



Physician Nomination Form

If your provider is not currently with **Aetna**, and you would like him/her to be considered for our network, please have your physician complete this form and return to us at the address or fax number listed below. We 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 our network.

Referring Member Name: _____

PROVIDER INFORMATION

Last Name: _____ First Name: _____

Tax ID #: _____

Specialty: _____ Degree: _____

Practice Name: _____

Years in Practice: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Office Mgr: _____

Hospital Affiliations:

Facility: _____

Facility: _____

Facility: _____

To Providers:

For a complete application packet, please return this form to:

**Aetna
Attn: King County Account Team
601 Union Street, Suite 810
Seattle, WA 98101
Fax: 866-434-7660**