CENTER CARE®

REQUEST FOR PROVIDER UPDATE

Provider Name		Individual NPI		Tax ID of Group Requesting Change	
Will provider be seeking enrollment with Aetna Better Health of Kentucky?				☐Yes ☐No	
If Yes, Center Care provides credentialing services for Aetna Better Health of Kentucky and will notify Aetna upon completion of provider's credentialing, if applicable.					

REASON FOR SUBMISSION

(select all that apply)

Add	Group Changes	Term
☐ Add Billing Address	☐ Change Billing Address	☐ Term Group
☐ Add Billing Fax #	☐ Change Billing Fax #	☐ Term Location
☐ Add Billing Phone #	☐ Change Billing Phone #	☐ Term Provider
☐ Add Physical Location Address	☐ Change Group Name	**Provider Demographic Changes** (or corrections)
☐ Add Physical Location Fax #	☐ Change Location Address	☐ Change Name: ☐ Last ☐First ☐Middle
☐ Add Physical Location Phone #	☐ Change Location Fax #	☐ Change Individual NPI
☐ Add Correspondence Address	☐ Change Location Phone #	**Individual or Group-Level Change**
	☐ Change TIN	☐ Change applies to this provider only
	☐ Change Group NPI	☐ Change (or info) applies to entire group

☐ Other/Notes (If group or address is to be termed, please indicate term info here) (See also change section below)	Eff Date of Change

NEW ADDRESS INFORMATION

Address Type	If provider does not accept patient appointments at location, please indicate as "Covering Only" or Hospital-based ("HB"), as applicable. Hospital-based (HB) and Covering Only locations will be suppressed from directory.

☐ Primary Office ☐ Alternate Office ☐ Covering Only ☐ Billing Address ☐ HB Address ☐ Correspondence Address

Group Name			TIN
Address Line 1		**Address Line 2**	
City	**State**	**Zip**	**Group NPI**

Phone	Fax	If location is not primary care, list scope of practice	Ages Seen

Is provider at location at least 16 hrs per week? ☐Yes ☐No Can patients schedule appointments with provider at this location? ☐Yes ☐No	Medicaid & Medicare Panels (PCPs only) ☐N/A (Optional) Panel Max# *Is panel open or closed for Medicaid?* ☐Open ☐Closed *Is panel open or closed for Medicare?* ☐Open ☐Closed

Office Hours								Location Accessibility Information ☐N/A (billing/correspondence)
	MON	*TUE*	*WED*	*THU*	*FRI*	*SAT*	*SUN*	
Start:								*Does this site offer handicapped access?* ☐Yes ☐No
End:								*Does this site offer Text Telephony (TTY)?* ☐Yes ☐No
								Is this site accessible by bus? ☐Yes ☐No

Supervising Physician (NP/PA only)	Supv Phys Specialty	Lab Services provided?	CLIA Number ☐N/A	CLIA Expiration
		☐Yes ☐No		

CHANGE INFORMATION

CHANGE PROVIDER NAME		**CHANGE NPI** ☐Individual ☐Group	
Previous Name	New Name	Previous NPI	New NPI
CHANGE TIN		**CHANGE ☐ PHONE ☐ FAX ☐ LOCATION ☐ BILLING** **(indicate applicable location in address section below – address Line 1 only)**	
Previous TIN	New TIN	Previous Number	New Number
CHANGE GROUP NAME AND/OR ADDRESS		**Change is for Address:**	
Previous Group Name		New Group Name	
Previous Address		New Address	

CONTACT PERSON	**Phone**	**Email**