Aetna Better Health® of New Jersey Doula Application Screening Form

Please complete one per Doula in practice

Aetna Better Health of NJ contracting standards require that ***Aetna Better Health of NJ*** obtain personal information such as your name, address, and social security number. Personal information is maintained in contracting database at ***Aetna Better Health of NJ*** **for** in-house tracking, reporting purposes, contracting and payment of claims. Failure to complete all fields may delay the contracting process.

In order to be contracted, **you must:** have an individual NPI number and be registered with NJ State Medicaid in accordance with the **January 1, 2018, 21st Century Cures Act 114 P.L, 255,** Network providers are required to register with NJ State Medicaid program in order to be eligible to participate in Medicaid, submit claims electronically, have internet access and participate with all ***Aetna Better Health of New Jersey*** lines of business. *W-9 forms for each Doing Business As (dba) entity is required in order to establish/recognize all billing entities and/or the official Tax Identification Number (TIN) owner. Additionally, please note the establishment/recognition of multiple DBA/billing entities under one TIN require a unique billing NP/ for each DBA/business entity.*

Date _____

Provider Info	Last name	First name MI	Degree	Title
	Gender Male☐ Female☐	Date of birth	Social Security Number	Practice name
	Joining as Individual☐ Group☐		An Existing Group Yes ☐ No ☐	A New Provider ☐Yes No☐
	Other: Doula Location: Office Based			
	DBA name		Employment start date	
EDI and Internet	Electronic Claim Submissions ☐Yes No☐		Does business have internet access? ☐Yes No☐	
	If no to either, please explain.			
Practicing Specialties	Maximum number of new members accepted _____		Is provider accepting new members? ☐Yes No☐	
	Do you have age limits for practice? ☐Yes No ☐ If Yes, what are the limits?			
Administrative Contact for Health Plan Contact	Contact name		Email	
	Phone number		Fax number	

NPI:	Pay To NPI: that a Group own this number	Individual NPI: Only one person can own this number
Other ID's:	Medicaid number	CAQH number
	Effective date	

	Medicare number (if you have one)			
	Effective date	Taxonomies		
State License:	State License number	Date First issued	Exp date	
Language and Culture	Language(s) spoken other than English			
	Primary	Secondary		
	Cultural Heritage	Completed Cultural Competence Training ☐ Yes No ☐		
	Asian ☐ African ☐ American/Black ☐ Hispanic/Latino ☐ Caucasian/White ☐ Native American ☐ Pacific Islander ☐ Other ☐			
	Is this a: Minority ☐ Female ☐ Disable person owned business ☐ None of the previous ☐			
Primary (Main location where provider offers services)	Street			Suite
	City	State	ZIP code	County
	Phone	Fax	Toll Free phone	
	Email address			Handicap Accessible Yes ☐ No ☐
	Office hours (list)			
	Experience treating AIDS/HIV ☐ Mental Illness ☐ ESRD ☐ Co-occurring disorders ☐ Visual Impairment ☐			
	Is office located on public transportation route? Bus ☐ Rail ☐	Evening hours ☐ Yes No ☐	Weekend hours ☐ Yes ☐ No	
	Accommodate special needs patients: Developmentally Disabled ☐ Yes No ☐	Physically Disabled ☐ Yes No ☐		
	Services offered to the deaf / hearing impaired (check) Sign language ☐ TTD/TTY ☐	Language interpreters		
Additional Office (if applicable)	Street			Suite
	City	State	ZIP code	County
Indicated other offices on separate sheet	Phone	Fax	Toll Free phone	
	Email Address			Handicap Accessible ☐ Yes No ☐
	Office hours (list)			
	Is office located on public transportation route? Bus ☐ Rail ☐	Evening hours ☐ Yes No ☐	Weekend hours Yes ☐ No ☐	
	Accommodate special needs patients: Developmentally Disabled ☐ Yes No ☐	Physically Disabled ☐ Yes No ☐		
	Services offered to the deaf/ hearing impaired (check) Sign language ☐ TTD/TTY ☐	Language interpreters		

<table>
<tr><td>Payment Info</td><td colspan="3">Pay to Information Address:</td><td>Contract will be mailed to this address unless otherwise specified</td></tr>
<tr><td rowspan="6">This information must be the same as the W-9 information provided</td><td colspan="2">Name</td><td colspan="2">Tax ID Number</td></tr>
<tr><td colspan="3">Street</td><td>Suite</td></tr>
<tr><td>City</td><td>State</td><td>ZIP code</td><td>County</td></tr>
<tr><td>Phone</td><td>Fax</td><td colspan="2">Toll Free phone</td></tr>
<tr><td colspan="2">Billing contact name</td><td colspan="2">Billing email</td></tr>
<tr><td colspan="4">(All correspondence, checks, remits, contracts & credentialing info will be sent to this address)</td></tr>
</table>

The completion of this form does not guarantee network participation. Please allow approximately 20 business days to evaluate the application and allow Aetna Better Health of NJ to verify a CAQH application has been completed.

I am _____ of _____ and authorized to submit this application on behalf of _____. I affirm that all of the information on this form is accurate and complete to the best of my knowledge, information, and belief. I Promise to keep confidential any information that Aetna Better Health shares with me during this process.

Authorized Signature:_____ **Date:**_____

Please email, mail, or fax completed form to the attention of Kim Lees, Network Development

Email: AetnaDoulaProgram@Aetna.com

Fax number: 959-282-8627