Practitioner Application Screening Form

PLEASE COMPLETE ONE FORM PER PRACTITIONER IN PRACTICE

Mail completed form to:

Aetna Better Health, 333 West Wacker Dr, Mail Stop F646, Chicago, IL 60606

Or Fax to 1-860-754-0435

Aetna Better Health contracting and credentialing standards require that Aetna Better Health obtain personal information such as your name, address, and social security number. Personal information is maintained in contracting and credentialing databases at Aetna Better Health for in-house tracking, reporting purposes, contracting, credentialing and payment of claims. Providing the required personal information is voluntary; however, failure to provide it will delay the contracting and credentialing process.

IN ORDER TO BE CONTRACTED, **YOU MUST:** HAVE AN NPI NUMBER, BE REGISTERED WITH [*MEDICAID]* AGENCY, (if applicable), BE ELIGIBLE TO PARTICIPATE IN MEDICARE, SUBMIT CLAIMS ELECTRONICALLY, HAVE INTERNET ACCESS AND PARTICIPATE WITH ALL Aetna Better Health LINES OF BUSINESS.

Date: _____/________/________

Provider Info:	___________________	___________________	______ ________	___________________
	(Last Name)	(First Name)	(MI) (Degree)	(Title)
	Male Female	_____/____/_____	____/____/_____	__________________
	Gender	DOB	SSN	Practice Name
	Joining as: Individual Group		An Existing Group: Y N	A New Provider: Y N
	FQHC	RHC		Other: _________
	Are you: Locum Tenen	Hospital Based Physician	Hospitalist	
	DBA Name: ____________________	Employment Start Date: _____/_____/_____		Does your office utilize physician extenders? Y N
EDI and Internet:	**Electronic Claim Submissions:** Y N		**Does Business have internet Access:** Y N	
	If no to either, please explain:			
Practicing Specialties	Primary:___________________________		Secondary:_________________________	
	Board Certified Y N		Board Certified Y N	
	If not Board Certified, are actively pursuing Board Certification: Y N			
	Malpractice Coverage: Y N Limits: _________		FTCA Y N	
	Malpractice Carrier: _______________		Policy Number: _______________	
	Are you a primary care physician? Y N		If Yes, is provider accepting new members? Y N	
	Maximum number of new members accepted: _____________		Are you designated as a Medical Home? Y N	
	Do you have age limits for practice? Y N		If Yes, what are the limits? ____________________________	
Administrative Contact (Health Plan's Contact)	Contact Name: __________________________		Email: _________________________________	
	Phone Number: ( ) ___________________		Fax Number: ( ) _____________________	
NPI:	Pay To NPI: ____________________________		Individual NPI: __________________________	
Tax ID:	Pay To Tax ID #: __________________________________			
Other ID's:	**Medicaid # ____________________________**		**CAQH#____________________________**	
	Eff. Date: ___/___/___			
	Medicare #: ________________________		Medicare Opt Out? Yes No	
	Eff. Date:___/___/_____		Taxonomies: ____________________	
	DEA#:____________________________________			Exp date: ____/___/____
	340B Y N			
State License:	State License#: _____________________	Date First issued: ____/___/___		Exp date: ____/___/____
Hospital/Free Standing Surgery Facilities	_______________________________________		Active Courtesy Delivery Provisional	
	_______________________________________		Active Courtesy Delivery Provisional	
	_______________________________________		Active Courtesy Delivery Provisional	
	_______________________________________		Active Courtesy Delivery Provisional	
	Indicate other Affiliations or names on a separate attached sheet			
	Call Coverage Practice(s)/ Physician Name(s) (must be registered with Medicaid Entity, if applicable):			
Dental Providers Only need to complete this portion	**GENERAL ANESTHESIA AND SEDATION**			
	☐ I do not administer any type of sedation (including nitrous oxide) in my practice. (No permit required)			
	☐ I only administer nitrous oxide in my practice (No permit required)			
	☐ I administer general anesthesia and semi-conscious sedation in my practice [1301] Permit #_____			

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	☐ I administer conscious sedation in my practice [1302] Permit #______________			
	☐ I administer oral conscious sedation in my practice [1303] Permit #______________			
	IF A PERMIT IS REQUIRED INCLUDE A COPY OF THE CERTIFICATE WITH THIS INITIAL REQUEST FORM			
Please list other services or important information you want *[Health Plan]* to know that is unique or different from peers.				
Language and Culture	Language(s) spoken other than English			Primary: ______________________________
	Cultural Heritage: ______________________			Secondary: ____________________________
	☐ Asian ☐ African-American/Black ☐ Hispanic/Latino ☐ Caucasian/White ☐ Native American ☐ Pacific Islander Other_________________			
	Is this a: ☐ Minority ☐ Female ☐ Disable person owned business ☐ None of the previous			
	Are you certified as a Business Enterprise Program provider? Y N			
Primary Address: (Main location where provider offers services)	Street: ____			Suite: __________________
	City: ________________________	State: _________	Zip Code:_____________	County: _________________
	Phone: (____) ______________	Fax: (____)________________	Toll Free Phone: (____) _______________	
	Email Address: ________________________			Handicap Accessible: Y N
	Office Hours: (list)			
	On bus route: Y N		Evening hours: Y N	Weekend hours: Y N
	Accommodate special needs patients: Developmentally Disabled Y N			Physically Disabled Y N
	Services offered to the deaf / hearing impaired (circle): sign language TTD/TTY			Adjustable exam table: Y N
Additional Office (if applicable) Indicated other offices on separate sheet	Street: ____			Suite: __________________
	City: ________________________	State: _________	Zip Code:_____________	County: _________________
	Phone: (____) ______________	Fax: (____)________________	Toll Free Phone: (____) _______________	
	Email Address: ________________________			Handicap Accessible: Y N
	Office Hours: (list)			
	On bus route: Y N		Evening hours: Y N	Weekend hours: Y N
	Accommodate special needs patients: Developmentally Disabled Y N			Physically Disabled Y N
	Services offered to the deaf / hearing impaired (circle): sign language TTD/TTY			Adjustable exam table: Y N
Payment Info This information must be the same as the W-9 information provided	Pay To Information Address:	**Contract will be mailed to this address unless otherwise specified**		
	Name: ________________________________	Tax ID Number: _______________________		
	Street: ___________________________________			Suite: __________________
	City: ______________________	State: _________	Zip Code:_____________	County: __________
	Phone: (____) ______________	Fax: (____)________________	Toll Free Phone: (____) ________________	
	Billing contact Name_____________________________________		Billing Email: ______________________________________	
	(All correspondence, checks, remits, contracts & credentialing info will be sent to this address)			

The completion of this form does not guarantee network participation. Please allow approximately 20 business days to evaluate the application and allow Aetna Better Health to verify that a CAQH application has been completed; please allow approximately 60 business days to complete the credentialing process.

I am __________________________ of ____________________________ and authorized to submit this application on behalf of ____. I affirm that all of the information on this form is accurate and complete to the best of my knowledge, information, and belief. I Promise to keep confidential any information that Aetna Better Health shares with me during this process.

Authorized Signature: ____ **Date:** _____/_____/_______

Please Do Not Write Below This Line – Aetna Better Health Representative Only – [as required]

☐ Specialist ☐ Dentist ☐ PCP* ☐ FP/OB* ☐ Allied Provider ☐ Above Health Form ☐ Request Approved by ND&C ☐ EFT

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Please Remember: Site Visits/MRR are required for all PCP & OB Practitioners

Aetna Better Health Representative Signature: ___________________________ **Date: ____/______/_____**

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