AETNA BETTER HEALTH OF NEW JERSEY PROVIDER SPOT CHECK QUESTIONNAIRE

Network Providers are asked to complete the below questionnaire about their practice including general information (name, address, telephone number, etc.), to confirm the accuracy of the information Aetna Better Health of New Jersey has on file about this practice. Please complete and email or fax the complete questionnaire to: AetnaBetterHealth-NJ-ProviderServices@Aetna.com /1-844-219-0223

Please enter the information indicated below:

Office Information	PLEASE PRINT CLEARLY			
Administrative Contact (Office Manager's Contact)	Contact Name: _____	Email: _____		
	Phone Number: ( ) -	Fax Number: ( ) -		
	Name of Practice:			
Aetna Better Health of New Jersey Participating Provider (circle): Y N	Number of Providers at Practice: _____			
	Street:	Suite:		
	City:	State:	Zip:	County:

Please complete the "Individual Provider Information" questionnaire below for each provider contracted within the practice.

Individual Provider Information	PLEASE PRINT CLEARLY				
Provider Info:	Last Name:	First Name:	MI:	Degree:	
	Gender (circle): M☐ F☐	Accepting New Patients (circle): Y☐ N☐	Age Restriction (circle): Y☐ N☐ If yes, please note: _____	Open Panel (circle): Y☐ N☐	Number of patients: Please list: _____
	Primary Care Provider (circle): Y☐ N☐ If no, please note specialty: _____		Individual NPI#: _____		Group NPI #: _____
	NJ State License #: _____	Medicaid ID #: _____	Taxonomy Code: _____		
	Languages Spoken Please List: _____				

Main location where provider offers services:	Street:			Suite:
	City:	State:	Zip:	County:
	Phone: ( ) -	Fax: ( ) -	Toll Free Phone: ( ) -	
	Email Address: _____		Participating Provider (circle) Y ☐ N ☐	
	Office Hours: Monday – Tuesday – Wednesday- Thursday – Friday -		Weekend hours: Saturday – Sunday -	
	Handicap Accessible (circle): Y ☐ N ☐	Accommodate special needs patients (circle): Developmentally Disabled: Y ☐ N ☐ Aged: Y ☐ N ☐ HIV and/or AIDS: Y ☐ N ☐		
	Physically Disabled (circle): Y ☐ N ☐		Services offered to the deaf / hearing impaired (circle): sign language ☐ ☐ TTD/TTY	
	Adjustable exam table (circle): Y ☐ N ☐		Hospital Affiliation: Please list: _____	

The person signing this questionnaire warrants that he or she has fully authority to do so and the signature below confirms that the information provided is accurate.

*****IMPORTANT NOTE***** *In order for Aetna Better Health of New Jersey to update our Business Application with the information above, please include along with the Questionnaire, an authorization letter (on company letter head) stating that you'r*e authorizing us to update your demographic information. If you fail to send the authorization letter, we will not be able to update our application.

_____ _____

Signature **Date of Completion**