Medical
Provider Nomination Form

If your Provider is not currently a part of Aetna Inc.'s network of doctors and you would like him/her to be considered, please follow the directions below.

1. Approach your provider and express your desire for him/her to become part of Aetna Inc.'s network.

2. The application process may take up to six months following receipt of your provider's information. Acceptance into the network is contingent upon successful completion of our credentialing process, provider acceptance of our contracts and provider practices at a location within our defined service area.

3. If you have any questions regarding the status of the application, please contact your provider directly.

PROVIDER INFORMATION: ***to be completed by nominated provider.***

Last Name:______________________________ **First Name:** ___________________________

Tax ID: _______________________ **Group:** ☐ **Individual:** ☐

Specialty:____

Degree:_________________________________

Practice Name:_________________________________ **Years in Practice:**_______________

Street Address:___________________________ **City:**_________________________________

State:_______________ **Zip Code:**_________________ **County:**________________________

Phone: (___)________________ **Office Manager:**______________________________________

Fax: _(___)___________________**E-mail:** ____

___________________ employees may nominate providers for participation in the network by having their provider submit this nomination form to the address listed below. A nomination by an employee does not guarantee that the provider will automatically be added to the network.

Provider: when completed, please return or fax this form to the following address:

Thea LaCouture
Aetna, Inc
Fax# 860-754-0884