Application for GMC registered provider

You should complete this form to apply to be a registered provider to Cigna Healthcare. Please note by applying to be a registered provider you agree to adhere to the Cigna Healthcare Fee Schedule.

All sections marked with * are mandatory, your application will not be successful if these sections are not fully completed and signed by the applicant at the bottom of the form. The form must be completed fully using BLOCK CAPITALS. When you have completed the form, please return it via email to commercialteamuk@cigna.co.uk.

1. Provider details	
Title (Mr, Mrs, Dr, etc.)*	
Full name*	
Gender	Female ◯ Male ◯
Correspondence address 1*	
Correspondence address 2	
Correspondence town/city*	
Correspondence postcode*	
Email address*	
Telephone number*	
Website address	
GMC number*	
Any other details	
2. Secretary details	
Title (Mr, Mrs, Dr, etc.)	
Full name	
Telephone number	
Email address	
3. Specialty	
Is the consultant a*	Specialist ◯ Anaesthetist ◯
Consultant specialty*	
Sub specialty	
Clinical areas of interest	
4. Billing Please note by signing this form you agree to bill Cigna Healthcare directly. Please advise of any electronic billing practice	
Healthcode	Yes ◯ No ◯
Other (if NO above)	

5. Practicing privileges at hospitals and/or clinics Please advise us of any facilities (private or NHS) the consultant has practicing privileges at*	
Facility name	**Facility address**

6. Banking details Please note: Payments will ONLY be paid by Direct Credit (BACS) to your bank account and a separate remittance advice will be sent.	
Bank name*	
Bank account name	
Bank address	
Sort code*	
Account number*	
IBAN number	

7. Remittance advice Remittances will be sent via Healthcode if you are invoicing us via that method. Otherwise they will be sent to the email address in section I unless specified differently below.	
Alternative email	

8. Web consent	
I hereby give consent for our details to be included on Cigna Healthcare's website (Please tick)	☐

9. Declaration By signing this form you are agreeing to bill directly to Cigna Healthcare and agreeing to adhere to the Cigna Healthcare Fee Schedule when treating a Cigna Healthcare member. If you do not sign this declaration this application will not be considered and Cigna Healthcare members will be directed to an alternative provider. Below is a link to the Cigna Healthcare fee schedule web pages: **https://www.cigna.co.uk/healthcare-providers/fee-schedule/search.aspx**	
Signature*	
Date*	

***Mandatory Field**

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If you have a Cigna plan, please refer to your member materials for further information, including details of the insurance entity providing cover, broker information (if any) guide to claiming, the list of benefits, exclusions and limitations.

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