Aetna Better Health® of Kentucky
9900 Corporate Campus Drive, Suite 1000
Louisville, KY 40223

Provider Credentialing Information/Request Form

A. Please submit this checklist to Aetna Better Health of Kentucky and attach all documents listed below:

- ☐ All pages of your signed contract, if applicable
- ☐ Completed application
- ☐ Provider Roster on Aetna provided spreadsheet, if applicable
- ☐ Completed W9
- ☐ Completed Ownership Information Form

B. Please complete /update the following, but DO NOT submit with request form:

CAQH Online Application must be current and complete, including:

- ✓ Application Attestation- less than 30 days old at time of request submission
- ✓ Section 2- Education and Training (all training must be completed prior to submitting request)
- ✓ Section 3- Professional/Medical Specialty Information
- ✓ Section 4- Practice Location Information (**must include Tax ID**)
- ✓ Current Licensure*- including medical, DEA, CLIA (if applicable)- upload licensure in CAQH and update application attestation
  *providers with temporary or provisional licenses cannot be credentialed
- ✓ Current Malpractice Insurance- upload current certificate in CAQH and update application attestation

C. Please submit all provider credentialing information to Aetna Better Health of Kentucky Provider Relations/Credentialing by email, fax or mail:

Email: Please submit required documentation to your assigned Provider Relations Representative.

Fax: **1-855-454-5584**

Mail: Aetna Better Health of Kentucky
Attn: Provider Relations/Credentialing
9900 Corporate Campus Drive, Suite 1000
Louisville, KY 40223

Complete the information below and return to Aetna Better Health of Kentucky

Practitioner's Name (please print):

_____

Last First Title

Practitioner's NPI:

_____

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Section 1: Practitioner Demographics Information

Practice Name: _____
Practitioner Name (Last/First/MI: _____
Degree: _____ SSN: _____ DOB: _____ Practitioner NPI: _____
Location Address: _____
City/State/Zip: _____
Phone: _____Fax: _____ E-mail: _____
☐ Additional Locations – please list additional addresses on separate page

Section 2: Practitioner Credentialing Information

CAQH #: _____
Kentucky State License #: _____ Kentucky Medicaid #: _____
Individual NPI: _____ Group NPI: _____
Federal Employer Identification #: _____
Provider Type (MD/DO/NP/PA/Other-Specify): _____
Primary Specialty: _____ Taxonomy: _____
Secondary Specialty: _____ Taxonomy: _____
Other Specialty: _____ Taxonomy: _____
Do you provide Obstetrical Care? Yes: _____ No: _____
Do you provide Pediatric Care? Yes: _____ No: _____
Provider is one of the following: PCC: _____ FQHC: _____ RHC: _____ Hospitalist: _____
Provider is: Primary Care only: Yes: _____ No: _____
If PCP, open or closed panel: _____ Age Range: _____
Specialty Care only: _____ Facility: _____
Both Primary and Specialty Care: _____
Behavioral Health Substance Abuse Provider? Yes _____ No _____ _____

Section 3: Billing Contact:

☐Check here if same as practice address

Billing Contact Name: _____
Billing Remit Name: _____
Billing Address: _____
Billing Phone: _____ Billing Fax: _____

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Section 4: Credentialing Contact:

☐ Check here is same as practice address

Credentialing Contact Name: _____

Credentialing Remit Name: _____

Credentialing Address: _____

Credentialing Phone: _____ Billing Fax: _____

Section 5: Practitioner Choice for Communication from Aetna Better Health of Kentucky:

Aetna Better Health of Kentucky communicates information to providers on a regular basis via fax or email, whatever the preference of the provider. Please indicate below if your office would rather receive these communications via fax or email.

☐ Fax
☐ Email

Please list the fax number or email address preferred:

Fax number: _____

Email: _____