CIGNA DESIGNATED FACILITY FOR BARIATRIC SURGERY

CIGNA HealthCare

Please Type or Print Legibly

Section One – General Information

Ambulatory Surgical Center
Hospital (Type)______________________________

Other (Type) ______________________________

____
Facility Name

CIGNA Participating Provider Yes No

____
CIGNA Provider ID Number

____
State License Number

____
Exp. Date

Facility Address	Billing Address
Street, Suite	Street, Suite
City, State, ZIP	City, State, ZIP
Main Telephone Number	Billing Telephone Number
Fax Number	Fax Number

____
Chief Administrator (Name & Title)

____
Telephone Number

____
Contact Person (Name & Title)

____
Telephone Number

Section 2 – Bariatric Surgery Outcome Measures

Outcomes for the preceding 12 months for procedures performed in this facility only:

Measure	Gastric Bypass Procedures Open and Laparoscopic	Gastric Banding Procedures Open and Laparoscopic
Total cases		
* Overall mortality rate		
Inpatient mortality rate during initial Bariatric surgery hospital stay		
60 day mortality rate post initial Bariatric surgery		
90 day mortality rate post initial Bariatric surgery		
Overall re-operation rate for Bariatric surgery complications		
* Re-operation rate within 30 days of initial Bariatric surgery		
Transfer to another facility rate during initial Bariatric surgical hospital stay		
* Overall readmission rate within 30 days post initial Bariatric surgery for anastomotic leak, subphrenic abscess, splenic injury, pulmonary embolism or wound infection		

* Used in designation decision making

Section 3 – Bariatric Surgeons

Name and Degree: ________________________________ ______________ ___________ ___________
CIGNA Participating Provider Yes No Tax ID Number: SS Number: UPIN Number:

Name and Degree:________________________________ ______________ ___________ ___________
CIGNA Participating Provider Yes No Tax ID Number: SS Number: UPIN Number:

Name and Degree: ________________________________ ______________ ___________ ___________
CIGNA Participating Provider Yes No Tax ID Number: SS Number: UPIN Number:

Name and Degree: ________________________________ ______________ ___________ ___________
CIGNA Participating Provider Yes No Tax ID Number: SS Number: UPIN Number:

Name and Degree: ________________________________ ______________ ___________ ___________
CIGNA Participating Provider Yes No Tax ID Number: SS Number: UPIN Number:

Name and Degree: _______________________________ ______________ ___________ ___________
CIGNA Participating Provider Yes No Tax ID Number: SS Number: UPIN Number:

Section 4 - Attestation

All information provided on this application or in connection with this application is complete and accurate to the best of the facility's knowledge. The facility understands that this application does not entitle the facility to participation in CIGNA's networks. It is further understood that if the facility is accepted as a CIGNA Certified Facility for Bariatric Surgery, it shall provide an update to this information when requested by CIGNA. The facility further agrees to notify CIGNA within 30 days of any changes to the information provided on the application.

____ ______________________
Signature of Chief Administrator or Authorized Designee Date

____
Print Name of Chief Administrator or Authorized Designee

____
Facility Name

____
Address

____
City, State, ZIP Code

CIGNA Contact Person

Tracy LaBranche
Senior Credentialing Coordinator
CIGNA Corporation
2 College Park Drive
Hooksett, NH 03106
Phone: 603-268-7688
Fax: 347-821-5999
Email: BariatricSurgeryCertificationProgram@Cigna.com