



## Physician Nomination Form

If your provider is not currently with **Aetna**, and you would like him/her to be considered, please have your physician complete this form and return to us at the address or fax number listed below. Aetna will then send an application packet to the physician (provider). The application process takes approximately 12 weeks.

**Please note that this is only a Nomination Form. Providers must complete a full application, sign an agreement form and successfully complete Aetna’s credentialing process before becoming part of the Aetna network. Therefore, a nomination does not guarantee providers will be automatically added to Aetna’s network.**

Referring Member’s Name: \_\_\_\_\_

### PROVIDER INFORMATION:

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Tax ID #: \_\_\_\_\_ Practice Name: \_\_\_\_\_

Speciality: \_\_\_\_\_ Degree: \_\_\_\_\_ Years in Practice: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Office Manager: \_\_\_\_\_

### **Hospital Affiliations:**

Facility: \_\_\_\_\_

Facility: \_\_\_\_\_

Facility: \_\_\_\_\_

**For the Provider to receive a complete application packet,  
please return this completed form to:**

**Aetna  
Attn. National Accounts Division – McClatchy Team  
One Front Street, Suite 600  
San Francisco, CA 94111**

**Or via fax to:  
(860) 975-0347**