# Provider Nomination Form

Join Our Aetna Better Health of Florida Network

To nominate a provider for inclusion in the Aetna Better Health of Florida (ABHFL) network, please complete the information on this form. Provide as much information possible about the provider/practice to assist us identify and contact the nominated provider/practice. **Please return the Provider Nomination Form via email or fax to: FLMedicaidContracting@aetna.com or 1-860-262-9414.**

| **Requestor Information** | |
|---|---|
| Last Name: | First Name: |
| Phone Number: | Fax Number: |
| Email Address: | |

| **Group Information** | | |
|---|---|---|
| Is the physician a member of a participating group practice? ☐ Yes ☐ No | | |
| Group Name: | | |
| Tax ID: | National Provider Identifier (NPI): | |
| Medicaid ID: | License Number: | |
| Office Address: | | |
| City: | State: | Zip: |
| Email Address: | | |

| **Physician Information** | | |
|---|---|---|
| Physician's First Name: | | Last Name: |
| Degree (MD, DO): | CAQH: | National Provider Identifier (NPI): |
| Medicaid ID: | | License Number: |
| Specialty: | | Board Certified: ☐ Yes ☐ No |

| **Hospital Affiliation(s):** | |
|---|---|
| Hospital Name | Location |
| 1. | 1. |
| 2. | 2. |
| 3. | 3. |

| **Additional Practice Locations (s):** | | |
|---|---|---|
| Address: | Ste: | |
| City: | State: | Zip Code: |
| Phone #: | Fax #: | |
| Email Address: | | |
| **Additional Practice Locations (s):** | | |
| Address: | | |
| City: | State: | Zip Code: |
| Phone #: | Fax #: | |
| Email Address: | | |

**PLEASE NOTE:** This is not a guarantee of Contract. The information you provide is used by Aetna Better Health of Florida to evaluate the offering of a Contract and is not representative of an application or a Legal Agreement. Requests are processed in the order they are received and take 7-14 business days to process. The determination notification will be sent to the email provided on the Provider Nomination Form.


**FL-20-09-02**