Aetna Better Health Medicaid/CHIP
PROSPECTIVE PROVIDER FORM
Please complete this form and submit with a copy of your W-9
Please fax to: 1-866-510-3710

Tax ID# ______________________________ Group NPI#______________________________

Organization / Provider Name First, Middle, Last with Suffix____

Individual Medicaid TPI # ______________________________________Is TPI Attested? YES NO
Group Medicaid TPI # ____Is TPI Attested? YES NO
THSteps Unique TPI#____________________________ Individual NPI # _____________________________
API: ____
DOB________________ SSN_____________________________Gender_______
Board Certification Specialty: ____________________ License Number and State: ______________________
CDS License Number: ____________________________ DEA License Number: __________________________
CAQH ID: ______________________________________ Significant Traditional Provider Y/N
Type of Service / Specialty: ____

Details/Special Services Rendered: ____

Are you a PCP Y/N Are you a hospital based provider Y/N

Current Insurance Limits: ____

Participating with Aetna in Commercial Network (HMO, PPO, POS)? Yes No

Is this a New Provider joining a currently contracted group? Yes No

Group Name on Contract:____

Age Limits: _______Minimum ______Maximum

Service Location: (ALL locations must be included, attach list of locations if necessary)
Primary Practice Location Name: ____________________________ __
Primary Practice Tax ID #: ________________________________ __________________________
Primary Address to include Suite, City, State and County

____

Phone: ____________________ Fax: ____________________

Contact Name: __________________________ E-Mail Address: ____

Correspondent Address to include Suite, City, State, Zip and County:
____
Phone: ___________________________ Fax: ______________________________
Service Coverage Area (COUNTIES): ____

Indicate any languages spoken by staff, other than English:
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