

CIGNA for Health Care Professionals Website Direct Contracted Providers Only

After completing this eCourse, you will:

- ✓ Know how to view changes to CIGNA's standard fee schedules
- ✓ Understand how to request fee schedule information for one or more procedures
- ✓ Be familiar with how to request a copy of your participating provider agreement

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- ▶...General assistance, call 1.800.88CIGNA (1.800.882.4462)
- ▶...Technical assistance with this site, call 1.800.261.6232
- ▶...Assistance with site navigation and registration *only*, call 1.800.853.2713

If you work for a health care professional that is part of a medical group, you should register using the option **A medical group, hospital or ancillary facility**. This will ensure you have access to the claims and precertification data that you need.

Inquiry Tools

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Direct Contracted Providers Only

- [View Fee Schedule Change\(s\)](#)
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The **Direct Contracted Providers Only** section provides users the ability to:

- View fee schedule changes
- Update demographic information
- Request a copy of participating provider agreement

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Click the **View Fee Schedule Change(s)** link to view fee schedule changes.



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[eServices](#) > **Fee Schedule Changes**

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Fee Schedule Changes


* Indicates required field

- * Provider ID
- * Location
- * ZIP Code

[Help](#)

Continue

Select the **Provider ID**, **Location**, and **Zip Code** of your provider, and then click **Continue**.



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eServices > **Fee Schedule Changes**

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Fee Schedule Changes

* Indicates required field

Provider ID: MAIN STREET MEDICINE INC(9468171)

Location: CT

ZIP Code: 06516

* Network:

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Next, select the network for which you want to check fee schedule changes, and click **Submit**. The fee schedule changes will then be displayed.

Note: If there are no changes to the standard fee schedule, you will receive a message.

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Click the **Update Demographic Information** link to make changes to your demographic information, which is what appears in the Provider Directory.

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Provider Directory Changes

Please review your listing in the Provider Directory to confirm that the information is accurate and up-to-date. If you need to correct or update your demographic information, follow the instructions below.

- **CIGNA-contracted Providers:** [Use this form to update](#) your demographic information
- **CIGNA-contracted facilities and other Health Care Providers:** [Use this form to update](#) your demographic information
- **Non-participating Providers:** If you are interested in joining the CIGNA HealthCare Network, please refer to [Credentialing and Recredentialing](#).

To update demographic information with CIGNA, select the appropriate form based on the provider's status with CIGNA.

Note: Please review your listing in the Provider Directory before submitting your changes.



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[eServices](#) > [Update Demographics](#) > **Practitioner Directory Change Form**

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CUSTOMER SERVICE
If you need...

Practitioner Directory Change Form

Please review your listing in the [Provider Directory](#) before entering changes below.

Requestor Information

Name: Lucky Precert

Phone Number: (860)226-7376 ext.

Email Address: amanda.kingston@cigna.com

Are the phone number and email shown correct? If not, please update them on your [My Profile](#) page.

* Indicates required fields [Help](#)

Provider Information

Please enter information in the required fields below. Your entries are used to match the information to our Provider Directory

Provider/Group Name (if applicable) * Tax ID Number

* Last Name * First Name Middle Initial Suffix


Medical Degree * Location

Select Select

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For contracted practitioners, enter the appropriate updates and click **Submit**.

Your updates will be processed within 14 business days.



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Provider Information

Please enter information in the required fields below. Your entries are used to match the information to our Provider Directory

Provider/Group Name (if applicable)

* Tax ID Number

* Last Name

* First Name

Middle Initial

Suffix

Medical Degree


* Location

Submit

Clear Form

For contracted facilities or other health care providers, enter the appropriate updates and click **Submit**.

Your updates will be processed within 14 business days.



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Quality Initiatives

CIGNA HealthCare is committed to achieving and maintaining quality in our business with respect to:

- [Accreditation Recognition](#)
 - [National Committee for Quality Assurance \(NCQA\)](#)
 - [URAC \(formerly the Utilization Review Accreditation Committee\)](#)
 - [Joint Commission on Accreditation of Health Care Organizations \(JCAHO\)](#)
- [Clinical Programs](#)
 - [Preventive Care](#)
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 - [CIGNA Care Network](#)
- [Provider Credentialing and Recredentialing](#)
- [Medical Record Reviews](#)
 - [Other important information](#)

We compare our clinical outcomes (HEDIS) to the industry standards established by NCQA to evaluate areas of opportunity for quality improvement. To see how we're rated, visit www.ncqa.org.

If the provider does not participate with CIGNA, refer to the information regarding credentialing and recredentialing.

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To request a copy of a participating provider agreement, click ***Request a Copy of Participating Provider Agreement***.

Request a copy of Participating Provider Agreement

Please allow 30 days to process your request. The information you provide below will be validated and, if accurate, you will receive a hard copy of your agreement via mail.

Requestor Information

Name: Lucky Precert

Phone Number: (860)226-7376 ext.

Email Address: amanda.kingston@cigna.com

Are the phone number and email shown correct? If not, please update them on your [My Profile](#) page.

* Indicates required fields

[Help](#)**Requestor Mailing Address:**

* Mailing Address:

* City:

* State:

* Zip Code:

*** Select the type of contract you are requesting:**

☐ Practitioner Agreement ☐ Group Agreement ☐ Facility ☐ Other

If you are requesting a Group or Facility Agreement, provide the name of the authorized designee.

Authorized Designee Name:

Last:

First:

MI:

Provide information regarding the provider for whom you are requesting a contract copy.

* Provider Name (if applicable):

Last:

First:

MI:

* Group/Facility Name (if applicable):

* Location:

* Provider Tax ID Number:

To request a copy of your participating provider agreement, enter the appropriate information and click **Submit**.

Please allow 30 days to process your request. The information you provide will be validated and, if accurate, you will receive a hard copy of your agreement in the mail.

Submit

Congratulations!

You've completed the
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