AETNA BETTER HEALTH®
AETNA BETTER HEALTH® KIDS
Practitioner information change

Make sure your contact information is current with us. If you want to make changes to your information, all you have to do is fill out the form on page 2. It's easy!

Make a change request today

You can fill out one form per provider in your practice. You can make changes to your:

- Name
- Physical and mailing addresses
- TIN
- NPI
- Social security number
- Specialty type
- Board certification
- License
- Hospital affiliations

You'll also want to attach important information with your change request, like a W-9 or your licensure.

Remember to complete the whole form. If you leave anything blank, it may delay your request. Once complete, fax it to **1-860-754-5435** or email it to **ABHProviderRelationsMailbox@AETNA.com**.If you have more than ten providers that require changes, use our provider roster update spreadsheet instead. Send the updated spreadsheet to **ABHProviderRelationsMailbox@AETNA.com**.

Your information is important

Your information helps us:

- Send payment to you without delay or error
- Make updates in a timely manner
- Send important information about new products and initiatives
- Meet state and NCQA requirements

We'll take care of the rest

Once we receive your change request, we'll process and complete it within 14 business days. You'll receive a fax within 5 business days of the effective change. Remember, we can only process requests for in-network providers with a signed, executed agreement on file. So, if you're an out-of-network provider and want to join our network, fill out our practitioner application form. For more questions about enrollment, contact Provider Relations at **1-866-638-1232**, prompt 3 and 5.

Sincerely,

Shalini Patel
Director, Provider Relations
Aetna Better Health

Date: _____/_____/_____

Please state what needs to be changed or updated on your record:

_____

_____

_____

_____

Provider Info				
	(Last Name)	(First Name)	(MI) (Degree)	(Title)
	☐ Male ☐ Female			
	Gender	DOB	SSN	Practice Name
	Joining as: ☐ndividual ☐ Group ☐ FQHC ☐ RHC		An Existing Group: ☐ Y ☐N	A New Provider: ☐ Y ☐N
			Other:	
	Are you: ☐ Locum Tenens ☐Hospital Based Physician ☐ Hospitalist ☐Office Based			
	DBA Name:	Employment Start Date: _____/_____/_____		Does your office utilize NPs and PAs? ☐ Y ☐ N
Practicing Specialties	Primary Specialty:		Secondary Specialty:	
	Provider Type :			
	Board Certified ☐ Y ☐N		Board Certified ☐Y ☐N	
	If not Board Certified, are you actively pursuing Board Certification:☐Y ☐ N			
	Malpractice Coverage:☐ Y ☐N Limits:		FTCA:☐Y ☐N	
	Malpractice Carrier:		Policy Number:	
	Are you a primary care physician? ☐Y ☐N		If Yes, are you accepting new members?☐Y ☐N	
	Maximum number of new members accepted:			
	Do you have age limits for practice? ☐Y ☐N		If Yes, what are the limits?	
NPI	Group/Billing NPI:		Individual NPI:	
Other IDs	**Medicaid #:**		**CAQH#:**	
	Eff. Date:			
	Medicare #:			
	Eff. Date:		Taxonomies:	
	DEA#:			Exp. date:
State License	State License#:	Date First issued:		Exp. date:

Hospital/Free Standing Surgery Facilities		☐Active ☐ Courtesy ☐ Delivery ☐Provisional
		☐Active ☐Courtesy ☐Delivery ☐Provisional
		☐Active ☐ Courtesy ☐Delivery ☐Provisional
		☐Active ☐Courtesy ☐Delivery ☐Provisional
	Indicate other Affiliations or names on a separate attached sheet	Hospital 3 Digit Code:
	Call Coverage Practice(s)/ Physician Name(s) (must be registered with Medicaid Entity, if applicable)**:**	

Primary Address (Main location where provider offers services)	Street:			Suite:
	City:	State:	Zip Code:	County:
	Phone:	Fax:	Toll Free Phone:	
	Email Address:			Handicap Accessible: ☐Y ☐N
	Office Hours: (list)			
	On bus route: ☐Y ☐N		Evening hours: ☐Y ☐N	Weekend hours: ☐Y ☐N
	Accommodate special needs patients: ☐Y ☐N			
Payment Info (This information must be the same as the W-9 information provided)	Group Information Address:	**Contract and remits will be mailed to this address unless otherwise specified**		
	Name:		Tax ID Number:	
	Street:			Suite:
	City:	State:	Zip Code:	County:
	Phone:	Fax:	Toll Free Phone:	
	Billing contact Name:		Billing Email:	
	(All correspondence, checks, remittance advices, contracts & credentialing information will be sent to this address)			

The completion of this form does not guarantee network participation. Please allow approximately [14] business days for Aetna Better Health to review and make the necessary changes.

I am _____of _____and authorized to submit this change request on behalf of _____. I affirm that all of the information on this form is accurate and complete to the best of my knowledge, information, and belief. I promise to keep confidential any information that Aetna Better Health shares with me during this process.

Authorized Signature: _____Date: _____/_____/_____

Please Do Not Write Below This Line – Aetna Better Health Representative Only –

☐ Specialist ☐ Dentist ☐ PCP* ☐ FP/OB* ☐ Allied Provider ☐ Aetna Better Health Secure Web Portal

☐ Request Approved by ND&C ☐ EFT

Please Remember: Site Visits and MRR are required for all PCP & OB Practitioners

Aetna Better Health Representative Signature: _____ Date: ____/_____/_____

Please mail to:

Aetna Better Health and Aetna Better Health Kids
Attention: Provider Relations
2000 Market Street, Suite 850
Philadelphia, PA 19103

Or fax completed form to 1-860-754-5435, Attention: Provider Relations