



REQUEST FOR PROVIDER UPDATE

Provider Name	NPI		Tax ID of Group Requesting Change					
Will provider be seeking enrollment with Aetna Better Health of Kentucky?			<input type="checkbox"/> Yes <input type="checkbox"/> No					
If Yes, Center Care provides credentialing services for Aetna Better Health of Kentucky and will notify Aetna upon completion of provider's credentialing, if applicable.								
I. REASON FOR SUBMISSION (select all that apply)								
Add		Group Changes		Term				
<input type="checkbox"/> Add Billing Address		<input type="checkbox"/> Change Billing Address		<input type="checkbox"/> Term Group				
<input type="checkbox"/> Add Billing Fax #		<input type="checkbox"/> Change Billing Fax #		<input type="checkbox"/> Term Location				
<input type="checkbox"/> Add Billing Phone #		<input type="checkbox"/> Change Billing Phone #		<input type="checkbox"/> Term Provider				
<input type="checkbox"/> Add Physical Location Address		<input type="checkbox"/> Change Group Name		Provider Demographic Changes (or corrections)				
<input type="checkbox"/> Add Physical Location Fax #		<input type="checkbox"/> Change Location Address		<input type="checkbox"/> Change Name: <input type="checkbox"/> Last <input type="checkbox"/> First <input type="checkbox"/> Middle				
<input type="checkbox"/> Add Physical Location Phone #		<input type="checkbox"/> Change Location Fax #		<input type="checkbox"/> Change Individual NPI				
<input type="checkbox"/> Add Correspondence Address		<input type="checkbox"/> Change Location Phone #		Individual or Group-Level Change				
<input type="checkbox"/> Update Hospital Affiliation		<input type="checkbox"/> Change TIN		<input type="checkbox"/> Change applies to this provider only				
<input type="checkbox"/> Update Covering Arrangements		<input type="checkbox"/> Change Group NPI		<input type="checkbox"/> Change (or info) applies to entire group				
<input type="checkbox"/> If group or address is to be termed, please indicate term info on page 2, Section F.				Eff Date of Change				
<input type="checkbox"/> If new address is a billing address, fill out Group Name, TIN, and Pay To/Billing Address section at the bottom.								
<input type="checkbox"/> If new address is a correspondence address, fill out address section at the top.								
II. NEW ADDRESS INFORMATION								
A. Address Info		If provider does not accept patient appointments at location, please indicate as "Covering Only" or Hospital-based ("HB"), as applicable. Hospital-based (HB) locations, Covering Only locations, and locations where provider does not see patients at least 16 hours per week will be suppressed from directory. If covering arrangements have changed, see page 2, section I.						
<input type="checkbox"/> Primary Office <input type="checkbox"/> Alternate Office <input type="checkbox"/> Covering Only <input type="checkbox"/> HB Address <input type="checkbox"/> Billing Address <input type="checkbox"/> Correspondence Address								
Group Name		TIN						
Address Line 1		Address Line 2		Phone Fax				
City		State	Zip	Group NPI				
CLIA Number <input type="checkbox"/> N/A	CLIA Exp	If location is not primary care, list scope of practice		Primary Hospital Affiliation or Covering Arrangements				
Location-Specific Info (N/A if above is Billing/Correspondence)		Y	N	Location-Specific Info (N/A if above is Billing/Correspondence) Y N				
Does practice offer lab services at this site? (CLIA Required)				Is address handicap accessible?				
Is provider at this site at least 16 hours per week?				Is address TDD hearing (text telephony) equipped?				
Can patients call this site to make appointment with provider?				Is address accessible by bus route?				
Is provider accepting new patients at this site?				Does practice provide American Sign Language services at this site?				
Is provider a PCP at this site?				Does provider provide telemedicine services at this site?				
Does provider provide EPSDT services at this site?				Does provider bill for DME services? (Provide sample claim)				
If PCP, is provider's panel open at this site for Medicaid?				Does this site participate in KHIE?				
If PCP, is provider's panel open at this site for Medicare?				Is provider a locum tenens provider?				
What is the maximum panel capacity for Medicaid at this site?				Has provider completed cultural competence training?				
What is the maximum panel capacity for Medicare at this site?				Is provider certified in trauma-informed care (TIC)?				
What are the age limitations for patients seen?				Has provider been trained in evidence-based practice?				
Is there a gender restriction at this site? (If yes, please specify)								
Office Hours	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	
Practice Website (for directory)				Practice Email (for directory)				
Supervising Physician (NP/PA only)				Supervising Physician Specialty				
B. Pay To/Billing Address				City, State, Zip		Billing Phone		Billing Fax

III. CHANGE INFORMATION

If more space is needed for the change being indicated, please use Notes section to provide all necessary details.

A. CHANGE TIN (Attach W9; see also Section E)		B. CHANGE NPI		<input type="checkbox"/> Individual <input type="checkbox"/> Group	
Previous TIN	New TIN	Previous NPI	New NPI		
C. CHANGE PROVIDER NAME		Name Changing: <input type="checkbox"/> First Name <input type="checkbox"/> Middle Name <input type="checkbox"/> Last Name			
Previous Name		New Name			
D. CHANGE Number		Phone Number Change is for this Address: <input type="checkbox"/> Location <input type="checkbox"/> Billing			
Previous Phone Number	New Phone Number	Previous Fax Number	New Fax Number		
E. CHANGE GROUP NAME		<input type="checkbox"/> Legal name change only; no DBA change <input type="checkbox"/> Applies to all locations under TIN <input type="checkbox"/> Applies only to (please specify):			
Previous Group (or Legal) Name		New Group (or Legal) Name			
F. TERM INFORMATION		<input type="checkbox"/> Term Provider <input type="checkbox"/> Term Address(es) (specify below) <input type="checkbox"/> Term TIN: (includes all locations)			
Address to Term		Address to Term			
Address to Term		Address to Term			
G. CHANGE BILLING ADDRESS		New Pay To Name:			
New Billing Address	City, State, Zip	Billing Phone	Billing Fax		
H. CHANGE in Specialty, Category, or Panel		Change in Panel: <input type="checkbox"/> Close Panel <input type="checkbox"/> Open Panel <input type="checkbox"/> Member Capacity	Panel change is for address:		Capacity:
<input type="checkbox"/> Update Primary Specialty		<input type="checkbox"/> Update Secondary Specialty			
<input type="checkbox"/> Change to PCP <input type="checkbox"/> Change to SCP		at Address:			
I. Update Hospital Affiliation or Covering Arrangements		<input type="checkbox"/> Update Covering Physician or Hospitalist Group:			
<input type="checkbox"/> Update Primary Hospital Affiliation		Start Date	<input type="checkbox"/> Update Secondary Hospital Affiliation		Start Date

IV. UPDATE NOTES and CONTACT INFO

Notes	Include any other information that will help us process your change request correctly. For example, changes not indicated above (e.g., taxonomy change or use to indicate multiple addresses affected by a change).	
Contact Name	Phone	Email