Aetna Better Health of Louisiana
Medicaid/CHIP

PROSPECTIVE PROVIDER FORM

Tax ID# _____Group NPI#_____

Organization / Provider Name: _____

PCP ☐ Specialist ☐ Facility ☐ Behavioral Health ☐

Practicing Specialty (Type of License): _____

Participating with Aetna in Commercial Network (HMO, PPO, POS)? Yes ☐ No ☐

Primary Service Location (Cannot be a PO Box):

Address_____ City_____ State_____ Zip_____

Parish: _____

Please list additional information, which may be of interest:

_____

_____

Contact Name: _____

E-Mail Address: _____

Contact Phone #: _____

Date: _____

Submit via email: MBU-LAProviderEnrollmentForm@aetna.com

Revised 6/18/2018
Created Date: 9/13/2016