AETNA BETTER HEALTH®

Practitioner application

Aetna Better Health (ABH) is committed to the quality of health care services delivered to our members. In support of this commitment, we have structured provider credentialing and contracting processes in place.

Practitioners wishing to apply for participation in the ABH network should complete and return the ABH Practitioner Application Screening Form in its entirety. As a participant with the Council for Affordable Quality Healthcare (CAQH), ABH utilizes the CAQH uniform provider application.

- Practitioners ***joining an existing, participating ABH provider practice*** should complete, sign and return the Practitioner Application Screening Form and the attached ABH Participating Health Provider Agreement Attachment C.
- Practitioners applying for participation with ABH ***as a new provider*** should complete and return just the ABH Practitioner Application Screening Form. Our Network Development department will follow up with your office with ABH contract documents, as appropriate.
- Nurse Practitioners must provide the name and NPI number of the collaborating provider for each practice group where participation is being requested.

If you have a current CAQH application on file, be sure to include your CAQH ID # on the Application Screening Form.

> Please fax all completed documents to ABH at **1-860-754-5435**, or by mail to**: Aetna Better Health 2000 Market Street, Suite 850 Philadelphia, PA 19103**

ABH assesses all provider applicants before initiating credentialing and contracting processes[1]. After an initial review of the application prescreening form, providers will be sent either 1) ABH Participating Health Provider (PHP) Agreement (contract) (if one is not already on file) or 2) notification in writing, if ABH determines the provider is unable to join the network.

The following steps must be successfully completed for providers to be eligible to provide care to ABH members:

1) The Practitioner Application Screening Form must be submitted correctly and completely.
2) Provider must be fully credentialed by ABH.
3) New providers will be mailed a ABH contract. Providers joining an existing group must complete the applicable contract documents to be added to the existing contract.
4) Provider must sign and return the ABH contract documents.
5) When credentialing is complete and contract documents have been fully executed, the provider will receive notice from ABH's Network Development department with the provider's effective date of participation, along with the fully executed contract (if it is a new contract).
6) Providers should refrain from scheduling and seeing ABH members until you are notified of your participation effective date.

You will be notified of your participation effective date with ABH when the full credentialing and contracting process is complete.

Please contact your Provider Relations representative with any questions about ABH's provider application process at **1-866-638-1232 Opt 3, Opt 5.**

Date: / / Line of Business: □ CHIP □ Medicaid □Community Health Choices-MLTSS

[1] Aetna Better Health does not credential or contract with Locum Tenens providers.

AETNA BETTER HEALTH® OF PENNSYLVANIA

Practitioner Application Screening Form
PLEASE COMPLETE ONE FORM PER PRACTITIONER IN PRACTICE
Fax completed form to 860-754-5435 or mail to: Aetna Better Health 2000 Market St., Ste 850, Philadelphia, PA 19103

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 **mandatory**; failure to provide it will delay the contracting and credentialing process.

IN ORDER TO BE CONTRACTED, **YOU MUST** HAVE AN NPI NUMBER, BE ELIGIBLE TO PARTICIPATE IN MEDICARE, SUBMIT CLAIMS ELECTRONICALLY, HAVE INTERNET ACCESS.

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: Hospital Based Physician	Hospitalist	Office Based	
	DBA Name: _____	Employment Start Date: _____/_____/_____		Does your office utilize physician extenders? Y N If Yes, how many? _____
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: _____that a Group own this number _____		Individual NPI: __Only one person can own this number_____	
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)**:**			
Language and Culture	Language(s) spoken other than English			Primary: _____
	Cultural Heritage: _____Completed Cultural Competence Training ☐ Y ☐ N			Secondary: _____
	☐ Asian ☐ African-American/Black ☐ Hispanic/Latino ☐ Caucasian/White			

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	☐ 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)			
	Experience treating: ☐ AIDS/HIV ☐ Mental Illness ☐ ESRD ☐ Co-occurring disorders ☐ Visual Impairment		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	
	Is Office Located on public transportation route ☐ Bus ☐ Rail ☐ Ferry/Boat		Language Interpreters:_____	
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)			
	Services offered to the deaf / hearing impaired (circle): sign language TTD/TTY		Adjustable exam table: Y N	Language Interpreters:_____
	Experience treating: ☐ AIDS/HIV ☐ Mental Illness ☐ ESRD ☐ Co-occurring disorders ☐ Visual Impairment			Evening hours: Y N
	Accommodate special needs patients: Developmentally Disabled Y N			Weekend hours: Y N
	Is Office Located on public transportation route ☐ Bus ☐ Rail ☐ Ferry/Boat			Physically Disabled: 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 ☐ Secure Web Portal Form ☐ Request Approved by ND&C ☐ EFT

AETNA BETTER HEALTH®

Provider and subcontractor disclosure of ownership and controlling interest worksheet

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.

<u>Identifying information of provider/subcontractor</u>

Name of provider/subcontractor: _____

Type of provider/subcontractor: _____

Tax ID #: _____ NPI #: _____

Medicaid provider ID #: _____

Primary business address: _____

If the provider is no longer affiliated with this tax ID #, check this box and sign and date the page □

If the primary business address has changed, provide new address: _____

Additional business locations, including PO boxes, if applicable: _____

Type of ownership: _____
(Examples may include: partnership, corporation, government, limited partnership, corporate-owned, investor-owned, etc.)

Disclosure of Ownership & Control Interest (Use & attach more sheets of paper if necessary).
Important: if not applicable, you must indicate N/A in the appropriate non-applicable section.

a. List any individual or organization (hereinafter referred to as "Person") & 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 (i) the primary business address, (ii) every business location; (iii) PO box addresses, if applicable; and (iv) 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.
_____
_____
_____
_____
_____

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

c. For any person disclosed above in (a), 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.
_____
_____
_____
_____
_____

For each service location:

d. 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.

Primary service address:
_____
_____
_____
_____
_____

Service address #2:
_____
_____
_____
_____
_____

Service address #3:
_____
_____
_____
_____
_____

Repeat for all service addresses covered under this provider/tax ID#. Any service addresses not listed will be considered nonparticipating for Medicaid.

e. Has there been a change in ownership or control within the last year? _____
If yes, give date _____

f. 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 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.

Signed: _____ **Print: _____**

Date: _____ **Title: _____**