BayCare Exclusive Network Physician Information Form

Physician's Name: ______________________________

Group Name: ______________________________

Specialty: ______________________________

Address: ______________________________

Phone Number: ______________________________

Fax Number: ______________________________

Tax ID Number: ______________________________

NPI Number: ______________________________

Start Date (with BayCare): ______________________________

Contracted with Cigna: Y or N Effective Date: ______________________________

Hospital Privileges: ______________________________

Termination Date/ Reason for Term: ______________________________

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Please complete form and return to Benefit Services via email: Benefit.Services@baycare.org