



Aetna Better Health of Louisiana
Medicaid/CHIP

PROSPECTIVE PROVIDER FORM

Tax ID# _____ Group NPI# _____

Organization / Provider Name: _____

PCP Specialist Facility Behavioral Health

Practicing Specialty (Type of License): _____

Participating with Aetna in Commercial Network (HMO, PPO, POS)? Yes No

Primary Service Location (Cannot be a PO Box):

Address _____ City _____ State _____ Zip _____

Parish: _____

Please list additional information, which may be of interest:

Contact Name: _____

E-Mail Address: _____

Contact Phone #: _____

Date: _____

Submit via email: LAProvider@aetna.com