PLEASE RESPOND TO:
Aetna Better Health of New Jersey
Email: NJMedicaidNetworkContracting@AETNA.com
Mail: **Aetna Better Health of New Jersey**
PO Box 818003
Cleveland, OH 44181-8003

Action requested – Complete the organizational provider application.

We are committed to the quality of health care services delivered to our members. We have a well-defined and structured organizational provider (re)credentialing process in place. Please complete the Aetna Better Health Medicaid organizational provider application so we can complete our (re)credentialing process as required by your agreement. Please return the completed application and supporting documents to the information listed above.

Organizational provider name	
Street address (to be credentialed)	
City, state, zip	
Primary phone number	
Primary fax number	

Enter current organizational provider credentialing contact information (required):

Organizational provider credentialing contact name	
Contact phone number	
Contact fax number	
Contact email (required)	

Please check all services provided at your location:

- ☐ Adult day health care
- ☐ Assisted living
- ☐ Counseling
- ☐ Durable medical equipment
- ☐ Family and community support services
- ☐ Family counseling and training
- ☐ Home health care
- ☐ Home infusion
- ☐ Hospice
- ☐ Home modification
- ☐ Home-delivered meals
- ☐ Mammography
- ☐ MRI
- ☐ Non-emergent transportation services
- ☐ Nursing care
- ☐ Pediatric day health care
- ☐ Personal emergency response services/Emergency communication services
- ☐ Radiology
- ☐ Residential-based supported community living services
- ☐ Retail clinic (medical)
- ☐ Service facilitation
- ☐ Urgent care
- ☐ Vehicle modification

☐ Other services/specialties: _____

The below information is required to complete the (re)credentialing process. Please provide the requested documents and enter information, where applicable:

- Current state of New Jersey license(s), business license or certification(s), as required by your state.
- Business entity information (New Jersey Tax certification or Trade Name registration).
- Current General and/or Professional liability insurance certificate(s).
- **Assisted/Senior living facilities and communities, residences and hospice providers only**: Food Establishment license and copy of one (1) food manager's certificate or other training program certificate. **Note**: If a caterer or outside vendor is used, provide documentation stating a caterer or vendor is used.
- Current signed and dated W-9. Tax ID#: _____
- Medicaid certification number: _____
- National Provider Identifier (NPI)#: _____

General liability insurance coverage	
Do you have general liability insurance coverage in force? ☐Yes ☐No If yes, provide details below and attach the policy face sheet. Does the general liability cover the location being credentialed? ☐Yes ☐No	
Name of insurance carrier/insurer:	
Policy number:	Policy expiration date:
Amount per occurrence: $	Amount per aggregate: $

Professional liability insurance coverage	
Do you have professional liability (malpractice) insurance coverage in force? ☐Yes ☐No If yes, provide details below and attach the policy face sheet. Does the professional liability cover the location being credentialed? ☐Yes ☐No	
Name of insurance carrier/insurer:	
Policy number:	Policy expiration date:
Amount per occurrence: $	Amount per aggregate: $

If you have additional insurance coverage, please provide details below:	
☐ Additional general and/or professional liability (including patient comp funds) ☐ Self-insured retention ☐ Excess coverage ☐ Umbrella	
Name of insurance carrier/insurer:	
Policy number:	Policy expiration date:
Amount per occurrence: $	Amount per aggregate: $

Attestation

By signing below, I consent and authorize the release of any and all information to Aetna that may be relevant and necessary to the process of reviewing and evaluating the qualifications of the Organizational Provider for Credentialing, including any applicable information about disciplinary actions and information that might otherwise be considered confidential or privileged.

I know that it is my responsibility to give enough information to Aetna to show that the organization is compliant with Aetna's credentialing process. I know that any false statement or mistake in this questionnaire will be a reason to reject or end the organization's participation in the network. If there are any changes in the information I provided, making the above information no longer correct and complete, I understand and agree that it is my responsibility to let Aetna know within (30) days of the occurrence. I know if I don't provide the necessary information on the organization's behalf within the 30-day timeframe, the organization may not be part of the Aetna network.

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

Signature:	Date:
Print name:	Title:

Employment Qualification Attestation Form

Pursuant to the Participating Health Provider Agreement with Aetna Better Health and in compliance with Aetna Medicaid requirements, under which the provider entity listed below ("Provider")provides direct support and/or services to Aetna Better Health members, I attest that I am duly authorized to sign and attest on behalf of Provider as follows:

1. Provider shall conduct effective, accurate and economical criminal background checks on all prospective employees who may have direct contact with members.
2. Provider shall maintain written policies and/or procedure(s) related to criminal background checks and verification of employee(s) qualifications as part of the prescreening employment process.
3. Provider shall maintain written policies and/or procedures related to monitoring of employees for continued employment.
4. Provider shall ensure employees who may be in contact with Aetna Better Health members have the relevant certification(s), education, experience, and training.
5. Provider shall maintain written policies and/or procedures related to staff competency and orientation.
6. Provider shall maintain written policies and/or procedures addressing Aetna Better Health member's complaints and/or grievances.
7. Provider shall maintain written policies and/or procedures related to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").
8. Provider shall remain compliant with the written policies and procedures noted above.
9. In the event such policies and procedures are modified, Provider shall send updated versions to Aetna Better Health Provider Relations Department for review.
10. Provider shall maintain written policies and/or procedure(s) related to an equipment test policy and/or maintenance and/or manufacturer recall.

By my signature below, I attest that the Provider represents and warrants the accuracy and complianceof the above representations and that Provider agrees to submit its above policies, upon request, to the Aetna Better Health Provider Relations Department.

Provider name: _____

Print name: _____

Title: _____

Signature: _____

Date: _____

Provider & Subcontractor Disclosure of Ownership & Controlling Interest Form

To comply with Federal law (42 CFR 455.100–106), health plans with Medicaid business must obtain certain information about the ownership and control of entities with which the health plan contracts for services for which payment is made under the Medicaid program.

The Centers for Medicare & Medicaid Services and the State Medicaid agency require Aetna (including Coventry and First Health) to obtain this information to show that we are not contracting with an entity that has been excluded from Federal health programs, or with an entity that is owned or controlled by an individual who has been convicted of a criminal offense, has had civil monetary penalties imposed against them, or has been excluded from participation in Medicare or Medicaid.

We require this form if you want to or keep participating with Aetna. You must promptly report any future changes to this information, and in no event more than 35 days after any such change, to the health plan. Use more blank sheets of paper if you need space to continue your responses. If you have questions, please contact the health plan.

If the practice group with which the Provider belongs has completed this form within the previous 180 days and can certify that no information on the form he/she sent previously has changed, you can initial below. Leave the "Disclosure of Ownership & Control Interest" Section of this Worksheet blank. Otherwise, you must complete all fields.

_____ I hereby certify that the information in the ownership and controlling interest worksheet that the practice group submitted within the previous 180 days is still complete and accurate.

Identifying information of provider/subcontractor

Name of provider/subcontractor	
Type of provider/subcontractor	
Tax ID#	
NPI#	
Medicaid provider ID	
Primary business address *If the primary business address has changed, provide new address	
Type of ownership (i.e., partnership, corporation, investor-owned, etc.)	

Enter any additional business locations, NPI and Tax ID# or attach an additional location form with this information:

Disclosure of Ownership & Control Interest (attach additional sheets as needed)

1. List any individual or organization (hereinafter referred to as "Person") and their address that has a direct or indirect ownership or control interest of 5 percent or more in your entity (hereinafter referred to as "Interest"). If the Person with the Interest is a corporation, please include (a) the primary business address, (b) every business location; (c) PO box addresses, if applicable; and (d) the tax identification number. If the person with the interest is an individual (this includes officers and directors of the corporation, or partners in the case of a partnership), list the individual's name, date of birth and Social Security number.

2. For any Person disclosed above in (1) with an ownership or control interest, list whether such person is related to another person with ownership or control interest in your entity such as a spouse, parent, child or sibling.

3. For any Person disclosed above in (1), list the name(s) of any other disclosing entity (defined as a Medicaid/Medicare provider, other than an individual practitioner or group of practitioners, or any entity that is otherwise required to disclose certain ownership and control information because of participation in a Federal health care program) in which such person has an ownership or control interest.

4. For each service location, list any managing employees and their address, date of birth and Social Security number. Managing employees are individuals such as general managers, business managers, administrators or directors who exercise operational or managerial control over the entity or part thereof, or directly/indirectly conduct the daily operations of the entity, or part thereof.
   Repeat for all service addresses covered under this provider/tax ID#. Any service addresses not listed will be considered nonparticipating for Medicaid.

Primary service address: _____

_____

_____

_____

Additional service address: _____

_____

_____

_____

Additional service address: _____

_____

_____

_____

Additional service address: _____

_____

_____

_____

5. Has there been a change in ownership or control within the last year? ☐ Yes ☐ No

   If yes, provide date: _____

6. Has any person listed on this form ever been excluded from Federal health programs, had civil monetary penalties imposed against them, or been convicted of a crime related to that person's involvement in any program under Medicaid, Medicare, or Title XX programs? ☐ Yes ☐ No

   If yes, list those persons below in addition to the exclusion type, date of exclusion and date the exclusion ended, as applicable.

   _____

   _____

   _____

☐ Check here if you listed more information on other pages

I certify that the information contained above is true, complete and accurate. If you knowingly and willfully fail to fully and accurately disclose the information requested, the Plan may deny your request to join the network.

Provider name: _____

Print name: _____

Title: _____

Signature: _____

Date: _____