Cigna Connect Hospital Admission Agreement Form

I, _____ (the referring physician/practitioner), practice in the specialty of _____. I confirm that if any of my patients with Cigna Connect should require admission to the hospital, they will be admitted to Methodist Health System, John Peter Smith Health Network, Hunt Regional Medical Center, or any other Connect Network–participating facility. In accordance with my provider agreement, I understand that the hospital must be contracted and participating in the Connect Network. **Note:** Participating facilities are subject to change; refer to the directory at Cigna.com > Find a Doctor > Healthcare.gov or Direct Purchase for the most current list of participating providers.

By signing below, I am attesting that the above information is true and correct.

_____

Printed name (referring physician/practitioner)

_____

Signature (referring physician/practitioner)

_____

Date