Intent to Use a Substitute Provider

Instructions
Complete this form, and fax it to Aetna at 1-860-262-9619 (telephone: 1-800-720-4009).

1. Contracted Provider Information

Name	
Aetna PIN (if known)	Tax ID number
Address	
Telephone	Fax
Office manager's name	

2. Substitute Provider Information

Name	
Aetna PIN (if known)	Tax ID number
Address	
Telephone	Fax
Office manager's name	Is the substitute provider contracted with Aetna? ☐ Yes ☐ No

3. Reason for Use of Substitute Provider

☐ Military service ☐ Illness ☐ Parental leave
☐ Continuing medical education ☐ Vacation ☐ Other (please explain) ______________________________

4. Length of Time Substitute Is Needed

Start date of substitution	Planned end date of substitution*

*NOTE: If substitution end date needs to be extended beyond the planned end date, please submit a revision to this form at least 10 business days in advance for Aetna's review/acceptance of the extension.

5. Provider Signature

Contracted provider signature	Date
Printed name	

6. Aetna Signatures

☐ Accepted ☐ Rejected	Medical Director signature	Date
	Printed name	
Change (if form was revised)* ☐ Accepted ☐ Rejected	Medical Director signature	Date
	Printed name	