CLEAR FORM

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.

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.

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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