



HOSPITAL BASED PROVIDER - REQUEST FOR PARTICIPATION

This form is to be completed in its entirety and submitted to KYProviderUpdates@Aetna.com.

INSTRUCTIONS FOR COMPLETION:

This form must be completed in its entirety and the following supporting documents must be provided. An incomplete form and/or missing supporting documentation may result in resubmission of the provider's application and/or delay in provider's effective date for participation.

Required Supporting Documentation:

- Copy of current State License (applies to all provider types);
- Copy of DEA Certificates (for applicable provider types);
- Copy of Certificate of current Malpractice Insurance Coverage including group name, coverage amounts, expiration date, and name of covered provider(s) (applies to all provider types);
- For APRNs: please provide your Collaborative Agreement for Prescriptive Authority.
- Completed W-9 Form;

Will the provider be seeking enrollment with Aetna Better Health of Kentucky?

Yes

No

I. PERSONAL INFORMATION			
Full Legal Name:		Maiden Name:	
Social Security Number:	Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
II. IDENTIFICATION NUMBERS			
Individual NPI:			
KY Medicaid ID:			
DEA Number(s):		DEA Exp. Date:	
Primary Taxonomy:		Secondary Taxonomy:	
III. LICENSURE			
State:	License #:	Issue Date:	Exp. Date:
State:	License #:	Issue Date:	Exp. Date:
IV. LIABILITY INSURANCE			
Carrier:		Limits:	
Policy #:		Exp. Date:	
V. BOARD CERTIFICATION			
Indicate your specialty/sub-specialty field(s) of practice and respective board certification:			
Specialty	Board Certified Y/N	Sub-Specialty	Board Certified Y/N
	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>
	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>
	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>
VI. SCOPE OF PRACTICE			
<input type="checkbox"/> Anesthesiology	<input type="checkbox"/> Hospitalist	<input type="checkbox"/> Pathology	<input type="checkbox"/> Other (please specify)
<input type="checkbox"/> Emergency Medicine	<input type="checkbox"/> Neonatology	<input type="checkbox"/> Radiology	
		<input type="checkbox"/> Telemedicine	_____
Supervising Physician (for PAs or APRNs):			
Supervising Physician Specialty:			
Does provider practice as a locum tenens provider? Yes <input type="checkbox"/> No <input type="checkbox"/>		Provider Start Date:	
Languages spoken by provider other than English (including American Sign Language):			

VII. PRACTICE INFORMATION (See next page for additional locations)

Primary Location		Billing/Pay To
Practice Name:		
Address:		
City/State/Zip:		
Tax ID:		
Group NPI:		
Phone:		
Fax:		
Telemedicine: (Y/N)		

VIII. HOSPITAL PRIVILEGES

List all facilities where you currently provide hospital-based services.

	Hospital Name	City/State	Type of Privileges	Department
Primary:				
Secondary:				
Other:				

IX. EDUCATION and TRAINING – Complete the following or attach CV

	Degree/Specialty	Start Date (MM/YY)	End Date (MM/YY)	Mailing Address
Medical School:				
Internship:				
Residency #1:				
Residency #2 or Fellowship #1:				

X. CONTACT INFORMATION

Contact Name:		Contact Title:	
Contact Email:		Contact Phone:	
Practice Website:			
Practice Email:		Date Submitted:	

XI. SUPPLEMENTAL PRACTICE INFORMATION**

Alternate Location #1		Alternate Location #2
Practice Name:		
Address:		
City/State/Zip:		
Tax ID:		
Group NPI:		
Phone:		
Fax:		
Telemedicine: (Y/N)		
Billing Address:		
City/State/Zip:		
Billing Phone		
Billing Fax		
Alternate Location #3		Alternate Location #4
Practice Name:		
Address:		
City/State/Zip:		
Tax ID:		
Group NPI:		
Phone:		
Fax:		
Telemedicine: (Y/N)		
Billing Address:		
City/State/Zip:		
Billing Phone		
Billing Fax		

****If the number of locations exceeds the amount provided above, please attach a roster of locations, complete with the information requested in the above table.**