Aetna Better Health of Texas
Provider/Group Application Data Form

You don't join us, we join you! We appreciate and thank you for your interest in allowing us to join you to serve all Aetna Better Health of Texas members. Please complete this data application accurately and correctly. Failure to provide all required data elements (identified by *) will result in delay in processing your application. If you prefer to fill this information in Microsoft Excel or if there are any questions, please email us at abhtxstarplus@aetna.com

- Complete Page 2 and 3 for each clinic location if Group has more than practice location
- Complete Page 4 and 5 for each provider

Group Information

Group Name*:

Doing Business As (DBA) *:

Group Tax ID*:

Group NPI/API*:

Group Specialty*:

Group TPI/API*:

Contact Name*:
Contact Email Address:
Contact Phone Number*:

Address*:

Group Physical Address*	Group Mailing Address*

Phone Number*:

Fax:

Website:

Practice Location Detail

Clinic Name*:

Clinic Primary Contact Name*:

Clinic Primary Contact Phone Number*:

Clinic Primary Contact Email Address:

Clinic Address*:

Clinic Phone Number*:

Clinic Fax Number:

Clinic Website Address:

Clinic offering non-English (including ASL) languages by qualified interpreters:

Spanish ☐	French ☐	German ☐	Vietnamese ☐
Arabic ☐	Cantonese ☐	Hindi ☐	Bengali ☐
Mandarin ☐	Japanese ☐	Korean ☐	Other:

Accessibility Options offered at this location:

Parking ☐	Wheelchair accessible ☐	Public Transit Access ☐
Accommodates Blind/Visually Impaired ☐	Accommodates Special Needs ☐	Accommodates Deaf/Hearing Impaired ☐
Adjustable Exam Table/Scale ☐	Exterior Building ☐	Interior Building ☐
Restroom ☐	Exam Rooms/Medical Equipment ☐	

Tele-services Offered:

Telehealth:	Y ◯	N ◯	Existing Patients Only: Y ◯	N ◯	Direct Telehealth Line:	
Telemedicine:	Y ◯	N ◯				
Telemonitoring:	Y ◯	N ◯				

Behavioral Health (BH) – Level of Care Provided for each Practice Location

(required for sites providing BH care)

Data Required	Clinic Name:	Clinic Name:	Clinic Name:
Clinic Street Address			
Psychiatric/Mental Health			
• Inpatient	☐	☐	☐
• Partial Hospitalization Program (PHP)	☐	☐	☐
• Intensive Outpatient Program (IOP)	☐	☐	☐
• Residential	☐	☐	☐
• Other			
Chemical Dependency, Substance Use			
• Inpatient	☐	☐	☐
• Partial Hospitalization Program (PHP)	☐	☐	☐
• Intensive Outpatient Program (IOP)	☐	☐	☐
• Residential	☐	☐	☐
• Other			

Practitioner Profile

Provider Last Name*:

Provider First Name*:

Provider Middle Initial*:

NPI/API Number*:

Date of Birth*:

Gender*: Male ◯ Female: ◯

Provider Ethnicity*:

White ◯	Black ◯	Hispanic ◯	Asian or Pacific Islander ◯
American Indian ◯	Other ◯	Not Provided	

Professional Designation*: MD ◯ DO ◯ NP ◯ PA ◯ Other (Please Specify):

Specialty*:

Subspecialty:

State License Number*:

Controlled Dangerous Substance (CDS) License Number:

Drug Enforcement Administration (DEA) Number:

CAQH Number*(if not available, mark N/A):

CLIA Number (if applicable):

Languages Spoken:

English ☐	Spanish ☐	German ☐	Vietnamese ☐
Arabic ☐	Cantonese ☐	Hindi ☐	Bengali ☐
Mandarin ☐	Japanese ☐	Korean ☐	Other:

Hospital Affiliation(s)/Admitting Privilege(s) (required if MD or DO/PCP):

Cultural Competency Trained: Y ◯ N ◯

Practitioner Information for each Clinic Site
Practitioner Name:

Data Required	Primary Clinic	Additional Clinic 1	Additional Clinic 2
Clinic Street Address			
TPI			
Texas EPSDT	YES ◯ NO ◯	YES ◯ NO ◯	YES ◯ NO ◯
PCP*	YES ◯ NO ◯	YES ◯ NO ◯	YES ◯ NO ◯
Accept New Patients (required for PCPs)	YES ◯ NO ◯	YES ◯ NO ◯	YES ◯ NO ◯
Panel Capacity (required for PCPs)			
Age Range	Minimum:	Minimum:	Minimum:
	Maximum:	Maximum:	Maximum:
Weekday Office Hours (Specify Hours)	Mon Tue Wed Thurs Fri	Mon Tue Wed Thurs Fri	Mon Tue Wed Thurs Fri
Weekend Office Hours (Specify Hours)	Sat Sun	Sat Sun	Sat Sun
After Hours	YES ◯ NO ◯	YES ◯ NO ◯	YES ◯ NO ◯
Include in Directory	YES ◯ NO ◯	YES ◯ NO ◯	YES ◯ NO ◯
Is the Provider hospital based	YES ◯ NO ◯	YES ◯ NO ◯	YES ◯ NO ◯

Certification

To the best of my knowledge, I hereby certify that the information provided above is accurate.

Signature*:

Name* Date*:

Designation*: