Aetna Medicare FIDE (HMO D-SNP)

Quick Reference Guide

This guide provides quick access to helpful resources. For detailed information, please refer to the Aetna Medicare FIDE 's Provider Manual located on the provider **website** .

Provider Services

1-866-600-2139 (TTY:711) 8 AM to 5 PM Monday to Friday (except major holidays).
Call Aetna Medicare FIDE (HMO D-SNP) main provider services number for any provider services including care management, utilization management, claims research and billing, and more.

Eligibility Verification

Please contact us at **1-866-600-2139** or log into our Availity Web Portal to verify eligibility.

Provider Website

- Provider Manual
- Availity Provider Portal
- Clinical Guidelines
- Forms
- **Provider Education and training**
  - **Model of care training**
- Notices and Newsletters

Availity Provider Portal

The Availity portal can be found at **www.availity.com**, and it provides participating providers tools, resources, and the ability to perform tasks such as:

- Eligibility verification
- Access to prior authorization forms
- Submission and verification of prior authorization requests, including status checks
- Prior authorization requirement search tool
- Claims status checks
- PCP roster of assigned members
- Review of claim payments and access the Explanation of Benefits (EOB)

Participating providers can register for Availity at **Availity Registration** or, if already a user, add "**Aetna Better Health All Plans NJ-VA MAPD-DSNP**" to your list of payers at **Availity**. More information can be found on the ..

NOTE: Do not select "Aetna Medicare and Commercial".

Claim Inquiries

Participating providers may review the status of a claim by checking the Availity provider portal or calling our Claims Investigation and Research Department at **1-866-600-2139**.

Claim Status Through The Portal

Aetna encourages providers to take advantage of the Availity provider portal, as it is quick, convenient and can be used to determine status (and receipt of claims) of paper and electronic claims. The portal can be accessed on the **provider website** or **directly**. Providers must **register** to use our portal.

Claims Submissions

Aetna Medicare FIDE (HMO D-SNP) requires 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 120 calendar days from the Date of Service (DOS) or discharge (unless contract states otherwise). The claim will be denied if not received within the required timeframes.
- Corrected claims must be submitted within 180 days from the DOS or discharge (unless contract states otherwise).
- Coordination of Benefits (COB) claims must be submitted within 180 days from the date of primary payer's EOB

Electronic Claims Submission

Aetna Medicare FIDE (HMO D-SNP) encourages participating providers to electronically submit claims through Availity Please use the following Payer ID when submitting claims to:

- **Payer ID# 26337**

Paper Claims Submissions and or Resubmissions

Please use the following address when submitting claims:

Aetna Medicare FIDE (HMO-DSNP)

Claims and Resubmissions
PO Box 79998-2967
El Paso, TX 79998-2967

To differentiate for resubmissions, please stamp or write one of the following on the paper claims: "Resubmission", "Rebill", "Corrected Bill", "Corrected," or "Rebilling"

Claim Resubmission

Participating providers may dispute 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 dispute:

- Use the Dispute 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 "Dispute" at the top of the claim in black ink and mail to appropriate claims address.

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 (Explanation of Benefits) when their disputed claim has been processed. Providers may call to speak with a representative about their claim dispute. Provider Services will be able to verbally acknowledge receipt of the resubmission, reconsideration and or the claim dispute. Providers have 180 days from the date of determination, unless otherwise indicated in your provider agreement, to submit a claims resubmission/reconsideration, corrected claim or dispute. Our staff will be able to discuss and provide details about claim status. Providers can review our provider portal to check the status of a resubmitted, reprocessed, and/or adjusted claim. These claims will be noted as "Paid" in the portal. To view information on our portal, please visit the **provider portal page**.

Care Management

The Care Management Department is equipped to work with members to facilitate multi-faceted services for our members. To reach the Care Management Department, contact us at **1-866-600-2139.** The Care Management Department can be reached at **ILFIDECM@Aetna.com**

How to request Prior Authorizations

A prior authorization request may be submitted by:

- Submitting the request through **Availity**
- Fax the **Prior Authorization Request Form** to **1-855-802-4292** 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 number at **1-866-600-2139**

To check the status of a prior authorization you submitted or to confirm that we received the request, please visit the **Availity** , or call us at **1-866-600-2139**.

If response for non- emergency prior authorization is not received within 15 days, please contact us at **1-866-600-2139**.

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
- DOS

Important Note:

- Emergency services do not require prior authorization; however, notification is required the same day.
- All out of network services must be authorized.
- Unauthorized services will not be reimbursed, and authorizations are not a guarantee of payment.
- If providers do not receive outreach or response to non-emergency authorizations, please reach out to provider services at **1-866-600-2139**
- For post stabilization services, hospitals may request prior authorization by calling **1-866-600-2139**

Decision and Notification Requirements

Decision	Decision/notification timeframe
Urgent pre-service approval	Within forty-eight (48) hours after receipt of the request for authorization unless clinical information was not received. If no clinical information is received, we will allow an additional twenty-four (24) hours for you to submit clinical. The turn-around-time will not exceed seventy-two (72) hours.

Urgent pre-service denial	Within forty-eight (48) hours after receipt of the request for authorization unless clinical information was not received. If no clinical information is received, we will allow an additional twenty-four (24) hours for you to submit clinical. The turn-around-time will not exceed seventy-two (72) hours.
Non-urgent pre-service approval	Within five (5) calendar days of receipt of request
Non-urgent pre-service denial	Within five (5) calendar days of request
Post-service approval	Within thirty (30) calendar days of receipt of request
Post-service denial	Within thirty (30) calendar days of receipt of request

Due to the federal and state guidelines, the turnaround time (TAT) for non-urgent pre-service decisions (5 days). It is critical that you submit complete and accurate information upfront to support your authorization request. This includes the designated point of contact, all required medical documentation, and relevant medical history. Missing or incomplete details can delay the review process and impact timely access to care for enrollees. Ensuring thorough submissions helps us meet regulatory requirements and deliver prompt decisions within the timeframe.

Electronic Visit Verification (EVV)

All claims submitted for designated home health services must have supporting EVV data and license/certification numbers included on applicable claims. Failure to comply may result in limiting referrals or transition of existing members to providers who have achieved compliance. Providers can submit the EVV **authorization form** to the Care Management Department by faxing to **1-855-320-8445**.

If you have questions regarding EVV integration requirements, please contact **HHAeXchange Support** or contact the Support Line at **1-866-245-8337**. You may also inform Aetna of your status with this requirement by emailing **AetnaEVVCompliance@AETNA.com**.

Provider and Pharmacy Search Tool

For a list of participating providers, including behavioral health, please access our online search tool located on our **website.**

Please note: Laboratories and radiology participating providers are included in the online search tool. Check the coverage for prescription drugs on the 2026 **Prescription drug search tool** or by looking at the **List of Covered Drugs (Formulary)**.

Payer Order, Coordination, And Third Party Liability

Aetna is managing both the member's Medicaid and Medicare services under the Aetna Medicare FIDE (HMO SNP) plan. Providers won't have to submit the claim twice as a participating provider. Aetna's internal process will settle the secondary Medicaid claim up to allowable rates once the Medicare claim is processed. Providers must have a Medicaid ID to receive Medicaid cost share.

Medicaid is the payer of last resort. Medicare-covered services will pay with Medicare as primary payer. If a third-party payer should be primary, claims should be sent to the third-party payer before submitting to Aetna under “Medicare Secondary Payer” rules. Providers with questions related to claim payment can contact the Claims Investigation and Research Department (CICR) at **1-866-600-2139**

Appointment Standards and Timeframes

Providers are required to schedule appointments for eligible enrollees in accordance with the minimum appointment availability standards and based on the acuity and severity of the presenting condition, in conjunction with the enrollee's past and current medical history. Our Provider Services Department will routinely monitor compliance and seek Corrective Action Plans (CAP), such as panel or referral restrictions, from providers that do not meet accessibility standards. Providers are contractually required to meet the National Committee for Quality Assurance (NCQA) standards for timely access to care and services, considering the urgency of and the need for the services.

Visit our website to review the appointment wait time standards

Provider Registrations

If you are billing services that are primary to Medicaid (i.e., services that are not Medicare eligible), Illinois Department of Healthcare and Family Services (HFS) requires registration to receive payment. Providers must complete a revalidation to remain active in the program. If you need a Medicaid ID, please visit the registration site at **https://impact.illinois.gov/** Either registering or obtaining an Active Medicaid ID is sufficient to receive a Medicaid payment for Medicaid primary services.

All providers will be required to re-validate based on their enrollment date. All providers must complete the IMPACT revalidation process to remain enrolled in Medicaid. This includes providers who participate in the Aetna Medicare FIDE (HMO D-SNP).

Joining The Provider Networks

If you are already participating with the Medicare Advantage program and registered as a Medicaid provider with the state of Illinois, there is no need to sign up as you will automatically be placed in our system.

If you are interested in applying for participation in our Medicare network, please contact us at **AetnaDualsContracting@AETNA.com** and complete the provider online request form. If you would like to speak to a representative, just call **1-866-600-2139**.

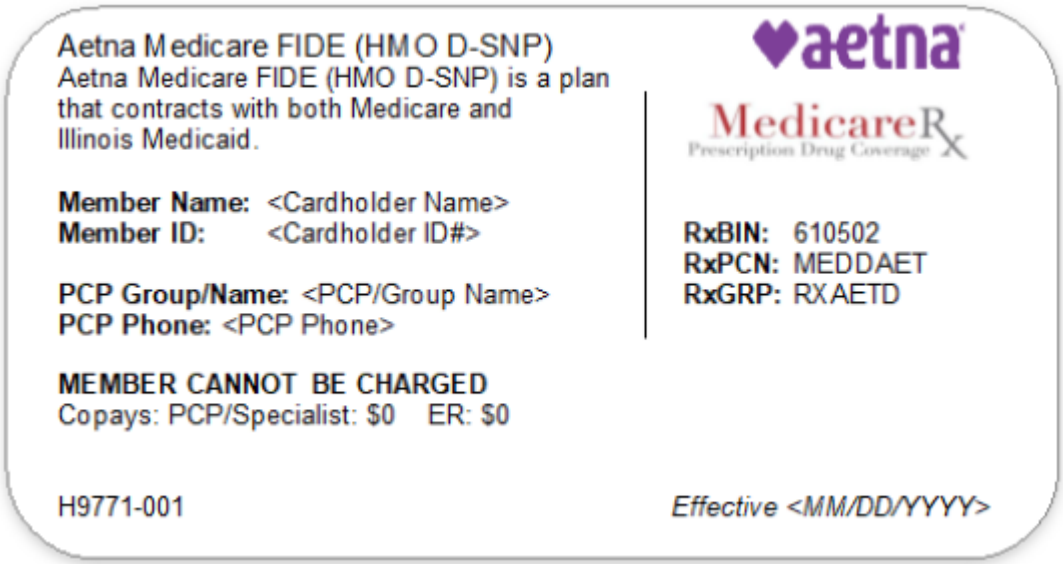
If you would like more information about joining our Medicaid network, call us at **1-866-329-4701** or **send us an email**.

Applications will be reviewed and responded to within 3 days. We currently service members in all Illinois counties. The enrollment resources listed above are applicable to all provider types including but not limited to assisted living, behavioral health, HCBS and MLTSS, hearing, hospice, maternity (including doulas), and skilled nursing facilities.

Aetna Medicare FIDE (HMO D-SNP) Provider Inquires and Contacts

Member and Provider Services	**1-866-600-2139**
Credentialing and Escalation Email	**AetnaDualsContracting@AETNA.com**
Compliance Hotline (Reporting Fraud, Waste or Abuse)	**1-866-536-0542** (24/7 through Voice Mail inbox)
For Dental Providers: DentaQuest	**1-800-416-9185** **www.dentaquest.com/**
For Vision Providers: March Vision Care, Inc.	**1-888-493-4070**
Durable Medical Equipment	Please see provider search tool for details surrounding DME providers. **www.aetnabetterhealth.com/illinois/find-provider**
Quest Diagnostics	**www.questdiagnostics.com/home.html**

Sample ID Cards



Important information: In case of emergency, call 911 or go to the nearest emergency room (ER). Prior authorization is not required for emergency services.

Member Services:	1-866-600-2139 (TTY: 711)
Behavioral Health:	1-866-600-2139 (TTY: 711)
Pharmacy Help Desk:	1-800-238-6279 (TTY: 711)
Care Management:	1-866-600-2139 (TTY: 711)
24 Hour Nurse Advice:	1-866-600-2139 (TTY: 711)
Dental/Vision Services:	1-866-600-2139 (TTY: 711)
Transportation Services:	1-888-513-1612
Mental Health Crisis:	988
Website:	AetnaMedicare.com/ILDSNP

Send Claims To:	Aetna Medicare FIDE P.O. Box 982980, El Paso, TX 79998-2980
Claim Inquiry:	1-866-600-2139 (TTY: 711)