a date in excess of 95 days is requested).

If you represent a clinic and/or affiliated clinics, or a facility, and would like to initiate termination, email [Behprep@Cigna.com](mailto:Behprep@Cigna.com).

*Please allow 15 business days for your request to be reviewed. You will receive confirmation once the termination has been processed. Confirmation letters are sent via certified mail.*

### BEHAVIORAL PROVIDER DEMOGRAPHIC INFORMATION

**Cigna Behavioral Provider ID Number:** \_\_\_\_\_

**Provider Name:** \_\_\_\_\_  
First Name Last Name

**National Provider Identifier (NPI):** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

### TERMINATION REQUEST SPECIFICS

- Request reason:**
- ☐ Retired
  - ☐ Retiring (Date of retirement: \_\_\_\_ / \_\_\_\_ / \_\_\_\_)
  - ☐ Left or changing practice
  - ☐ Fee schedule
  - ☐ Dissatisfaction/other (please explain briefly):

**Name and title of submitter:** \_\_\_\_\_

**Name of clinic/group practice (if applicable):** \_\_\_\_\_

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