AETNA BETTER HEALTH® OF PENNSYLVANIA

Out of Network Request to Join Form

This form should be completed only by facility/ancillary provider groups and sole practitioners who do **not** have an existing agreement with ABH PA. Provider groups with an existing agreement who want to add practitioners to their agreement should reference the Practitioner Application. That application can be found on our website.

To: Aetna Better Health of PA – Network Team From:_____

Fax: 1-877-533-5887 Fax: _____

Email: PAMedicaidNetworkDevelopment@Aetna.com Email: _____

Subject: Request to Join Network Date: _____

Provider's Legal Name: _____

Please select: Facility ☐ Ancillary ☐ Sole Practitioner/Group ☐

Tax ID: _____ NPI: _____

Specialty: _____ Number of Practitioners: _____

PA Medicaid Certified: ☐ Yes ☐ No PA PROMISe ID: _____

Address: _____

Contact Name: _____

Contact Number: _____ Contact Email: _____

Please return this form to Aetna Better Health of Pennsylvania via fax or email. Your request will be reviewed and a decision will be made within 60 days.

- **If the panel is open and we intend to pursue a contract,** a Network Manager will reach out to proceed with the formal credentialing and contracting process.
- **If the panel is not open or we do not intend to pursue a contract,** a letter will be sent out advising that the request has been denied at this time.