435 N Whittington Pkwy, Suite 275
Louisville, KY 40223

Aetna Better Health® of Kentucky

New Provider Nomination Form

Participating Provider Agreement Request Form

Thank you for your interest in joining the **Aetna Medicaid** provider network. This form is used to evaluate providers seeking participation in the **Aetna Better Health® of Kentucky** network through a **Participating Provider Agreement**. Submission of this request does not guarantee network participation. Aetna Better Health® of Kentucky's policies and procedures govern all decisions regarding participation and acceptance related to this request.

Please note: If you are requesting to add practitioners to an existing group that already has a Participating Provider Agreement with Aetna Better Health of Kentucky, do not complete this form. Instead, complete an Enrollment Application and submit it to KyProviderUpdates@aetna.com.

Section 1: REASON FOR SUBMISSION			
☐ New Participating Agreement	☐ Add new service(s) to existing Participating Agreement		
Section 2: PRACTICE STRUCTURE			
☐ Solo Practitioner	☐ Group Practice	☐ Facility	☐ Ancillary / Other Other: _____
Section 3: PROVIDER INFORMATION			
Legal Provider or Organization Name: _____			
Doing Business As (DBA), if applicable: _____			
Tax ID (TIN/EIN): _____		Group/Billing NPI: _____	
KY Medicaid ID*: _____ *Please be advised that an active Kentucky Medicaid enrollment is required for all providers seeking participation.		Primary Specialty: _____ Additional Specialty: _____	
Section 4: PRIMARY PRACTICE LOCATION INFORMATION			
Physical Street Address: _____ City: _____ State: _____ Zip: _____			
Billing/Pay-to Address: _____ City: _____ State: _____ Zip: _____			
Phone #: _____		Fax #: _____	
Office Manager: _____ Email Address: _____			

Section 5: SERVICE DELIVERY METHOD			
Indicate how services will be rendered to Aetna Medicaid members (select all that apply):			
☐ In-Person Care – Office / Clinic Setting	☐ In-Person Care – In-Home or Community Setting	☐ Hospital-Based	☐ Telehealth / Virtual Care*
*If Telehealth is selected: Telehealth Modality (select all that apply): ☐Audio-Visual ☐Audio-Only Address where telehealth services will be provided from: _____			
Section 6: CONTACT INFORMATION			
Requestor's Name: _____Title: _____			
Requestor's Email Address: _____ Requestor's Phone #: _____			
Authorized Official's Name & Title: _____			
Authorized Official's Email Address: _____			
Section 7: REQUIRED DOCUMENTATION - include the following documentation with this request:			
☐ W-9	☐ Disclosure of Ownership and Controlling Interest Form		
Section 8: ATTESTATION			
I certify that the information provided is accurate and complete to the best of my knowledge. I understand this request is for vetting consideration of a new Provider Participating Agreement with Aetna Medicaid and does not guarantee network participation. Authorized Signature: _____ Printed Name: _____ Title: _____ Date: _____			
Section 9: SUBMISSION INSTRUCTIONS			
Please submit this completed form and the required documentation together via one of the following methods: • Email: KyProviderUpdates@aetna.com • Fax: 1-855-454-5584 • Provider Portal (if applicable): Provider Request Form For questions regarding this request, please call Network Relations at 1-855-300-5528.			