Aetna Better Health® of Florida
1340 Concord Terrace
Sunrise, FL 33323

AETNA BETTER HEALTH® OF FLORIDA

Provider Nomination Form

Client/Requestor Name (if applicable) _____

*Physician First Name _____

*Physician Last Name _____

Provider CAQH Number (if applicable) _____

*Phone Number _____

*Email Address _____

*Address Line 1 _____

Address Line 2 _____

*City _____

Country _____

*State _____

*Zip Code _____

*Office Contact _____

Degree of Provider _____

*Specialty _____

Is the provider a member of a participating group practice? _____

Group Name (Required if the provider is a member of a group) _____

*Tax ID _____

*National Provider Identifier (NPI) _____

*Hospital Affiliation(s) _____

Additional Practice Locations _____

Please return via email to **FLMedicaidProviderRelations@aetna.com** or via fax to **1-844-235-1340**.