Aetna Better Health® of Maryland
Participating Provider Quick Reference Guide

This guide is intended to be used for quick reference and may not contain all of the necessary information. For detailed information, refer to the Aetna Better Health of Maryland provider manual located at **AetnaBetterHealth.com/Maryland**.

Eligibility verification
Please contact us at **1-866-827-2710** or log into our Secure Web Portal to verify eligibility.

Tools & Resources
Website
- Provider manual
- Member handbook
- Availity Provider Portal (*See below for full details)*
- Clinical guidelines
- Forms
- Provider education

Availity Provider Portal
The Availity Portal offers secure online access to multiple health plans, and the ability to manage business transactions through a single, easy to use site. Providers already registered with Availity can log in with your regular credentials and choose Aetna Better Health of Maryland from your list of payers. Availity features include:
- Member Eligibility Search
- Panel Roster – View the list of members currently assigned to the provider as the PCP
- Provider List
- Submission of verification of prior authorization request, including status checks

- Claims Status Search
- Remittance Advice Search
- Submit an appeal or payment dispute
- Claims Dispute Form
- View Claim Dispute Form through EDI

Claims
Claim inquires
Participating providers may review the status of a claim by checking Availity or by calling our Claims Investigation and Research Department (CICR) at **1-866-827-2710**.

Claims and resubmissions
We require clean claims submissions for processing. To submit a clean claim, the participating provider must submit:
- Member's name
- Member's date of birth
- Member's identification number
- Service/admission date
- Location of treatment
- Service or procedure

Participating providers are required to submit valid, current HIPAA compliant codes that most accurately identify the member's condition or service(s) rendered.

Please note:
- Claims must be submitted within 180 days from the date of services. The claim will be denied if not received within the required timeframes.
- Corrected claims must be submitted within 180 days from the date of service.

Electronic claims submission

We encourages participating providers to electronically submit claims through Change Healthcare (formerly Emdeon). Please use the following Payor ID when submitting claims to Aetna Better Health of Maryland **– Payor ID# 128MD.**

For electronic resubmissions, participating providers must submit a frequency code of 7 or 8. Any claims with a frequency code of 5 will not be paid.

Paper claims submissions and/or resubmissions

Please use the following address when submitting paper claims us:

> Aetna Better Health of Maryland
> P.O. Box 982968
> El Paso, TX 79998-2968

For resubmissions, please stamp or write one of the following on the paper claims: Resubmission, Rebill, Corrected Bill, Corrected or Rebilling

Online claim status through Availity

We encourage providers to take advantage of using Availity provider portal, as it is quick, convenient and can be used to determine status (and receipt of claims) for multiple claims, paper and electronic. Please see Chapter 4 of the provider manual for additional details surrounding the Availity provider portal.

Claim resubmission

Providers may resubmit a claim that:

- Was originally denied because of missing documentation, incorrect coding, etc.
- Was incorrectly paid or denied because of processing errors

Include the following information when filing a resubmission:

- Use the resubmission form located on our website.
- An updated copy of the claim. All lines must be rebilled. A copy of the original claim (reprint or copy is acceptable).
- A copy of the remittance advice on which the claim was denied or incorrectly paid.
- Any additional documentation required.
- A brief note describing requested correction.
- Clearly label as "Resubmission" at the top of the claim in black ink and mail to appropriate claims address.

Resubmissions may not be submitted electronically. Failure to mail and accurately label the resubmission to the correct address will cause the claim to be denied as a duplicate.

Please note: Providers will receive an EOB when their disputed claim has been processed.

Providers may call our CICR Department during regular office hours to speak with a representative about their claim dispute. The CICR Department will be able to verbally acknowledge receipt of the resubmission, reconsideration and or the claim dispute. Our staff will be able to discuss, answer questions, and provide details about status.

Providers can review Availity to check the status of a resubmitted/reprocessed and or adjusted claim. These claims will be noted as "Paid" in the portal.

Prior Authorizations
How to request prior authorizations

A prior authorization request may be submitted by:

- Submitting the request through Availity.
- Fax the request form (form is available on our website). Please use a cover sheet with the practice's correct phone and fax numbers to safeguard the protected health information and facilitate processing.
- Through our toll-free fax number - **1-855-661-1695**

To check the status of a prior authorization you submitted or to confirm that we received the

request, visit Availity or call us at **1-866-827-2710**. Availity will allow you to check status, view history, and or email a case manager for further clarification if needed.

For further information about Availity, please review chapter 4 of the provider manual. If response for non-emergency prior authorization is not received within 15 days, please contact us at **1-866-827-2710.**

Requesting Prior Authorization

When requesting prior authorization, please provide the following:
- Member's identification number
- Demographic information
- Requesting provider contact information
- Clinical notes/explanation of medical necessity
- Other treatments that have been tried
- Diagnosis and procedure codes
- Date(s) of service (DOS)

Important note:
- Emergency services do not require prior authorization; however, notification is required the same day.
- For post stabilization services, hospitals may request prior authorization by calling **1-866-827-2710.**
- All out of network services must be authorized.
- Unauthorized services will not be reimbursed and authorizations are not a guarantee of payment.

Decision/Notification Requirements

Decision	Decision/Notification
Urgent pre-service approval	Forty-eight (48) hours or two business days from receipt of request not to exceed seven (7) days
Urgent pre-service denial	Twenty-four (24) hours from the date of determination for emergency, medically related requests
Non-urgent pre-service approval	Seven (7) calendar days from receipt of the request
Non-urgent pre-service denial	Seventy-two (72) hours from the date of the determination
Urgent concurrent approval	Twenty-four (24) hours of receipt of request
Urgent concurrent denial	Twenty-four (24) hours of receipt of request
Post-service approval	Thirty (30) calendar days from receipt of the request
Post-service denial	Thirty (30) calendar days from receipt of the request
Termination, Suspension Reduction of Prior Authorization	At least ten (10) calendar days before the date of the action.

Online Provider/Pharmacy Search Tool

For a list of participating providers, including behavioral health, please access our online search tool located on
AetnaBetterHealth.com/Maryland

Please note: Laboratories and radiology participating providers are included in the online search tool.

Sample ID Cards
(Front & Back):

Aetna Better Health® of Maryland
MDH HealthChoice

♥aetna®

Member ID# [Member ID#]   **Date of Birth** [00/00/0000]
Member Name [Last Name, First Name]   **Sex** [X]
PCP Name [Last Name, First Name]
PCP Phone [000-000-0000]   **Effective Date** [00/00/0000]

RxBIN: 610084   RxPCN: ADV RxGRP: RX8817
Pharmacist Use Only: **1-844-345-2797**   ♥**CVS** caremark®

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THIS ID CARD IS NOT A GUARANTEE OF ELIGIBILITY, ENROLLMENT OR PAYMENT.

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Member Services 24/7: **1-866-827-2710 (TTY: 711)**
24-Hour Nurse Line, Vision Services and Adult Dental Services available at
1-866-827-2710 (TTY 711)

HealthChoice Enrollee Help Line: **1-800-284-4510**

Emergency care: If you are having an emergency, **call 911** or go to the closest hospital. You don't need preapproval for emergency transportation or emergency care in the hospital.

Prior authorization is required for all inpatient admissions and selected outpatient services. To notify of an admission, please call **1-866-827-2710.**

Send medical claims to: **To verify member eligibility:**
Aetna Better Health of Maryland   1-866-827-2710
PO Box 982968   **EDI Payor ID:**
El Paso, TX 79998-2968   128MD

MDMED1

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