



CIGNA Healthcare Physician Nomination Form

CIGNA Healthcare
Open Access Plus Network

**For Employees of:
City of Bristol and
Bristol Board of Education**

Employee Name: _____

Company/Department: _____

I would like the following doctor to be considered for participation in the Open Access Plus Network:

Physician's Name

Phone Number

Address

Specialty

I understand that this doctor's participation is subject to his or her desire to participate in the network and is subject to the CIGNA Healthcare credentialing criteria.

Employee Signature

Date

Please return completed forms to:

Angela Diaz
CIGNA
Fax: 877.828.3849