**Provider Credentialing Information/Request Form**

1. **Please submit this checklist to Aetna Better Health of Kentucky and attach all documents listed below:**

All pages of your signed contract, if applicable

Completed application

Provider Roster on Aetna provided spreadsheet, if applicable

Completed W9

Completed Ownership Information Form

1. **Please complete /update the following, but DO NOT submit with request form:**

**CAQH Online Application** must be current and complete, including:

* Application Attestation- less than 30 days old at time of request submission
* Section 2- Education and Training (all training must be completed prior to submitting request)
* Section 3- Professional/Medical Specialty Information
* Section 4- Practice Location Information (**must include Tax ID**)
* Current Licensure\*- including medical, DEA, CLIA (if applicable)- upload licensure in CAQH and update application attestation

\*providers with temporary or provisional licenses cannot be credentialed

* Current Malpractice Insurance- upload current certificate in CAQH and update application attestation

1. **Please submit all provider credentialing information to Aetna Better Health of Kentucky Provider Relations/Credentialing by email, fax or mail:**

**Email:** Please submit required documentation to your assigned Provider Relations Representative.

**Fax:** 1-855-454-5584

**Mail:** Aetna Better Health of Kentucky

Attn: Provider Relations/Credentialing

9900 Corporate Campus Drive, Suite 1000

Louisville, KY 40223

**Complete the information below and return to Aetna Better Health of Kentucky**

Practitioner’s Name (please print):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last First Title

Practitioner’s NPI:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Complete the information below and return all pages to Aetna Better Health of Kentucky

Practitioner’s Name (please print):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last First Title

Practitioner’s NPI \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section 1: Practitioner Demographics Information**

Practice Name \_\_Transformations hope for today’s families LLC\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Practice TIN \_\_\_61-1351752\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Practitioner Name (Last/First/MI\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Degree \_\_\_\_\_\_\_\_\_ SSN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_\_\_\_\_\_\_\_Practitioner NPI\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Location Address \_\_4010 Dupont Circle Suite 582\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State/Zip \_Louisville KY 40207\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone \_\_\_502-899-5411\_\_\_\_\_\_Fax\_\_502-899-5411\_\_\_\_\_\_\_\_E-mail\_transformationsllc@yahoo.com\_\_\_

* Additional Locations – please list additional addresses on separate page

**Section 2: Practitioner Credentialing Information**

CAQH #: ­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Kentucky State License #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Kentucky Medicaid #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Individual NPI: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group NPI: \_\_\_1427229483\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Federal Employer Identification #: \_\_\_\_\_\_61-1351752\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider Type (MD/DO/NP/PA/Other-Specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Specialty: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Taxonomy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Specialty: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Taxonomy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Specialty: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Taxonomy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you provide Obstetrical Care? Yes \_\_\_\_\_\_\_\_\_\_ No \_\_\_\_\_X\_\_\_\_\_\_\_

Do you provide Pediatric Care? Yes \_\_\_\_\_\_\_\_\_\_ No \_\_\_\_\_X\_\_\_\_\_\_\_

Provider is one of the following: PCC \_\_\_\_\_\_\_\_ FQHC \_\_\_\_\_\_\_\_RHC \_\_\_\_\_\_\_\_ Hospitalist \_\_\_\_\_\_\_

Provider is: Primary Care only \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If PCP, open or closed panel \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age Range: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Specialty Care only \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Facility \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Both Primary and Specialty Care \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Behavioral Health Substance Abuse Provider? Yes \_\_\_\_\_\_\_\_\_\_ No \_\_\_\_\_X\_\_\_\_\_\_

**Section 3: Billing Contact:**

X Check here if same as practice address

Billing Contact Name: \_\_\_\_Laura Krebs Lewis\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Billing Remit Name: \_\_\_\_\_Transformations\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Billing Address: \_4010 Dupont Circle Suite 582\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Billing Phone: \_\_502-899-5411\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Billing Fax: \_\_\_502-899-5411\_\_\_\_\_\_\_\_\_\_\_

**Section 4: Credentialing Contact:**

X Check here is same as practice address

Credentialing Contact Name: \_\_\_Teri Lloyd\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Credentialing Remit Name: \_\_\_\_\_Teri Lloyd\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Credentialing Address: \_4010 Dupont Circle Suite 582 Louisville KY 40207\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Credentialing Phone: \_502-905-9494\_\_\_\_\_\_\_\_\_\_ Billing Fax: \_\_\_\_502-899-5411\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section 4: Practitioner Choice for Communication from Aetna Better Health of Kentucky:**

Aetna Better Health of Kentucky communicates information to providers on a regular basis via fax or email, whatever the preference of the provider. Please indicate below if your office would rather receive these communications via fax or email.

* Fax

X Email

Please list the fax number or email address preferred:

Fax: \_\_\_\_502-899-5411\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_transformationsllc@yahoo.com\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_