Behavioral Health Provider Nomination Form

We are committed to providing you with customer satisfaction and continually growing our behavioral health provider network. Please use the form below to tell us about a behavioral health provider who might be interested in joining our network. Simply complete the lower half of this page and fax it back to us at 860.731.3443. If you prefer, you may give the form to your provider to complete and return.

To make sure the provider isn't already part of our network, check the directory on our website www.CignaBehavioral.com. Simply click on "Find a Therapist/ Psychiatrist" under the "Member" tab and then "Search by Name."

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CIGNA
Provider Services
1.800.926.2273
Fax: 860.731.3443

BEHAVIORAL PROVIDER'S FULL NAME: _____

PROVIDER TYPE (please check one):

- ☐ **Psychiatrist**
- ☐ **Psychologist**
- ☐ **Social Worker**
- ☐ **Counselor**
- ☐ **Other** _____

PROVIDER ADDRESS: _____

CITY, STATE & ZIP CODE: _____

TELEPHONE: (____) _____ **FAX NUMBER: (___)** _____

PROVIDER EMAIL: _____

YOUR NAME (optional): _____

Please note that submission of this form does not guarantee the behavioral provider will be added to our network.