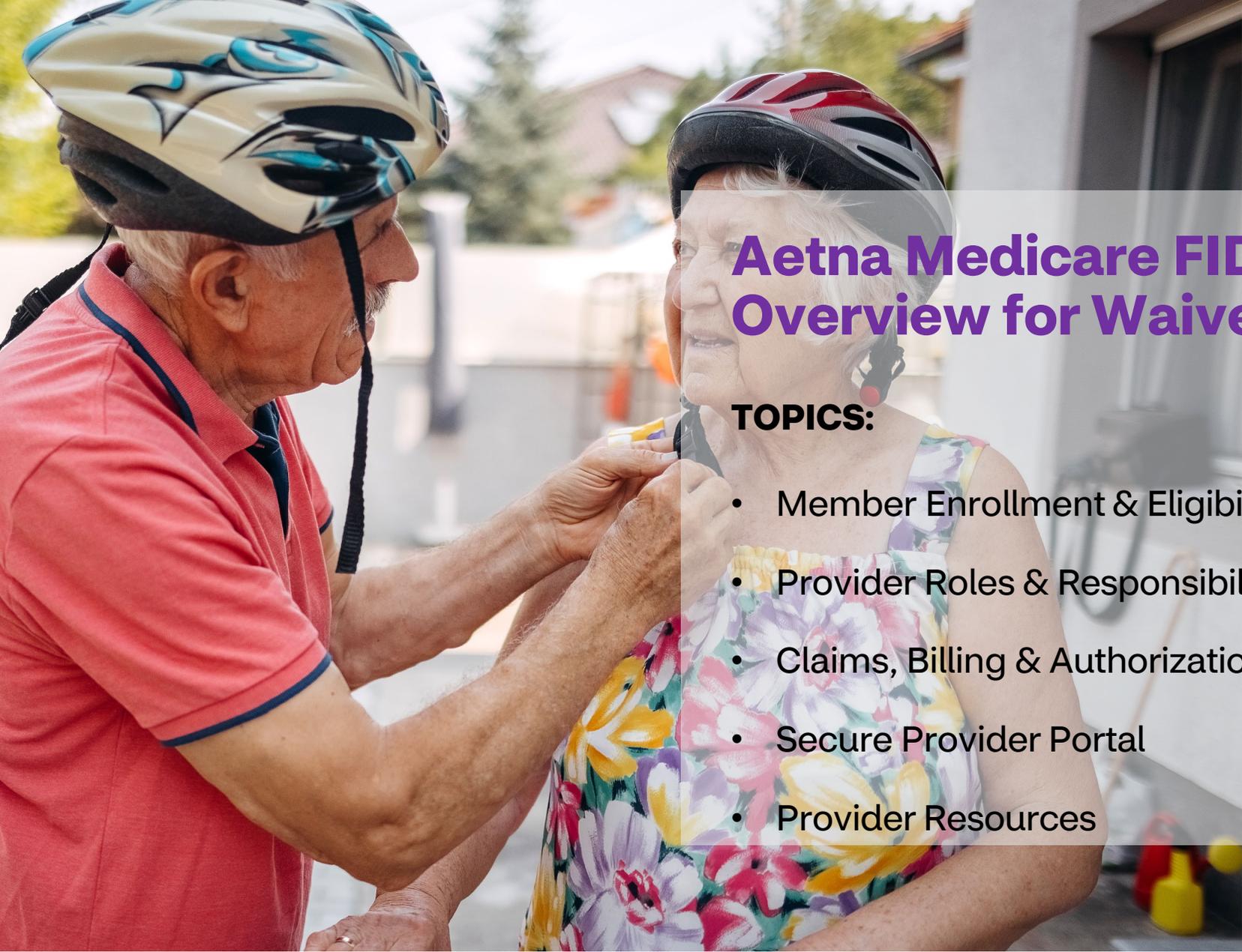




**NJ LTSS and Wavier Services
Provider Overview**

2026





Aetna Medicare FIDE (HMO D-SNP) Overview for Waiver Providers

TOPICS:

- Member Enrollment & Eligibility
- Provider Roles & Responsibilities
- Claims, Billing & Authorizations
- Secure Provider Portal
- Provider Resources



Member Enrollment & Eligibility

Enrollment Qualifications & Service Area

Aetna Medicare FIDE (HMO D-SNP) is a Fully Integrated Dual Eligible Special Needs Plan available statewide. It is a special type of Medicare Advantage Plan that provides both Medicare and Medicaid health benefits to New Jersey Members who qualify for Medicare and NJ FamilyCare (Medicaid services) and who live in the state of New Jersey.

Aetna Medicare FIDE (HMO D-SNP) covers all the Member's Medicare, NJ FamilyCare (Medicaid), Managed Long Term Services and Supports, and prescription drug benefits, including Medicare Part D, and extra benefits, in one health plan, with one identification card, and no deductibles, coinsurance, or copays for plan-covered services or prescription drugs.



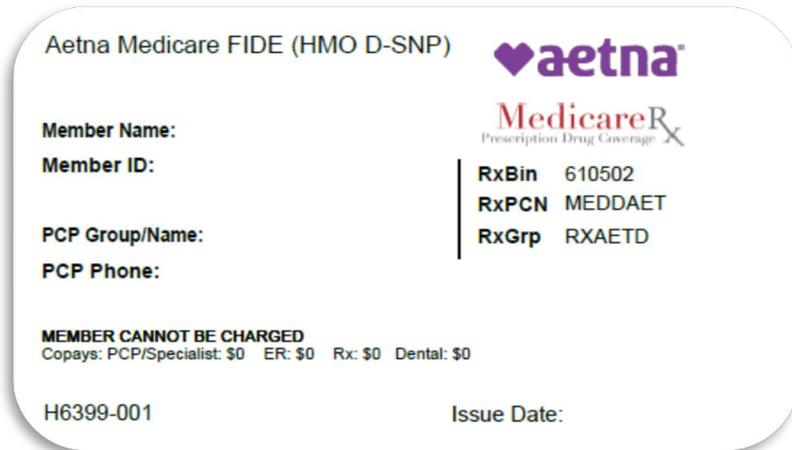
ID Cards & Enrollment

Verifying Member Eligibility:

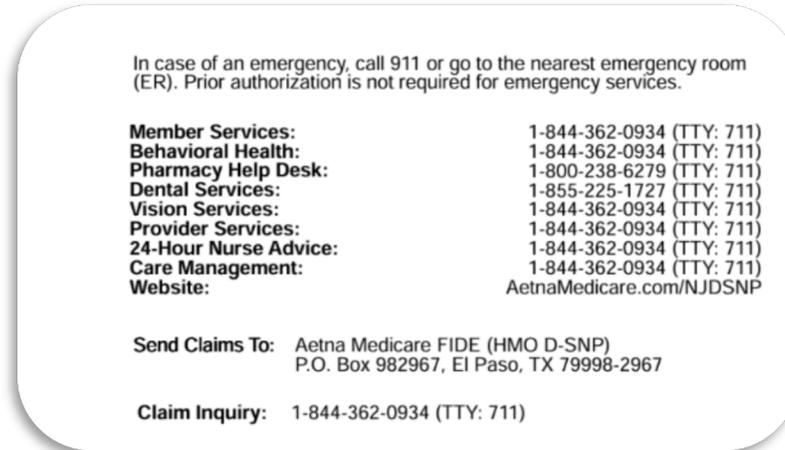
You can verify member eligibility, PCP assignment, and benefits by:

- Using the State [NJMMIS](#)
- Using the [Availity Provider Portal](#)

Front:



Back:



Members have only one ID card for Medicare and Medicaid. You will only submit claims directly to Aetna Medicare FIDE (HMO D-SNP). Do not submit claims directly to Medicare or Medicaid.

Aetna Medicare Extra Benefits Card

Extra Benefits Card

For members with a qualifying chronic condition, the plan provides a monthly allowance of \$255/month to help pay for every day expenses including: healthy food, over-the-counter (OTC) items, transportation (including gas at the pump and ride share services), utilities, and personal care items. Any unused amounts will not roll-over into the next month.

- Members with a chronic condition who qualify for SSBCI through claims will not need to take action. They will be able to spend their allowance on healthy food, utilities, personal care supplies and transportation costs (such as gas at the pump or Uber/Lyft) in addition to OTC products.
- Members who do NOT have a claim on file for a qualifying chronic condition, will be able to call into Member Services to let us know which qualifying condition they have or schedule an appointment with their PCP or Specialist for care of their qualifying condition. Once we confirm they qualify, the member will be able to use the new Extra Benefits Card for OTC products, plus healthy food, utilities, transportation and personal care items.





Aetna Medicare FIDE(HMO D-SNP) Benefits

Additional benefits for Aetna Medicare FIDE (HMO D-SNP) enrollees:

Housing-Related Services

This benefit is intended to ensure that members can live in a safe, healthy and affordable home.

- To be eligible for Housing Supports, a member must meet at least one social-risk criterion (including but not limited to: homelessness; being at-risk of homelessness; transitioning from an institution; or having been recently released from a correctional facility).
- The member must also meet at least one clinical-risk criterion (including but not limited to: a chronic health condition; a mental health condition; substance misuse; pregnancy; complex medical health due to disability; sexual/domestic violence; assisted living needs; or repeated hospitalization).

Durable Medical Equipment - Wigs

Annual allowance of up to \$400 each calendar year to support the cost of wigs due to chemotherapy-related hair loss.

Nutrition Support

A program intended to help members in MLTSS assess their dietary needs and nutritional options and includes services to provide pantry items and/or groceries to members under certain circumstances to ensure they have adequate access to food. The health plan will conduct an assessment via a standardized tool to determine eligibility for the benefit.

Aetna Medicare FIDE(HMO D-SNP) Benefits (Continued)

Additional benefits for Aetna Medicare FIDE (HMO D-SNP) enrollees:

Virtual medical visits

Members can schedule a Teladoc appointment at [Teladoc.com/Aetna](https://www.teladoc.com/Aetna) or by calling **1- 855-TELADOC (1- 855-835-2362) (TTY: 711)** or MinuteClinic® Video Visit which is available 24/7 via the CVS app or at by visiting the [Minute Clinic Website](#).*

Personal Emergency Response System (PERS)

Members pay \$0 copay for each item. Personal emergency response system is provided by LifeStation.

Meals at Home

Members can receive 14 meals over 7 days after an inpatient hospital discharge or skilled nursing stay.

Aetna 24-Hour Nurse Line

Member can get guidance and support on your basic health care questions, 24 hours a day, 7 days a week.

Fitness programs

SilverSneakers® gives members access to a large network of fitness centers, community classes, on-demand videos, Apple Fitness+ subscription, and at-home fitness kits.

Worldwide urgent and emergency coverage

There is a \$250,000 combined maximum benefit amount for worldwide emergency care, emergency transportation and urgently needed care.

Provider Roles & Responsibilities



Provider Roles & Responsibilities

- Aetna Medicare FIDE (HMO D-SNP) participating providers are contractually obligated to comply with all guidelines and laws outlined in their New Jersey FIDE Contract and their Provider Manual.
- The quality of our network and the ability to provide excellent service is dependent on having accurate provider data. Please update us if you have any change of address, telephone number, or other demographic information as soon as possible.

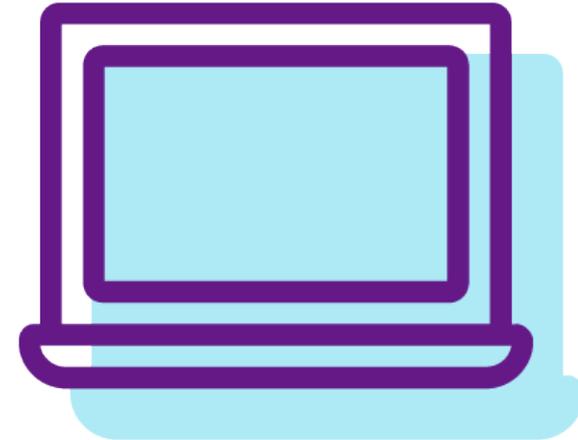
Provider Training Requirements

All dual-eligible SNP plans are required to have an approved Model of Care. Providers must take a mandatory Model of Care Training required by CMS each year. A simple Attestation Statement is provided within this training document as well to make it easy for you to get credit for completing the course.

You can take the training and record your attestation here on our website: [Welcome Providers](#)

Additional training, resources and information can also be located on our website. Including:

- Provider News
- Memos / notices
- Quarterly provider newsletter
- Clinical guidelines
- Fraud, Waste & Abuse education



The background of the slide is a solid purple color with a repeating pattern of white document icons. Each icon consists of a rounded rectangle with a small tab on the top right corner, resembling a sheet of paper or a document.

Claims, Billing, & Authorizations

Understanding Authorizations

- **Personal Care Services:** A Care Manager will reach out to you directly to provide authorization for a member needing personal care services. Authorizations for personal care services generally last for 6 months.
- **Chore Services:** We will send an email or fax to providers to bid on chore services. Responses are required within 14 days. If your bid is approved, an authorization for chore services will be issued. These authorizations generally last for 12 months.
- **Home Modifications:** We will send an email or fax to providers to bid on home modifications. Responses are required within 14 days. Authorizations are approved for 3 months, but work is expected to be completed as soon as possible (weather permitting and member agreeable).

Should a member require additional services, and an authorization is nearing its end date, please reach out to the assigned care manager for additional authorization. Please note that authorization dates can not overlap.

Waiver services are only paid if there is a current authorization in place in the name of the rendering provider. If you have general questions or are unable to reach a care manager directly, you may contact the New Jersey Care Management through [email](#).

Prior Authorizations

An authorization maybe be necessary before care or services are covered. When prior authorizations are required to initiate services or extend services, providers may send the corresponding authorizations and supporting evidence to the following addresses and faxes:

Pharmacy

Address: Aetna Medicare FIDE

Part D Coverage Determinations Dept.

4750 S. 44th Place, Suite 150

Phoenix, AZ 85040 -4015

Phone: 1-844-362-0934

Fax Number: 1-844-814-2260

[Part D Authorization Form](#)

Medical Authorization

Phone: 1-844-362-0934

Fax Number: 1-833-322-0034

[Medical Authorization Form](#)

Home Health Authorization

Phone: 1-844-362-0934

Fax Number: 1-844-814-2260

[Home Health Authorization Form](#)

Authorizations may also be submitted through the Availity Provider Portal

Claims Submission

Aetna Medicare FIDE (HMO D-SNP) members should NOT be balanced billed for any covered benefit.



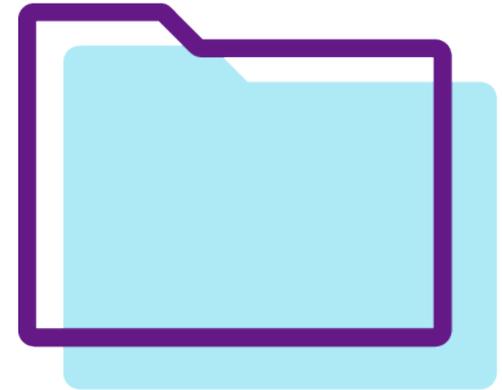
We have an automated system for processing claims for members enrolled in Aetna Medicare FIDE (HMO D-SNP)

- Using the member's ID number from the plan ID card, you'll only need to submit **one claim**. Your claims will automatically be processed first against the Medicare benefits and then against the Medicaid benefits.
- You'll receive two provider remittance advices (PRAs), one for Medicare and one for Medicaid. There's no need to resubmit a secondary claim to Aetna.
- We encourage participating providers to electronically submit claims through ECHO. Use submitter ID **#46320** when submitting claims Aetna Medicare FIDE (HMO D-SNP).

Claim Submission

Electronic claims can be submitted through three ways:

- Your own claim clearinghouse
 - Ensure that your clearinghouse is compatible with ECHO using the 837 file format.
 - Please use Submitter ID **#46320** when submitting electronic claims
- Availity
 - Information on Availity can be found at the [Provider Portal Website](#)
- Paper Claims
 - Please use Submitter ID **#46320** when submitting paper claims



Aetna Medicare FIDE (HMO D-SNP)

PO Box 982967

El Paso, TX 79998-2970

Tips for Submitting Claims

- Confirm member's eligibility before rendering services.
- To best ensure timely and accurate payment of your claim, submit a “clean claim”
- A “clean claim” is defined as one that can be processed (adjudicated) without obtaining additional information from the service provider or from a third party
 - It does not include claims submitted by providers under investigation for fraud or abuse or for claims that are under review for medical necessity
- Clean claims are processed according to the following timeframes:
 - 90% of clean EDI claims adjudicated within 30 days of receipt
 - 90% of clean paper claims adjudicated within 90 days of receipt
- If providers have an approved authorization for a claim, include the authorization number on all claim lines pertaining to the authorization.

Tips for Submitting Claims (continued)

- Bill only for the procedure codes and diagnosis codes that are included on your authorization. Do not submit an invoice, but please save them in case of a future audit.
- Include your authorization number in Box 23.
- Places of service that are acceptable are 12 (home) or 99 (other).

Please note, that members do not have a copayment and can not be balance billed. Should you have any questions about claims payment, you can reach out to Provider Services for assistance and clarification **1-844-362-0934**.

Timely Filing

In accordance with contractual obligations, claims for services provided to an enrollee must be received in a timely manner. Our timely filing limitations are as follows:

New claim submissions –

Claims must be filed on a valid claim form within your contracted timely filing timeframe. This is from the date services were performed, unless there is a contractual exception. For hospital inpatient claims, date of service means the date of discharge of the enrollee.

Claim Resubmission –

Claim resubmissions must be filed within your contracted timely filing period. The only exception to this is if a claim is recouped, the provider is given an additional contracted days from the recoupment date to resubmit a claim. Please submit any additional documentation that may effectuate a different outcome or decision.



Corrected Claims & Claim Resubmissions

- Corrected claims require a resubmission code of “7” in Box 22, along with the original claim reference number.
- Failure to submit a corrected claim will result in the claim denying as a duplicate.
- Corrected claims must include all lines from the original claim, not just the line item(s) to be corrected.
- Corrections must be made within 120 days from the date of service.

Provider Dispute and Provider Appeal Process

Participating Providers: Participating Providers can submit a provider dispute on behalf of the member. It is a request to review a denied service. Providers can dispute our decision if service was denied or reduced. Provider disputes must be received via Mail within ninety (90) days of the action taken by Aetna Medicare FIDE (HMO D-SNP).

Response Time?

Disputes average 30 business days. Disputes are reviewed by a third-party not involved in original decision. Please go through the dispute process first, before reaching out your assigned Provider Representative for assistance.

Non-Participating Providers: Non-Participating Providers can submit a Provider Appeal. It is a request to review a denied service. Providers can appeal our decisions through writing with documentation supporting they should receive different payment under the original Medicare within sixty (60) calendar days from the remittance date.

Need additional help? View our [Dispute Submission Guide](#) for further assistance.

Provider Disputes

If you are a Contracted Provider, you may use the [Dispute Form](#) found online to have your claim reconsidered.

Please fill the form out completely and accurately for proper handling of your Dispute. Disputes can be sent by mail to:

Aetna Medicare FIDE (HMO D-SNP)

PO Box 982967

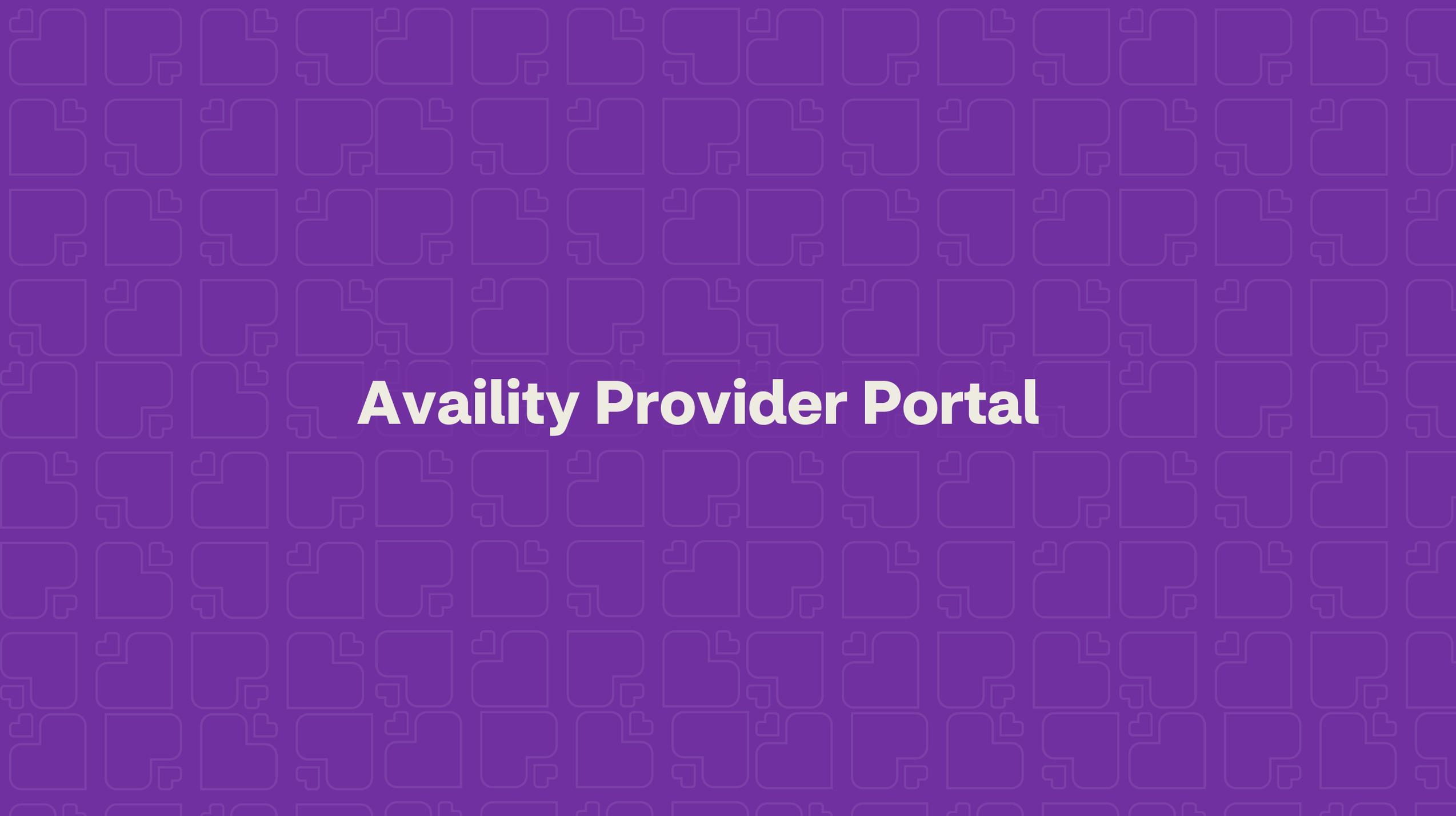
El Paso, TX 79998-2974

Incomplete or missing information may cause the decision to be upheld or returned to Provider. Common mistakes include:

- Incorrect Denial of Claim or Claim Line(s)
- Incorrect Denial of Authorization Code or Modifier Issue
- Medical Necessity
- Incorrect Rate Payment

Your Dispute must include:

- The completed form
- Factual or legal basis for appeal statement
- Copy of the original claim
- Copy of the remit notice showing the claim denial
- Any additional information (clinical records, required documentation) or Medicaid references as needed



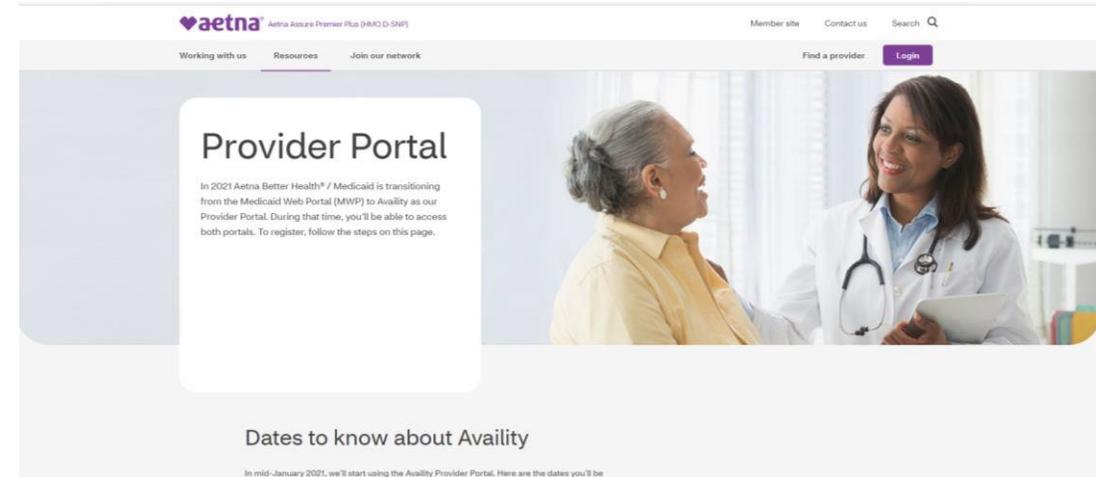
Availity Provider Portal

Provider Portal

If you are already registered in Availity, you will simply select **Aetna Better Health All Plans NJ-VA MAPD-DSNP** for Aetna Medicare FIDE (HMO D-SNP) from your list of payers to begin accessing the portal and all of the features.

[Find out more at the Aetna Medicare FIDE \(HMO D-SNP\) Provider Portal Website](#)

If you are not registered, we recommend that you do so immediately by going to the above portal location.





Provider Resources

Provider Relations

Our provider Relations staff is available to you Monday - Friday 8 AM - 5 PM to assist you on any facets of your relationship with Aetna Medicare FIDE (HMO D-SNP).

You can reach Provider Relations via:



Phone Number: **1-844-362-0934**



Email: COEProviderServices@AETNA.com



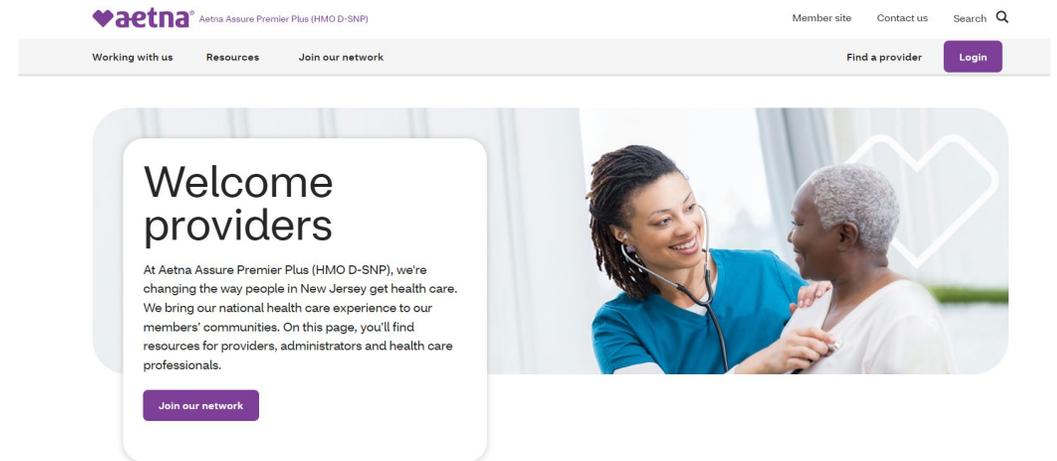
Each participating provider group is also assigned a Provider Relations Liaison who can assist with any escalated claim questions or other concerns.

Visit Our Website

Providers can access the Aetna Medicare FIDE (HMO D-SNP) Plan [website](#). There you'll find tools and resources to make doing business with us quick and simple.

We've listed a few of the tools and resources found on the "For Providers" tab below:

- Provider Directory
- Provider Manual
- Notifications and Newsletters
- Document Library
- Provider Education



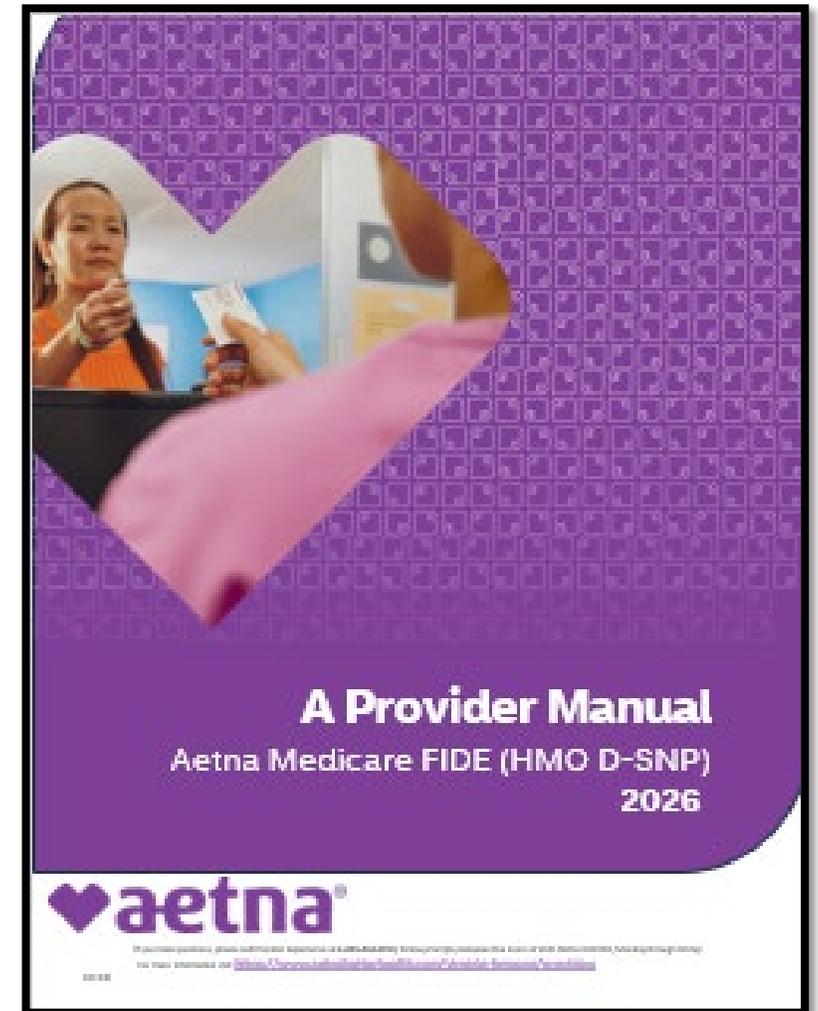
Provider Manual

The provider manual contains plan policies, procedures and benefits.

You'll also find general reference information such as the minimum standards of care required of Plan providers.

The most current version of the provider manual is available on our [Forms and Resources Page](#).

To request a copy of the provider manual by email, USPS mail or for general questions, simply contact our Provider Relations Department at **1-844-362-0934** or by email at COEProviderServices@Aetna.COM.



Additional Resources

[State of New Jersey Human Services](#)

[Programs/Services](#)

[NJ Family Care](#)

An elderly couple is shown in a close-up, intimate moment on a porch. The man, on the left, has white hair, glasses, and a light blue polo shirt. The woman, on the right, has short white hair and is wearing a white textured cardigan. They are holding hands, looking down at each other with a gentle expression. In the background, a large American flag is draped over the porch railing. The scene is set outdoors, likely in the late afternoon or early morning, as the lighting is soft and warm. The overall mood is one of care, support, and gratitude.

Thank You

The Aetna logo is positioned in the bottom right corner of the image. It consists of a white heart icon followed by the word "aetna" in a bold, lowercase, sans-serif font. A registered trademark symbol (®) is located at the top right of the word "aetna".

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