aetna

SPECIAL NEEDS PROVIDER SURVEY FORM

(*Please complete all blank fields*)

Name: _____ **Specialty:** _____
Address: _____ **City, State Zip:** _____
E-Mail: _____ **Phone:** _____

1. Please indicate *"Yes"* or *"NO"* with regard to which category of patients you currently treat in your practice:

Aged	☐ Yes	☐ No
Disabled (including Blind)	☐ Yes	☐ No
Division of Developmental Disabilities (DDD)	☐ Yes	☐ No
HIV+/AIDS:	☐ Yes	☐ No
Other	_____	

a. If you answered "Yes" to any of the above, please indicate your qualifications, including formal training and/or experience, to treat adults/children with special needs:

2. Are you willing to serve as a PCP and/or Specialist to members with special needs? *(Check all that apply)*

	Ages 0-21	Ages 21-65	Ages 65 & older
☐ I am a Primary Care Provider willing to serve as a PCP to members with Special Needs*	☐	☐	☐
☐ I am a Specialist willing to serve as a PCP to members with Special Needs*	☐	☐	☐
☐ I am a Specialist willing to serve as a Specialist to members with Special Needs*	☐	☐	☐
☐ I am NOT willing to serve as a PCP/Specialist to members with Special Needs	☐	☐	☐

**Medical Management may contact you to assist in care of our Special Needs members*

3. If you are willing to provide services to Aetna Better Health New Jersey Special Needs members, please check the category of members you are willing to see: *(check all that apply)*

☐ Aged, Blind and Disabled (ABD)
☐ Developmental Disabilities (DDD)
☐ HIV+/AIDS
☐ I do not wish to be listed as a Special Needs Provider

4. Appointment Availability *(Check all that apply)*

Appointment Instructions: ☐ Appointment Only ☐ Appointment & Walk In ☐ Walk in Only
After hours Coverage: ☐ Answering Service ☐ Answering Machine ☐ Other _____

5. Does the office meet ADA Accessibility requirements?* ☐ Yes ☐ No

Does the site offer handicapped access for the following? ☐ Yes ☐ No
Building? ☐ Yes ☐ No
Parking? ☐ Yes ☐ No
Restroom? ☐ Yes ☐ No

Does the site offer other services for the disabled? ☐ Yes ☐ No
Text Telephony (TTY) ☐ Yes ☐ No
American Sign Language ☐ Yes ☐ No
Mental/Physical Impairment Services ☐ Yes ☐ No

Accessible by public transportation? ☐ Yes ☐ No
Bus ☐ Yes ☐ No
Subway ☐ Yes ☐ No
Regional Train ☐ Yes ☐ No

Provider Printed Name: _____
Provider Signature or Designee: _____
Date: _____

Please complete and return to your Provider Liaison or to COEProviderServices@Aetna.com