435 N Whittington Pkwy, Suite 275
Louisville, KY 40223

Aetna Better Health® of Kentucky

Practitioner Enrollment Application

Please note: This application is intended for practitioners who already have an executed participating agreement with Aetna Better Health of Kentucky (ABHKY). If you do not have an executed participating agreement and are seeking network participation, please complete and submit a **Participating Provider Agreement Request Form** instead of the Practitioner Enrollment Application.

Enclosed is the Practitioner Enrollment Application required to process your credentialing request. Aetna Better Health of Kentucky (ABHKY) requires the use of Council for Affordable Quality Healthcare (CAQH) ProViewTM, a service that provides a fast and easy way to securely submit credentialing information to multiple plans and networks by entering information just once. This simplified credentialing process reduces paperwork and saves time. Please complete and return the application to us via email KyProviderUpdates@aetna.com.

The standard turn-around time to process an application is 60 days. If your request was submitted within the past 60 days, please contact us through email at KYProviderUpdates@aetna.com. If more than 60 days have passed since you submitted your request, please resubmit your request.

You will be notified of your participation effective date with ABHKY once the credentialing and enrollment process has been completed. Providers should refrain from scheduling appointments with or rendering services to ABHKY members until they have received confirmation of their effective participation date.

We look forward to a mutually successful partnership and appreciate your support as a network provider. Should you have any questions or require additional information, please contact us through email at kyproviderrelations@aetna.com.
Sincerely,

Credentialing Department
Aetna Better Health of Kentucky

Practitioners:

All practitioners must complete the attached Provider Enrollment Application. If you participate in the Council for Affordable Quality Healthcare (CAQH), the Provider Enrollment Application is the only form you are required to submit for the enrollment/credentialing process.

CAQH is a self-reported credentialing data exchange that allows you to keep all your credentialing information in a centralized location. Practitioners should update their CAQH every 90 days. This information can be accessed by a variety of credentialing entities. Please add Aetna Better Health of Kentucky as an authorized plan, giving permission to access the practitioner's CAQH application.

If you do not participate in CAQH, you must also complete and submit the Kentucky Application for Provider Evaluation and Re-evaluation (KAPER-1) application available at http://insurance.ky.gov.

Facilities:

Facilities, such as hospitals, surgical centers, home health agencies, etc., are not eligible to participate in CAQH. Facilities are required to fill out the Facility Credentialing & Enrollment Packet and return with the required documentation.

Request to Add New Provider

Instructions

Complete this form in its entirety and submit to KyProviderUpdates@aetna.com. Provider will be enrolled in Medicaid lines of business, as reflected in the group's contract. Please make sure to indicate panel status and member capacity for each address in the spaces provided below. An "open panel" will indicate a PCP provider's willingness to accept member assignment. Panels are only applicable to PCPs.

Practice website*:	☐ **No website**
Practice email*:	☐ **No email**

*Website and email may be published in payer directory

I. Provider Info

Provider's Full Name (Last, First, Middle)	**Title** (MD, APRN, etc.)	**Start Date**	**CAQH ID #**

Individual NPI #	**Provider Type**	**Date of Birth**	**Gender**	**Medicaid Number -** ☐ **pending**

Primary Specialty	**Secondary Specialty**	**Languages Spoken**
		☐ **English** ☐ **Spanish** ☐ **Other**_____

Primary Taxonomy	**Secondary Taxonomy**	**CDS Issue State**	**CDS License Number**

States License No.	**DEA Number** ☐ **pending**
KY_____ OH_____ IL_____ TN_____ IN_____ WV_____ VA_____ MO_____ Other_____	KY_____ OH_____ IL_____ TN_____ IN_____ WV_____ VA_____ MO_____ Other_____

Supervising Physician NA	**Primary Hospital Affiliation -** **No hospital privileges**	**City, State**	**Affiliation Start Date**
Name:_____			

or Covering Arrangements (admitting physician or hospitalist group)	**Hospital Name (used by admitting physician)**

II. Credentialing Contact Information – Email used for notices regarding credentialing

Credentialing Contact Name	**Phone #**	**Fax #**	**Email**

Credentialing Correspondence Address 1	**Address 2**	**City**	**State**	**Zip**

Practice Contact Name	**Phone #**	**Fax #**	**Email**

Practice Correspondence Address 1	**Address 2**	**City**	**State**	**Zip**

Notes: Please include any additional notes to assist us in processing this request

III. Primary Address Information. Primary address will be listed in directory as long as provider is at this location 16 hours or more (unless opted out of directory below). Covering sites will not be listed in directory. If provider practices at more than one location, please complete section IV. Additional Locations.

Address Type	Tax ID#	Group Name (include DBA)
☐ Primary Office ☐ Covering Only		

Scope of Practice for this site			Service Address 1	Address 2 (suite)
☐ Primary Care ☐ Specialty Care ☐ ASC ☐ Urgent Care	☐ FQHC ☐ RHC ☐ Behavioral Health ☐ Home Health	☐ DME ☐ Inpatient Care ASC Emergency Care ☐ Other		
			City, State, Zip location	☐ Dir Opt-OUT for this
If specialty care, please designate practice specialty			**Notes:**	

CLIA Number	CLIA Expiration	Group NPI	Phone #	Fax #

Location-Specific Information	Y	N		Y	N
Does practice offer lab services at this site? (CLIA Required)	☐	☐	Is address TDD hearing equipped?	☐	☐
Is provider at this site at least 16 hours per week?	☐	☐	Is address accessible by bus route?	☐	☐
Can patients call this site to make appointment with provider?	☐	☐	Does practice provide American Sign Language services at this site?	☐	☐
Is provider accepting new patients at this site?	☐	☐	Does office/service provide skilled medical language interpreter?	☐	☐
Is provider a PCP at this site?	☐	☐	Does provider provide telemedicine services at this site?	☐	☐
Does provider provide EPSDT services at this site?	☐	☐	Does this site participate in KHIE?	☐	☐
If PCP, is provider's panel open at this site for Medicaid?	☐	☐	Is provider a locum tenens provider?	☐	☐
Should this provider be printed in the directory?	☐	☐	Is provider certified in trauma-informed care (TIC)?	☐	☐
Is office/service location handicap accessible, including exam rooms?	☐	☐	Has provider been trained in evidence-based practice?	☐	☐

Is there a gender restriction at this site? (If yes, please specify)
What is the maximum panel capacity for Medicaid at this site?
What are the age limitations for patients seen by provider?

Service Delivery Method:	☐ In-Person Care	☐ Hospital-Based Care	☐ Telehealth/Virtual Care

Office Hours	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Billing/ Vendor Information *a sample claim must be submitted with this application unless contracted as full cap vendor*			
Name to who checks should be made payable *(if different than Practice/Group name)*			Tax ID #
Billing Address *(location where payments will be sent)*	City	State	Zip+4

Billing Contact Name	Billing Office phone #	Billing Office Fax #	Billing Office E-Mail

IV. Additional Locations. Please list alternate and/or covering-only locations below. Primary address should be listed on the prior page of this packet. If more than two addresses are required, AND the Pay To address is the SAME as that of the primary, please see the Appendix on page 7 to report the additional addresses. Alternatively, additional copies of this page can be made for each additional location.

Alternate Office Sites – Secondary sites where patients can call to make appointment to be seen by physician. If patients cannot make appointments with provider at this location, please designate location as "Covering only."
Covering-only Sites – Other sites that are to be loaded only for the times when provider covers for another provider or sites where provider does not accept appointments regularly. Patients cannot schedule appointments with provider at covering locations.
"Pay To" Name – This should match exactly how the claims are submitted from your billing system to insurance carriers, including abbreviations.

Additional Address. Alternate sites will only be listed in directory if provider is at location 16 hours or more, (unless opted IN to directory to over-ride). If opting IN to directory, provider MUST accept appointments at that location. Covering sites will not be listed in directory. Please see page 7, if more sites are required to be loaded.

Address Type	Tax ID#	Group Name (include DBA)
☐ Alternate Office ☐ Covering Only		

Scope of Practice for this site			Service Address 1	Address 2
☐ Primary Care	☐ FQHC	☐ DME		
☐ Specialty Care	☐ RHC	☐ Inpatient Care	City, State, Zip	☐ Dir Opt-Out for this location
☐ ASC	☐ Behavioral Health	☐ Emergency		
☐ Urgent Care	☐ Home Health	☐ Other		

If specialty care, please designate practice specialty

CLIA Number	CLIA Expiration	Group NPI	Phone #	Fax #

Location-Specific Information	Y	N		Y	N
Does practice offer lab services at this site? (CLIA Required)	☐	☐	Is address TDD hearing equipped?	☐	☐
Is provider at this site at least 16 hours per week?	☐	☐	Is address accessible by bus route?	☐	☐
Can patients call this site to make appointment with provider?	☐	☐	Does practice provide American Sign Language services at this site?	☐	☐
Is provider accepting new patients at this site?	☐	☐	Does office/service provide skilled medical language interpreter?	☐	☐
Is provider a PCP at this site?	☐	☐	Does provider provide telemedicine services at this site?	☐	☐
Does provider provide EPSDT services at this site?	☐	☐	Does this site participate in KHIE?	☐	☐
If PCP, is provider's panel open at this site for Medicaid?	☐	☐	Is provider a locum tenens provider?	☐	☐
Should this provider be printed in the directory?	☐	☐	Is provider certified in trauma-informed care (TIC)?	☐	☐
Is office/service location handicap accessible, including exam rooms?	☐	☐	Has provider been trained in evidence-based practice?	☐	☐

Is there a gender restriction at this site? (If yes, please specify)

What is the maximum panel capacity for Medicaid at this site?

What are the age limitations for patients seen by provider?

Service Delivery Method:	☐ In-Person Care	☐ Hospital-Based Care	☐ Telehealth/Virtual Care

Office Hours	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Billing/ Vendor Information *a sample claim must be submitted with this application unless contracted as full cap vendor*

Name to who checks should be made payable *(if different than Practice/Group name)*	Tax ID

Billing Address *(location where payments will be sent)*	City	State	Zip+4

Billing Contact Name	Billing Office phone #	Billing Office Fax #	Billing Office E-Mail

Evidence Based Practice Form

The Kentucky Department of Medicaid (DMS) requires that all participating behavioral health providers complete a survey upon enrollment and at least annually thereafter. Therefore, the following survey is a required part of our program.

Evidence Base Practice	YES	NO
Assertive Community Treatment	☐	☐
Assessing and Managing Suicide Risk (AMSR)	☐	☐
Cognitive Behavioral Therapy (CBT)	☐	☐
Consumer Operated Programs	☐	☐
Coordinated Care Model for Early Interventions for First Episode Psychosis	☐	☐
Dialectical Behavior Therapy (DBT)	☐	☐
Dual Diagnosis Capability in Addiction Treatment (DDCAT)	☐	☐
Eye Movement Desensitization and Reprocessing (EMDR)	☐	☐
Family Psychoeducational	☐	☐
First Episode Psychosis	☐	☐
Functional Family Therapy (FFT)	☐	☐
Individual Placement and Support (IPS) Supported Employment	☐	☐
Integrated Treatment for Co-occurring Disorders (MH and SUD)	☐	☐
Medication Assisted Treatment	☐	☐
Motivational Interviewing	☐	☐
Multi-Systemic Therapy	☐	☐
NIATx model for addiction treatment	☐	☐
Parent Child Interaction Therapy (PCIT)	☐	☐
Peer Support	☐	☐
Screening, Brief Intervention and Referral to Treatment	☐	☐
Seeking Safety	☐	☐
Supported Employment	☐	☐
Supportive Housing	☐	☐
Trauma Focused Cognitive Behavior Therapy (TF-CBT)	☐	☐
Trauma Informed Therapy	☐	☐
Trauma Recovery and Empowerment Model (TREM)	☐	☐
Treatment for Depression in Older Adults	☐	☐
Wraparound	☐	☐
Other	☐	☐

Behavioral Health Clinical Specialties Codes and Descriptions

Code	Description
AA	ADD/ADHD Counseling
AD	Addictionology (MD's Only)
AI	Adoption Counseling
AF	AIDS/HIV Counseling
AC	Alcohol and Substance Use Counseling (certified)
AS	Alcohol and Substance Use Counseling (self-reported)
AM	Anger Management Counseling
AE	Appointments Available in the Evening
AW	Appointments Available on the Weekends
AB	Autism Applied Behavioral Analysis (ABA)
AG	Autism Social Skills Training
AT	Autism Testing
AR	Autism Treatment
BP	Behavioral Pediatrics (MD)
BF	Biofeedback Counseling
BD	Bipolar Disorder (Manic Depression) Counseling
BR	Borderline Personality Disorder (BPD) Counseling
CD	Conduct/Disruptive Behavior Therapy Counseling
CE	Cultural/Ethnic Counseling
DL	Developmental Disorders Counseling
DB	Dialectical Behavior Therapy
DS	Dissociative Disorder (Multiple Personalities) Counseling
DV	Domestic Violence Counseling
RF	EAP: Assessment/Referral
ED	Eating Disorders Counseling
EC	Eye Movement Desensitization and Reprocessing (EMDR)
CC	Faith-Based Counseling: Christian
FB	Faith-Based Counseling: Other than Christian Only
FY	Family Counseling
FI	Fertility Counseling
FR	First Responder Counseling
GA	Gambling Counseling
GI	Gender Identity Counseling

Code	Description
DR	General Depression Counseling
GR	Grief and Loss Counseling
GT	Group Therapy
HV	Home-Based Behavioral Health Services
LD	Learning Disabilities
ML	Medical Illness Counseling
MC	Marriage/Couples Counseling
BS	Medication Assisted Treatment (MAT) for Substance Use: Buprenorphine/Suboxone
MV	Medication Assisted Treatment (MAT) for Substance Use: Vivitrol
MO	Menopause Counseling
MI	Men's Counseling
DD	Mental Health and Substance Use Counseling (Dual Diagnosis)
NT	Neuropsychological Testing (Psychologists Only)
OC	Obsessive Compulsive Disorder (OCD) Counseling
PM	Pain Management
PA	Panic Disorder Counseling
PH	Phobias Counseling
MH	Postpartum Depression Counseling
PT	Post-Traumatic Stress Disorder (PTSD) Counseling
MJ	Psychiatric Medication Management: Injectable Meds
MM	Psychiatric Medication Management: Oral Meds
PS	Psychological Testing
PD	Psychotic Disorders
SI	Sexual Abuse Counseling
SD	Sexual Health Counseling
SO	Sexual Offender Counseling
GL	Sexual Orientation Counseling
TM	Transcranial Magnetic Stimulation (TMS)
TH	Virtual Counseling Provided (via video)
TO	Virtual Counseling Only (via video)
WI	Women's Counseling

APPENDIX

Additional Address. If Pay To and Correspondence Information are NOT the same as that of the Primary Address, please make copies of page 4 to include this information. If more than 4 addresses are required, please make additional copies of either this page or page 4, as appropriate.

Address Type	Tax ID#	Group Name (include DBA)
☐ Alternate Office ☐ Covering Only		

Scope of Practice for this site			Service Address 1	Address 2
☐ Primary Care	☐ FQHC	☐ DME		
☐ Specialty Care	☐ RHC	☐ Inpatient Care		
☐ ASC	☐ Behavioral Health	☐ Emergency	City, State, Zip ☐ Dir Opt-OUT for this location	
☐ Urgent Care	☐ Home Health	☐ Other		

If specialty care, please designate practice specialty

CLIA Number	CLIA Expiration	Group NPI	Phone #	Fax #

Location-Specific Information	Y	N		Y	N
Does practice offer lab services at this site? (CLIA Required)	☐	☐	Is address TDD hearing equipped?	☐	☐
Is provider at this site at least 16 hours per week?	☐	☐	Is address accessible by bus route?	☐	☐
Can patients call this site to make appointments with provider?	☐	☐	Does practice provide American Sign Language services at this site?	☐	☐
Is provider accepting new patients at this site?	☐	☐	Does office/service provide skilled medical language interpreter?	☐	☐
Is provider a PCP at this site?	☐	☐	Does provider provide telemedicine services at this site?	☐	☐
Does provider provide EPSDT services at this site?	☐	☐	Does this site participate in KHIE?	☐	☐
If PCP, is provider's panel open at this site for Medicaid?	☐	☐	Is provider a locum tenens provider?	☐	☐
Should this provider be printed in the directory?	☐	☐	Is provider certified in trauma-informed care (TIC)?	☐	☐
Is office/service location handicap accessible, including exam rooms?	☐	☐	Has provider been trained in evidence-based practice?	☐	☐

Is there a gender restriction at this site? (If yes, please specify)

What is the maximum panel capacity for Medicaid at this site?

What are the age limitations for patients seen by provider?

Service Delivery Method:	☐ In-Person Care	☐ Hospital-Based Care	☐ Telehealth/Virtual Care

Office Hours	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Provider & Subcontractor Disclosure of Ownership & 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.**

Identifying information of provider/subcontractor

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#, please check this box and sign and date the second page.

If the primary business address has changed, please provide new address and continue. _____

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)

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: _____**