Aetna Signature Administrators℠

Request For Application

Please do not include attachments at this time.

Please print legibly inside the boxes provided.

Practitioner Information:

Last Name:		First Name:	MI:
Date of Birth (mm/dd/yyyy):	Type of Degree:	Specialty in which you are applying:	
Applying as: ☐ Primary Care Physician (PCP) ☐ Specialist ☐ Other Health Professional (Occupational Therapist, Physical Therapist etc.).			
Medical License Number:		State in which Medical License is issued:	
Tax Identification Number (if joining an Aetna participating group, please use the group's Tax ID to associate the request with the participating group):			
Are you registered with CAQH? ☐ Yes ☐ No		List your CAQH Identification Number:	

Service Location Information:

Service Location Street:				
Suite:	City:	State:	County:	Zip Code:
Service Location Phone Number:		Service Location Fax Number:		
Email Address:				
Practice/Group Name:				

Mailing Address Information: Complete ONLY if Mailing Address is different from the Service Location Address

Mailing Address Street:			
Suite:	City:	State:	Zip Code:

Hospital Affiliation Information:

Hospital Name:	Usage %:
Hospital Name:	Usage %:
Hospital Name:	Usage %:

Note: As a practitioner, you have the right to correct discrepant or erroneous information by working directly with any reporting entities used during the credentialing process.