Aetna Better Health® of Kentucky

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: ☐ Male ☐ 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 ☐ No ☐		Yes ☐ No ☐
	Yes ☐ No ☐		Yes ☐ No ☐
	Yes ☐ No ☐		Yes ☐ No ☐

VI. SCOPE OF PRACTICE

☐ Anesthesiology ☐ Hospitalist ☐ Pathology ☐ Other (please specify)

☐ Emergency Medicine ☐ Neonatology ☐ Radiology

☐ Telemedicine _____

Supervising Physician (for PAs or APRNs):	
Supervising Physician Specialty:	
Does provider practice as a locum tenens provider? Yes ☐ No ☐	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.