NETWORK PROVIDER NOMINATION*

CITY OF Irving Members

Physician name: ______________________________

Physician Specialty ______________________________

Address: ______________________________

____

Phone (including area code): ______________________________

Office Manager Name:

Nominated by: ______________________________

Employer: ______________________________

Date: ______________________________

Mail completed form to:

CIGNA HealthCare of Texas
Attn: City of Irving, Acct 3328453
Sulema Mendoza
1640 Dallas Parkway
Plano, TX 75093

PLEASE USE A SEPARATE FORM FOR EACH PHYSICIAN TO BE NOMINATED.