

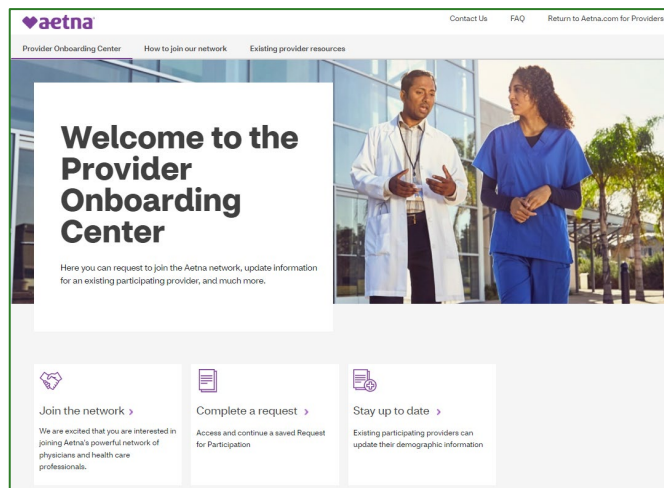


Provider Onboarding Center at Aetna.com

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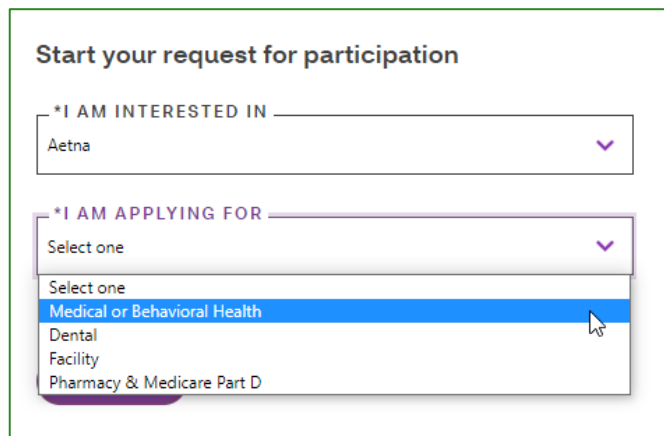
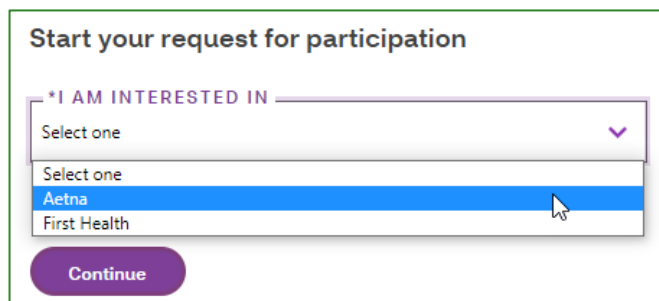
Provider Onboarding Center (POC)



Aetna’s new strategic platform that centralizes onboarding operations to complete the following.

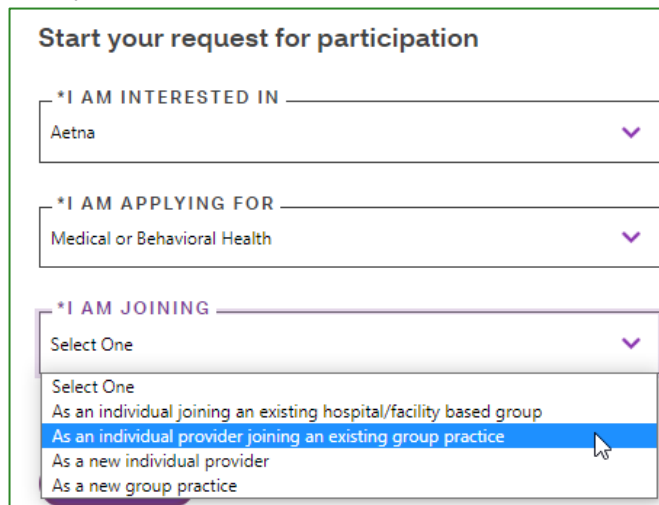
- Requesting credentialing
- Update demographics
- Get Contracted. Non-participating providers can request to join our network.

To start your request, select that you are interested in “Aetna”. This is true even for the Allina Health Aetna plan.



The POC only supports Medical and BH products. You are required to select a product that your applying for. If the user selects “Medical or Behavioral Health”, they will continue within the POC. If the users select any other product, they will be re-routed to the appropriate page outside the POC, but still within the Aetna website.

The POC only supports Medical and BH products. You are required to select a product that your applying for. If the user selects “Medical or Behavioral Health”, they will continue within the POC. If the users select any other product, they will be re-routed to the appropriate page outside the POC, but still within the Aetna website.



As an existing contracted provider, you should select that you are joining “As an individual provider joining an existing group practice”.

Then click on the “Continue” button after you have reviewed the list of what you need to get started.



New Practitioner Hospitalist

Fax a letter to 1-859-455-8650

Hospital based providers:

If you are joining an already contracted hospital-based group, you do not need to complete the Request for Participation.

Have your group administrator fax a letter to 1-859-455-8650 with details including:

- Provider Name
- Phone number(s)
- Billing location
- NPI
- TIN
- Group Name
- DOB
- Servicing Location(s)

Complete the Request for Participation if you are interested in contracting as a non-hospital-based or office-based provider type.

Request for Participation (RFP) Process



When completing a Request for Participation in the POC, a submitter will move through a series of web forms (see diagram) to provide the necessary information to complete an application.

At various points in the application process, the POC will check the information submitted against internal Aetna data in real-time to tailor the application process to the user’s scenario (see gray lines above).

Submitter Information

When starting a new Request for Participation, the submitter must enter general contact information, including Last Name, First Name, Role (optional), Email, Phone Number, and Fax Number. Communications regarding the status of the application will be sent to the email address provided. You now also have the ability to add a secondary contact in this section. The form notifies users that the secondary email will only be used for application communications if the primary email returns an “undelivered” response.

Request for Participation

Welcome, please indicate if you are starting a new Request for Participation or retrieving a Request for Participation. All fields marked with an asterisk (*) are required. If any of the information is incorrect or missing, please manually update.

* SELECT ONE

New Request for Participation

Retrieve Request for Participation

PLEASE ENTER THE CONTACT INFORMATION FOR WHO IS SUBMITTING THIS REQUEST FOR PARTICIPATION FOR THE PROVIDER:

* LAST NAME Last Name	* FIRST NAME First Name
ROLE Ex. Medical Office Manager	
* SUBMITTER EMAIL example@sample.com	* VERIFY SUBMITTER EMAIL example@sample.com

Please ensure this email is correct as we will email your Request ID to the email provided, when applicable.

* PHONE NUMBER 000-000-0000	EXT	* FAX NUMBER 000-000-0000
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Secondary Contact X Remove

This secondary email will only be used in the event that the submitter email fails.

LAST NAME Last Name	FIRST NAME First Name
ROLE Ex. Medical Office Manager	
SECONDARY CONTACT EMAIL example@sample.com	VERIFY SECONDARY CONTACT EMAIL example@sample.com

Network Participation Check

*** I AM INTERESTED IN JOINING THE AETNA NETWORK AS:**

Select an option

*** SELECT THE SITUATION THAT IS APPLICABLE TO YOU**

Select an option

*** WHAT STATE ARE YOU APPLYING TO?**

Minnesota

IMPORTANT: The state you selected cannot be changed once you click "Continue" and proceed beyond this page.

*** PRIMARY LOCATION ZIP CODE** 55386 - *** 4 EXT** Ex. 0000

Enter the primary service location ZIP code in the state you are applying to

*** MINNESOTA APPLICANTS:**
ARE YOU APPLYING FOR THE ALLINA HEALTH | AETNA JOINT VENTURE NETWORK?

Yes No

Network Check

Once the submitter completes the first page of the form, they will proceed to the “Network Check” page of the application, which includes two sections, the “Network Participation Check” and the “Tax ID and NPI Information”. Network Participation Check

In first section of the “Network Check” page, a submitter must complete the “Network Participation Check” questions. This portion of the Request for Participation collects information about how the provider wants to be added to the Aetna Network and the state and zip code the provider is applying to.

Network Participation Check

More than likely as an existing contracted provider, you will be selecting the “A solo practitioner joining an existing group that participates with Aetna” or Allina Health | Aetna.

Network Participation Check

*** I AM INTERESTED IN JOINING THE AETNA NETWORK AS:**

Select an option

- Select an option
- A solo practitioner joining an existing group that participates with Aetna
- A solo practitioner wanting to participate with Aetna
- A new group wanting to participate with Aetna
- A provider in a participating group wanting to start a solo practice

* SELECT THE SITUATION THAT IS APPLICABLE TO YOU

Select an option

Select an option

- I want to be contracted in the state selected below
- I am participating in one or more state(s) and want to be contracted in the additional state selected below
- I want to end participation in my current state and be contracted in the new state selected below

The “Minnesota Applicants” question will only appear when the submitter enters a Minnesota zip code.

NOTE: If applying for Allina Health | Aetna network, be sure to answer the question with “YES” following the selection of the state of Minnesota.

For “Select the situation that is applicable to you”, you will most likely be using the “I want to be contracted in the state selected below”

* WHAT STATE ARE YOU APPLYING TO?

Minnesota

IMPORTANT: The state you selected cannot be changed once you click “Continue” and proceed beyond this page.

* PRIMARY LOCATION ZIP CODE ———— + 4 EXT

55386 ———— Ex. 0000

Enter the primary service location ZIP code in the state you are applying to

* MINNESOTA APPLICANTS:
ARE YOU APPLYING FOR THE ALLINA HEALTH | AETNA JOINT VENTURE NETWORK?

Yes No

Tax ID & NPI Information section

- If the TIN is not found, the following question will be shown in a pop-up window: “Is your TIN a group or individual Tax ID?”
- If the NPI is not found or displays as non-par in Allina Health | Aetna Provider Database, the following question will be shown in a pop-up window: “I am joining as a:
 - Option 1) Medical Professional,
 - Option 2) Behavioral Health Professional”.
- If the TIN is not found and the NPI is non-par, both previous questions will appear.

Tax ID and NPI Information

* TAX ID TYPE ————
What tax ID type are you applying under?

* WHAT TAX ID ARE YOU APPLYING UNDER? ———— * VERIFY TAX ID ————
XXXXXXXX1234 XXXXXXX1234

SSN is not applicable if joining a group. Please use the group's tax ID if you are joining a participating group or as a new group.

* TAX ID NAME ————
Name of Tax ID owner

* INDIVIDUAL TYPE 1 NPI # ———— * PROVIDER NAME ————
(Do not enter spaces (ex. 12345678)) Last Name, First Name

* PLEASE VERIFY THAT THE ABOVE INFORMATION IS CORRECT. ONCE YOU SELECT “CONTINUE,” THE INFORMATION CANNOT BE UPDATED.

I agree the above information is correct.

Go Back Exit Continue

Please answer the following questions to help us direct you.

You entered the following TIN: XXXXX1234

* IS YOUR TIN A GROUP OR INDIVIDUAL TAX ID?

Group Individual

* I AM JOINING AS A:

Medical Professional (PCP, Specialist, Midlevel) Behavioral Health Professional

Go Back Continue

Please answer the following questions to help us direct you.

You entered the following TIN: XXXXX1234

PLEASE SELECT ALL THAT APPLY:

- Are you replacing your current participating Tax ID with another Tax ID?
- Are you adding a new Tax ID in addition to an existing participating Tax ID?
- Are you making demographic updates (for example: change of address, accepting patients)?
- Are you terminating your participation with Aetna (for example: moving to new state, retiring)?
- None of the above apply

Go Back

Continue

If the submitter selects “None of the above apply”, they will proceed with the application process as usual. If the user selects any other option, they will be directed to the “Existing Provider Resources” site, which provides instructions on how to update information for an existing par provider or terminate participation.

Specialty Details

* DEGREE TYPE

* PRIMARY SPECIALTY

⚙ Degree acronym definitions

* PROVIDER ROLE

Primary Care Physician (PCP) Specialist

* PLEASE VERIFY THAT THE ABOVE INFORMATION IS CORRECT. ONCE YOU SELECT "CONTINUE," THE INFORMATION CANNOT BE UPDATED.

I agree the above information is correct.

Go Back Save and Exit Continue

Specialty Details

Once the RFP has been assigned a Request ID, the submitter will complete the “Specialty Details” portion of the application. This page of the form collects information, like “Degree Type” and “Specialty” that will enable the POC to check the panel status in real time.

Please inform your Allina Health | Aetna contacts if you receive a denial for capacity. Or resubmit the application and make sure you select “Yes” to applying for the Allina Health | Aetna Joint Venture Network.

Request for Participation

Thank you for your interest in becoming a participating provider with Aetna.

We regret to inform you that the network in your area is currently at capacity, and we are not accepting new providers in your field of practice at this time. We have sent an email with this information to example@sample.com.

Again, thank you for your interest in Aetna.

Return to Aetna.com For Providers

Credentialing with CAQH

Aetna uses the Council for Affordable Quality Healthcare Proview® (CAQH) application to collect the data required for our credentialing and recredentialing processes. The credentialing process cannot begin until your CAQH ProView application is in “Reattestation” or “Initial Application Complete” status and Aetna is designated as an authorized health plan to access your information. To avoid delays in your participation, please visit the CAQH website to ensure these prerequisites are met.

You can save your Aetna Request for Participation and retrieve it with your Request ID, Tax ID and NPI to complete the application.

Go to CAQH ProView

Acknowledge and Continue

When applicable, a pop-up will appear with information around Aetna’s credentialing process through CAQH. The submitter must acknowledge that their CAQH ProView application needs to be in “Reattestation” or “Initial Application Complete” status with Aetna as an authorized health plan to allow for credentialing.

If you MCC/CredSmart, please select “Acknowledge and Continue”

Contact Information


Please fill out all the information that is required

Practitioner Information		
* LAST NAME <small>Last Name</small>	* FIRST NAME <small>First Name</small>	
MIDDLE INITIAL <small>Middle Initial</small>	* DATE OF BIRTH <small>MM/DD/YYYY</small>	
* STATE MEDICAL LICENSE WAS ISSUED <small>Select a state</small>	* MEDICAL LICENSE NUMBER	
INDIVIDUAL CACH PROVIDER ID <small>Do not enter spaces (ex. 12345678)</small>		
Contracting Information		
* WHO IS THE CONTACT PERSON FOR CONTRACTING?		
<input type="radio"/> Submitter	<input type="radio"/> Practitioner	<input checked="" type="radio"/> New contact person
* LAST NAME <small>Last Name</small>	* FIRST NAME <small>First Name</small>	
* EMAIL <small>example@sample.com</small>	* VERIFY EMAIL <small>example@sample.com</small>	
* PHONE NUMBER <small>000-000-0000</small>	EXT	* FAX NUMBER <small>000-000-0000</small>
* PREFERRED CONTACT METHODS		
<input type="checkbox"/> Email	<input type="checkbox"/> Phone	<input type="checkbox"/> Fax
* PREFERRED CONTACT DAYS AND TIMES		
<small>Standard contact days and times are Monday through Friday from 8am to 7pm Eastern Time (ET).</small>		
* SELECT DAYS AND TIMES		

Request ID

You will be assigned that request ID number that you can use when calling the credentialing call center about the status of your request. This request ID will also be sent to the submitter via email.

Credentialing Customer Care:
1-800-353-1232

Your Request for Participation has been submitted.	
	
Your Request ID is 	
What's next?	
If you have not heard back from us within 60 days, please call 1-800-353-1232. Provide your Request ID to assist in locating your submission.	
While you wait, you can learn more about becoming a part of Aetna's network by visiting our Provider Education and Manuals Page .	