Aetna Better Health Inc
Provider Services
333 West Wacker Drive, MS F646
Chicago, IL 60606
Fax Number (860) 754-0435
Phone (866) 212-2851

ORGANIZATION/FACILITY APPLICATION

Dear Provider:

We are committed to the quality of health care services delivered to our members, so we have a well-defined and structured facility credentialing process in place. Below, you'll find the information we need to complete our credentialing process, as required by Aetna Better Health agreement.

Please complete and submit the information requested in its entirety (including this letter) via fax to 860-754-0435 or mail to the address above within **ten (10) business days.**

Facility Provider Type:		
Facility/Organization Name:		
Service Location Address:		
Primary Phone#:		
Contact Name:	Contact Fax#:	
Contact Email:	Contact Phone:	
NPI#:		
Medicaid ID #: Effective Date:	CAQH#:	
Tax ID Number (TIN):		
Medicare Certification Number:	Effective Date:	
☐ Medicare part A OR	☐ Medicare Part B OR	☐ Medicare Part C (Ambulatory Surgery only)
340B Y N	On a bus route: Y N	

Include a copy of:

- The facility's current W-9
- A current Facility State License, Business Registration, or Certificate of Occupancy (if applicable)
- Accreditation certificates or letter (if applicable). Refer to page 2.
- The most recent CMS or State Survey/Inspection Report including Corrective Action Plan and compliance letters, (if the facility is not accredited)
- Clinical Lab Improvement Amendment (CLIA) – (for laboratories only)

Sign and Date the Attestation (bottom of questionnaire)

EDI and Internet:	Electronic Claims Submission Y N	Does Business have internet access Y N
	If no to either, please explain:	

Business Enterprise Program	Is this a: ☐ Minority ☐ Female ☐ Disabled person owned business? Y N
	Are you certified as a Business Enterprise Program provider? Y N

Do you have an Advance Directive policy? ☐ Yes ☐ No

Hospital, Nursing homes, Home health care agency and Skilled nursing facility: If you responded No, please include a copy of the specific section of your policy/process, which addresses that you do not maintain Advance directive policies. You do not have to include the complete policy.

PROFESSIONAL LIABILITY INSURANCE COVERAGE	
Do you have Professional Liability (Malpractice) Insurance coverage in force? ☐ Yes ☐ No If yes, provide a copy of current Professional Liability Insurance Certificate, including Carrier's Name, effective and expiration dates, policy number, and liability dollar limits or provide details below:	
Name of Insurance Carrier/Insurer:	
Policy effective date:	Policy expiration date:
Policy Number:	
Amount of coverage per occurrence: $	Amount of coverage per aggregate: $
If you have additional information or additional insurance coverage, please provide below:	
☐ Additional Professional Liability (including Patient Comp Funds) ☐ Self Insured Retention ☐ Excess Coverage ☐ Umbrella Name of Insurance Carrier/Insurer: Policy Number: ______________________ Policy expiration date: Amount of Coverage per occurrence: $ __________ Amount of coverage per aggregate: $ __________	

Please check the applicable box(es) below that describe your facility type and circle applicable accreditation or certification. If applicable, please provide copy of certificate.

Facility type	Accreditation/Certification
☐ Hospital	TJC or HFAP or DNV
☐ Children's Hospital	TJC or HFAP or DNV
☐ Long Term Acute Care Hospital	TJC or HFAP or DNV
☐ Nursing Home	TJC or CARF or CCAC
☐ Skilled Nursing Facility	TJC or CARF
☐ Home Care Agency	TJC or CHAP or ACHC
☐ Free Standing Surgical Center	TJC or AAAHC or AAAASF
☐ Voluntary Interruption of Pregnancy Center	
☐ Mental Health Hospital	TJC or CARF or HFAP or COA or DNV
☐ Chemical Dependency/Substance Abuse Hospital	TJC or CARF or HFAP or COA or DNV
☐ Community Mental Health Center	TJC or CARF or HFAP or COA
☐ Residential Treatment Facility	TJC or CARF or HFAP or COA
☐ Partial Hospitalization Program	TJC or CARF or HFAP or COA or DNV
☐ Intensive Outpatient Programs and Clinics	TJC or CARF or HFAP or COA
☐ Crisis Stabilization Program	TJC or CARF
☐ Laboratory	CLIA
Facility is a Draw Site only? ☐ Yes or ☐ No	
☐ Comprehensive Outpatient Rehabilitation Facility	TJC or CARF
☐ Outpatient Physical Therapy Facility	
☐ Outpatient Speech Pathology	
☐ Outpatient Diabetics Self-Management Training Providers	ADA or IHS
☐ End-Stage Renal Dialysis Center	
☐ Portable X-Ray Suppliers	FDA
☐ Rural Health Clinics	AAAASF
☐ Other: ______________________	

ORGANIZATION/FACILITY APPLICATION

<table>
<tr><td colspan="2">

Attestation

It is understood that the burden of providing adequate information to Aetna to demonstrate compliance with Aetna's credentialing process falls upon the individual signing below. It is understood and agreed upon that any misstatement or material omission in this questionnaire will constitute grounds for rejection or termination from the Aetna network. If any material changes occur in the information that has been provided making the above information no longer correct and complete, it is understood and agreed upon that it is my obligation to notify Aetna within (15) days of said occurrence. Failure to comply with this obligation may constitute grounds for rejection or termination from the Aetna network.

I certify that the information contained in this survey and all attachments is accurate, complete and true.

</td></tr>
<tr><td>Name:</td><td>Signature(s):</td></tr>
<tr><td>Title:</td><td>Date:</td></tr>
</table>