Provider Nomination Form (Join Our Network)

Completion and acceptance of this enrollment form by Aetna Better Health of Kentucky is not a guarantee of network participation. Aetna Better Health of Kentucky's policies and procedures will govern acceptance related to this enrollment form.

This enrollment form must be completed in its entirety to begin the contracting and credentialing process.

Reason for Submission

☐ **New Provider Group**	☐ **Add Additional or New Services**

Provider Information

Legal Entity Name (should match copy of W9)			
dba Name (if applicable)			
Federal Tax ID Number	**National Provider Identification (NPI)**		
Kentucky State Medicaid Number			

Provider Location Information

Primary Location

Street Address	**City**	**State**	**Zip**
Phone Number	**Fax Number**		
Contact Name	**Title**		
Email address			

Aetna Better Health® of Kentucky

Join Our Network
Provider Nomination Form

Provider Specialty

Individual Provider ☐	**Group of Providers** ☐	**Do you provide Behavioral Health Services** ☐
Provider Specialty:		

Authorized Individual Information

I attest that the information supplied on this enrollment form for participation with Aetna Better Health of Kentucky is accurate.

Signature	**Date**

Instructions for Form Submission

Please select one of the options below to submit your Nomination Form. Call 1-855-300-5528 if you have any questions.

Fax: (855) 454-5584 or Email KyProviderUpdates@Aetna.com

Proprietary