



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: _____

Specialty: _____ 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) 975-9114**