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 (HMO D-SNP) **Provider Manual**.

Provider Contact Center

1-855-463-0933 (TTY:711) 8 AM to 8 PM Monday to Friday (except major holidays).

Call the Aetna Medicare FIDE (HMO D-SNP) main provider contact center number for any provider services including care management, utilization management, claims research and billing, and more.

Eligibility Verification

Please contact us at **1-855-463-0933** or log into our Availity Web Portal to verify eligibility.

Provider Website

- Provider Manual
- Training
- Availity Provider Portal
- Clinical Guidelines
- Forms
- Provider Education
- Model of care training
- Announcements and News
- Newsletters

Availity Provider Portal

The Availity portal can be found at **apps.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" to your list of payers at **Availity**. More information can be found on the

provider portal page. While using the Availity Provider Portal, providers seeking either Aetna Medicare FIDE (HMO D-SNP) can access plan resources by selecting the "Aetna Better Health VA-NJ MAP D-SNP" from the plan drop down. **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- 855-463-0933**.

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 180 calendar days from the Date of Service (DOS). The claim will be denied if not received within the required timeframes, unless contract agreement states otherwise.
- Corrected claims must be submitted within 365 days from the DOS, unless contract agreement states otherwise.
- Coordination of Benefits (COB) claims must be submitted within 60 days from the date of primary payer's EOB or 180 days from the DOS, whichever is later. Unless contract agreement states otherwise.

Electronic Claims Submission

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

- **Payer ID# 128VA**

Paper Claims Submissions and or Resubmissions

Please use the following address when submitting claims:

Aetna Medicare FIDE (HMO D-SNP)
Payer ID# 128VA
PO Box 982974
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**
- 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. 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**.

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 **1-855-463-0933.** The Care Management Department can be reached at **ABH_VA_DSNP@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- 833-280-5224**. 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- 855-463-0933**.

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- 855-463-0933**.

If response for non- emergency prior authorization is not received within 7 days, please contact us at **1-855-463-0933**.

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- 855-463-0933.**
- For post stabilization services, hospitals may request prior authorization by calling **1-855-**

463-0933.

Decision and Notification Requirements

Decision	Decision/notification timeframe
Urgent pre-service approval/denial	Within seventy two (72) hours of receipt of request
Non-urgent pre-service approval/denial	Within seven (7) calendar days of receipt of request
Post-service review approval/denial	Within thirty (30) calendar days of receipt of request

Due to the updated 2026 CMS final rule, turnaround time (TAT) for non-urgent pre-service decisions—from 14 days to 7 days—it is critical that providers submit complete and accurate information upfront. 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 new timeframe.

Electronic Visit Verification (EVV)

The Department of Medical Assistance Services (DMAS) is implementing **Electronic Visit Verification** (EVV) for some home and community-based services in response to federal requirements set forth in the 21st Century Cures Act (Cures Act). EVV is an electronic system that verifies key information about the services provided. In accordance with the Cures Act, the system implemented by DMAS will record the date of the service, the time the service started and ended, the individual receiving the service, the person providing the service and the location of the service. Both agencies and non-agency providers are impacted by EVV.

Appointment Standards and Availability Timeframes

To meet our growing member population, we have to determine if participating offices in our network have sufficient office hours. Please review our **appointment standards**. We may be reaching out to your office about your response to our access and availability questionnaire.

Provider and Pharmacy Search Tool

For a list of participating providers, including behavioral health, please access our **Find Provider** tool.

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

Aetna Medicare FIDE (HMO D-SNP) prescription drug plans are available to all of its members. In addition, prescription drug plans filled at an Aetna Medicare FIDE (HMO D-SNP) network pharmacy may qualify for additional savings; however, other plan rules may apply.

View the latest **Formulary**. The formulary is continuously under review, and as changes occur, the

version on the website is updated.

For a drug that is not on the List of Covered Drugs (formulary), a statement must be provided documenting trial and failure of the formulary medications or a medical reason why the formulary medications cannot be used. Please visit our website for more details on our **prescription drugs**.

Payer Order, Coordination, And Third Party Liability

Aetna is managing both the member's Medicaid and Medicare services under the Aetna Medicare FIDE (HMO D-SNP). 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.

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 **1-855-463-0933**.

Provider Registrations

Providers offering Medicaid Primary covered services are required to have an active Medicaid ID number. If you do not have a Medicaid ID number please visit the **Virginia Department of Medical Assistance Services Online Provider Enrollment System** to access Virginia's Medicaid online application.

Providers should receive a DMAS notice to begin their revalidation applications at least 90 days before the end of their enrollment period. The notice is sent via email or U.S. Mail depending on the provider's communications preferences recorded in the provider services solution (PRSS) provider portal. Reminder notices are also sent 60 and 30 days prior to the revalidation deadline.

Joining The Provider Networks

Our Provider Experience staff works with you to understand your practice and meet your needs, whether you are a primary care provider or provide home- and community-based services. There are many great reasons to join our strong provider network, including:

- Competitive compensation
- Timely and efficient claims processing
- Ongoing support and learning opportunities
- Advanced technology that can help you enhance patient care

If you are interested in applying for participation in our Aetna Medicare FIDE (HMO D-SNP) network, you may **email** us. Or if you would like to speak to a representative, just call **1- 855-463-0933**.

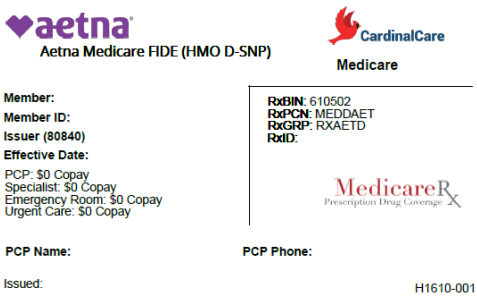
Please contact **DentaQuest**, 1-800-341-8478, if you are a dental provider and are interested in becoming part of their network).

Applications will be reviewed and responded to within 45 days. 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.

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

Member and Provider Services	**1-855-463-0933**
Credentialing and Escalation Email	**AetnaDualsContracting@AETNA.com**
Compliance Hotline (Reporting Fraud, Waste or Abuse)	**1-866-253-0540** (24/7 through Voice Mail inbox)
For Dental Providers: DentaQuest	**1- 800-341-8478** **www.dentaquest.com/state-plans/regions/virginia/**
For Vision Providers: Vision Service Plan	**1-800-877-7195** **https://www.vsp.com/**
Durable Medical Equipment	Please see provider search tool for details surrounding DME providers. **https://www.aetnabetterhealth.com/virginia-hmosnp/find-provider**
Quest Diagnostics	**www.questdiagnostics.com/home.html**

Sample ID Cards



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CardinalCare
Medicare

Member:
Member ID:
Issuer (80840)
Effective Date:

PCP: $0 Copay
Specialist: $0 Copay
Emergency Room: $0 Copay
Urgent Care: $0 Copay

RxBIN: 610502
RxPCN: MEDDAET
RxGRP: RXAETD
RxID:

MedicareRx
Prescription Drug Coverage

PCP Name:

PCP Phone:

Issued:

H1610-001

Important Information

Member Services:	1-855-463-0933 (TTY: 711)
24-Hour Nurse Line:	1-855-493-7019 (TTY: 711)
Behavioral Health and ARTS Crisis:	1-855-463-0933 (TTY: 711)
Pharmacy Help Desk:	1-800-238-6279 (TTY: 711)
Dental:	1-855-463-0933 (TTY: 711)
Transportation:	1-844-452-9375 (TTY: 711)
Website:	AetnaMedicare.com/VADSNP

For Providers:
Eligibility, Preauthorization and Claims **1-855-463-0933 (TTY: 711)**

Submit claims to:

Aetna Medicare FIDE (HMO D-SNP)
PO Box 982974
El Paso, TX 79998-9274

Submit grievances & appeals to:

Aetna Medicare FIDE (HMO D-SNP)
P.O. Box 818070
Cleveland, OH 44181 Payer ID: 128VA

In case of emergency go to the nearest emergency room or call 911.
This card is not a guarantee of eligibility, enrollment or payment.

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www.AetnaMedicare.com/VADSNP