State of Alaska 866219
Aetna Provider Nomination Form

If your provider is not currently with Aetna, and you would like him/her to receive an application, please complete this form and return to us at the fax listed below.

Referring Member Name: _____

PROVIDER INFORMATION

Provider Last Name:_____ Provider First Name: _____

Group/Practice Name: _____

Tax Identification Number (if known): _____

Specialty: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Office Manager's name (if known): _____

Please Return completed Nomination Form To:

Aetna Network Management
600 University Street, Suite 920
Seattle, WA 98101
Fax 860-262-9619

NOTE: This Nomination Form does not guarantee a provider's participation in Aetna's network. Providers must successfully complete Aetna's credentialing process and sign an agreement (a contract) before becoming part of the Aetna network.