CAQH #: ____________________________

Aetna Better Health - WV

Provider Data Sheet

This Provider Data Sheet must be ***completed in full*** and received by Aetna Better Health of WV to begin the Credentialing/Verification process. If not ***completed in full***, it will be sent back to you to complete which will delay the Credentialing/Verification process. If you have completed your application with CAQH (Council for Affordable Quality HealthCare), **please ensure you have authorized Aetna to access your data**. Using the CAQH credentialing process does not grant participation or constitute applying for participation with our network. The practitioner must first contact us directly to request participation and information. *REQUIRED INFORMATION*

***Last Name:**	***First Name:**	**Middle Initial:**	***DOB:**	***Gender:**
***Social Security #:**	***Pay To Tax ID#:**	***Group NPI #:**		***Individual NPI #:**

***Specialty to be contracted with Aetna:** ***PCP Accepting Pts: ___Yes ___ No**	***State & License No:** _________________ ***Issue Date:**____________ ***Exp Date:**____________	***Ethnicity:**	***Languages Spoken:**	***Degree/Title:**

***Board Certification: Yes ____ No ____** ***Effective Date:**____________________ ***Expiration Date:** ____________________ ***Specialty Certified In:**__________________	***Hospital Privileges: List all locations & Privileges (A=Admitting, C=Consulting, P=Provisional)**	***Pay-To Group and/or Solo Practice Name:**

***Primary Office Address:**

____

____

***County:** ____

***Telephone:**__________________ ***Fax:** ______________________

***E-Mail Address:** ____

***Office Contact Person:** ____

***Attach Add'l. Sheet for ALL Service Locations & Group NPIs used**

***Primary Location Hours:**

Monday	**From**	___________	**To**	___________
Tuesday	**From**	___________	**To**	___________
Wednesday	**From**	___________	**To**	___________
Thursday	**From**	___________	**To**	___________
Friday	**From**	___________	**To**	___________
Saturday	**From**	___________	**To**	___________
Sunday	**From**	___________	**To**	___________

HANDICAP ACCESSIBLE: ____ Yes _____No

***Credentialing Address: (if different from Primary)**

____

____

County: ____

Telephone:__________________ **Fax:** ______________________

E-Mail Address: ____

Office Contact Name: ____

***Claim Payment Name & Address: (if different from Primary)**

____

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____

***Billing Phone #:** ____

***Billing Fax:** ____

***Billing Contact Person:** ____

- If Provider does not have a CAQH number, go to https://proview.caqh.org/PR/Registration to become registered.
- Should you need assistance with completing your on-line application, please contact the **CAQH HelpDesk at 1.888.599.1771** or log on to the CAQH website: http://caqh.geoaccess.com/oas

Has had Cultural Competency Training:

Yes _____ No _____ FACILITIES: N/A

My signature below attests that the information provided on this form is truthful, correct and complete.

____

Physician Signature:

____

Date:

My signature below attests that I have completed the credentialing application on the CAQH Website, have e-mailed or faxed the application and attachments to CAQH and have granted permission for Aetna Better Health to access my information:

____

Physician Signature:

____

Date:

Effective January 1, 2018, providers MUST be enrolled with WV Bureau of Medical Services (BMS/Molina)

Molina Provider ID: ______________________

Is applicant currently enrolled with BMS/Molina:

_____Yes _____ No

***If No, please visit https://www.wvmmis.com/default.aspx for enrollment. *YOU CAN REAPPLY* with Aetna Better Health of WV when the State BMS/Molina Enrollment is completed.**