

Provider quick reference guide

This guide is intended to be used for quick reference and may not contain all of the necessary information. For more information, refer to our Provider Manual online at aetnabetterhealth.com/newjersey/providers.

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Contact Information

Provider Relations

Shanise Williams

Manager, Provider Relations

Hospital Billing Contact

Provider Correspondence on behalf of Member

Aetna Better Health of New Jersey

3 Independence Way, Suite 400

Princeton, NJ 08540

Office: 609-282-8226

Email: WilliamsS1e291@aetna.com

Towanna Richardson

Network Relations Consultant

Service Area:

Counties: Essex, Hunterdon, Mercer, Monmouth, Morris, Warren, Sussex

Office: 959-299-3251

Cell: 609-240-3354

Fax: 959-282-8644

Email: RichardsonT3@aetna.com

Dana Pizzi

Network Relations Consultant

Counties: Middlesex, Somerset

Cell: 609-751-6243

Email: PizziD@aetna.com

Sharon Hopson

Network Relations Consultant

Counties: Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester, Ocean, Salem

Cell: 609-212-3361

Email: HopsonS1@aetna.com

Network Management

Emma Rivera

Director, Network Management

Office: 609-282-8174

Email: Riverae5@aetna.com

Jessica Perez

Network Manager

Office: 609-282-7976

Cell: 609-664-8248

Fax: 959-282-8627

Email: PerezJ8@aetna.com

Tiffany Monitzer

Contract Negotiator

Cell: 609-580-0675

Fax: 860-900-1027

Email: MonitzerT@aetna.com

Case Management /MCO Care Coordination Contact

Malvina Williams, RN

*Supervisor, Clinical Management
ICM Discharge Planning, Care Coordination,
Special needs, and Maternity Contact*

Office: 609-282-8236

Email: WilliamsM5@aetna.com

Deborah Kim

*Supervisor, ICM Audits and Regulatory
Compliance*

Office: 609-282-8190

Cell: 609-580-0254

Email: KimD@aetna.com

Ann Marie McGinnis, RN

Supervisor, Clinical Health Services

Office: 609-282-8183

Email: McGinnisA@aetna.com

Joanna Jelleyman, BA

Supervisor, Health Services

Office: 609-282-8187

Email: JelleymanJ@aetna.com

Katie Sheeler, RN

Clinical Supervisor, Utilization Review

Office: 609-651-3926

Non MLTSS Outpatient Hospice Request

Fax: 844-737-7601

Participant Direction and Personal Preference Program (PPP)

Program Coordinator: Margareta Plotka

Office: 959-299-791

Managed Long Term Services and Support

Nursing Facility Specialty Care Nursing Facility Contact

MLTSS Care Management Line
833-346-0122

Ashley Lampley

Supervisor, Health Services
609-282-8206

Email: axlampley@aetna.com

MLTSS Case Management

Case Management Associate Line:
833-346-0122

Fax: 855-444-8694

Mary Pagano

Network Relations Manager

Service Area: MLTSS, Nursing Facility,
Assisted Living, Hospice, Chore Services,
Home and Community Based, DME, and
Hearing Services

Office: 609-282-8231

Cell: 609-578-0562

Fax: 959-282-8925

Email: PaganoM@aetna.com

Behavioral Health/Mental Health/ SUD

Liarra Sanchez

*Behavioral Health, Network Relations
Consultant, OBAT*

Cell: 609-455-8997

Fax: 959-333-2851

Email: SanchezL7@aetna.com

Sally O'Brien

*Director, Clinical Health Services
BH Discharge Planning, Care Coordination and
BH Case Management*

Office: 609-282-8232

Email: O'brienS@aetna.com

Deborah Kim

*Supervisor, ICM Audits and Regulatory
Compliance*

Office: 609-282-8190

Cell: 609-580-0254

Email: KimD@aetna.com

Customer Service

Website: aetnabetterhealth.com/nj

Claims Questions 855-232-3596 – Press * for healthcare provider - follow prompts for customer service needs

- Claim Status
- Eligibility
- Transportation
- Authorization
- Interpretation

Eligibility verification

To obtain online eligibility information, providers can access the Eligibility Verification System (EMEVS) to access eligibility data visit www.njmmis.com/login.aspx.

Important contact information

Aetna Better Health of New Jersey

Member Services & Provider Relations
1-855-232-3596, TTY 711

Aetna Better Health of New Jersey
3 Independence Way, Suite 400
Princeton, NJ 08540-6626

Behavioral Health After Hours
1-855-232-3596, TTY 711

Compliance Hotline Fraud, Waste or Abuse
1-855-282-8272 24/7 voicemail box

Special Investigations Unit (SIU)
Reporting Fraud, Waste or Abuse
Call 1-800-338-6361 24/7

Vendor

Pharmacy CVS Caremark
Claims submission issues
1-855-391-6286

CVS Mail Order
1-855-271-6603
8 a.m. to 8 p.m., Monday - Friday

Radiology
Aetna Better Health of New Jersey currently does not use a third-party vendor for radiology authorizations.
Please call us at 1-855-232-3596

Durable Medical Equipment (DME)
View our online provider search tool for details on our DME providers

Pharmacy Clinical

Prior Authorizations Aetna Help Desk
Phone **1-855-232-3596**. Follow prompts for
Provider and Pharmacy
Fax 1-844-219-0223

Lab

labcorp.com
bioreference.com
questdiagnostics.com/home.html

March Vision

Routine vision services are provided through
March Vision

LIBERTY Dental Plan

Aetna Better Health of New Jersey uses
LIBERTY Dental Plan to provide dental services
to our members

Tools & resources

Visit our public website at aetnabetterhealth.com/newjersey.

- Provider manual
- Member handbook
- 24/7 secure web portal
- Clinical guidelines
- Provider forms
- Provider education
- Webex provider training Dates
- Newsletters
- Dental services
- Authorization forms
- Gaps in care reports

Visit our secure web portal at aetnabetterhealth.com/newjersey/login.

The secure web portal allows participating providers to perform a variety of tasks 24/7 including:

- Review prior authorization requirement search tool
- Checking claims status
- Pull provider roster of assigned members

Participating providers must complete our user agreement in order to access the secure web portal.

Claims

Claim inquiries

Participating providers may confirm receipt and confirm adjudication status of a claim by checking the Secure Provider Web Portal located on our website

aetnabetterhealth.com/newjersey/providers/portal or by calling our Claims Investigation and Research Department (CICR) at **1-855-232-3596**.

The CICR team can assist you with claim related questions and concerns. They enhanced their

broad service model to include calls related to claims status, as well as inquiries. The CICR staff is available to assist from 8 a.m. to 5 p.m. Monday through Friday.

Who do providers contact regarding Electronic Funds Transfer (EFT) and Electronic Remittance Advices (ERA/835 files)?

Providers can call us at **1-855-232-3596** between the hours of 8 a.m. and 5 p.m., Monday through Friday, or e-mail us at **AetnaBetterHealth-NJ-ProviderServices@aetna.com**.

Claims and resubmissions

Aetna Better Health of New Jersey 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.

- Claims must be submitted within 180 calendar days from the date of services. The claim will be denied if not received within the required timeframes.
- Corrected claims must be submitted within 365 days from the date of service.
- Coordination of Benefits (COB) claims must be submitted within 60 days from the date of primary insurer's Explanation of Benefits (EOB) or 180 days from the dates of services, whichever is later.

Electronic claims submission

Aetna Better Health of New Jersey encourages participating providers to electronically submit claims through Emdeon. Please use the following Payer ID when submitting claims to Aetna Better Health of New Jersey:

- Payer ID# **46320**
- 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.

*** CORRECTED CLAIMS** - Resubmitted Claims with Corrections or Missing information should be submitted to:

Aetna Better Health of New Jersey

P.O. Box 61925

Phoenix, AZ 85082-1925

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 secure web portal

We encourage providers to take advantage of using our online secure web portal, as it is quick, convenient and can be used to determine status (and receipt of claims) for multiple claims, paper and electronic. The secure web portal is located on the website. Providers must register to use our portal. Please see Chapter 19 of our provider manual for additional details surrounding the secure web portal.

Claims 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.

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 our Secure Provider Web 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 our portal, please click on the portal tab, which is located under the provider page online at **aetnabetterhealth.com/newjersey**.

Claim appeals

Participating and Non-Participating Providers have the right to appeal ABHNJ claims determination(s) and also an apparent lack of activity on a claim. To appeal ABHNJ claims determination(s), provider must utilize the Health Care Provider Application to Appeal a Claims Determination that is posted on the ABHNJ website and submit it to the following address:

Aetna Better Health of New Jersey

P.O. Box 81040
5801 Postal Road
Cleveland, OH 44181

Dental Vendor: LIBERTY Dental Plan

Dental benefits are administered by LIBERTY Dental Plan "LIBERTY", which manages the dental network and does utilization management for all services covered under the dental benefit. LIBERTY has a Provider Reference Guide that describes expectations and requirements for dental providers in their network. This is available on their website below.

LIBERTY Contact Information

Provider Services

888.352.7927

Claims questions:

888.352.7927, Option 2

Payor ID – CX083

Credentialing Hotline

Hotline 888.352.7924

Email:

PRinquiries@libertydentalplan.com

Authorizations, Claims

LIBERTY Dental Plan

ATTN: Claims Department PO Box 401086

Las Vegas, NV 89140

claims@libertydentalplan.com

Member Services

855-225-1727

Eligibility or Benefit Questions:

888.352.7927, Option 1

Credentialing,

LIBERTY Dental Plan

ATTN: Professional Relations

P.O. Box 26110 Santa Ana, CA 92799-6110

Website

www.libertydentalplan.com

Dental services provided through the dental benefit are managed by Aetna Better Health's dental vendor, LIBERTY. Utilization management is among the services they provide. Criteria established for dental benefits are described in their Provider Reference Guide and available on their website at www.libertydentalplan.com

In situations where a complex treatment plan is being considered, the provider may sequentially submit several prior authorization requests, one for each of the various stages of the treatment. Proposed treatment plans are reviewed through the prior authorization process to assure that all services are medically necessary and within the benefit.

Dental providers are required to follow the dental appointment standards established by DMAHS. The standards are as follows: Emergency dental treatment to members no later than forty-eight (48) hours or earlier as the condition warrants, urgent dental care appointments within three days of referral, and routine nonsymptomatic dental care appointments within thirty (30) days of referral. If a member calls when the dentist's office is closed, the member should be given information for a covering emergency provider by an answering service or telephone message. If the dentist is not able to see the member or is unavailable the member can also call LIBERTY at 888.352.7927 for help in scheduling an appointment or finding another dentist or visit the member portal at LIBERTY Dental Plan's website. Members always have the option to call Aetna Better Health of New Jersey Member Services at **1-855-225-1727**, which is available 24 hours a day. If the member is out of town and in need of emergency dental care, he/she can go to any dentist for care or call **LIBERTY Dental Plan** for help to find a dentist. Members do not need a referral or Aetna Better Health of New Jersey's prior approval before receiving emergency dental care.

Dental emergencies include:

- Tooth fracture
- Loss of a permanent tooth
- Severe gingival, jaw or mouth pain and fever
- Oral-facial trauma

There are no out-of-network benefits. If a member does not have access to a contracted provider within a reasonable distance from their home or work, LIBERTY will make the necessary accommodations for covered dental services to be rendered by a non-contracted dentist within a reasonable distance to them at no additional cost other than any applicable copay (if any). In these instances, LIBERTY Member Services may coordinate with the member to identify a desired provider and will confirm that the out of network provider is within an acceptable distance from their home or workplace. Additionally, they will ensure that member will not incur any costs for covered services.

Prior authorizations

How to request Prior authorization

- A prior authorization request may be submitted by faxing at **1-844-797-7601**.
- To confirm status of prior authorization please call **1-855-232-3596 prompt 6** and **5**.
- All provider types including BH, MH, and SUD will utilize these numbers for non-emergency and emergency authorization submission, and authorization status Forms available online at aetnabetterhealth.com/newjersey/provider under **Resources** click **Prior Authorization** page.

If a provider has written member consent, the provider may file a formal appeal on behalf of a member in writing, with Aetna Better Health of New Jersey within sixty (60) calendar days from the Aetna Better Health of New Jersey Notice of Action. The expiration date to file an appeal is included in the Notice of Action.

All written appeals should be sent to the following address:

Aetna Better Health of New Jersey
PO Box 81139
5801 Postal Road
Cleveland, OH 44181

Request on prior authorization

All out of network services must be authorized. Unauthorized services will not be reimbursed, and authorizations are not a guarantee of payment.

Decision	Decision/notification timeframe
Urgent pre-service approval	Within 24 hours of receipt of necessary information, but no later than 72 hours from
Urgent pre-service denial	Within 24 hours of receipt of necessary information, but no later than 72 hours from
Non-urgent pre-service approval	Within 14 calendar days (or sooner as required by the needs of the member) of receipt of necessary information sufficient to make an informed
Non-urgent pre-service denial	Within 14 calendar days (or sooner as required by the needs of the member) of receipt of necessary information sufficient to make an informed
Continued / extended services approval (non-ED/acute inpatient)	Within one business day of receipt of necessary information
Continued / extended service denial (non-ED/acute)	Within one business day of receipt of necessary information
Post-service approval of a service for which no pre- service request was received.	Within 30 calendar days from receipt of the necessary information
Post-service denial of a service for which no pre-service request was	Within 30 calendar days from receipt of the necessary information

Emergency Services

Emergency medical services are permitted to be delivered in or out of network without obtaining prior authorization if the member was seen for the treatment of an emergency medical condition. Aetna Better Health of New Jersey will not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms. Payment will not be withheld from providers in or out of network. However, notification is encouraged for appropriate coordination of care and discharge planning.

Services Requiring Prior Authorization

Our Secure Web Portal located on our website lists the services that require prior authorization, consistent with Aetna Better Health of New Jersey's policies and governing regulations. The list is updated at least annually and updated periodically as appropriate. All out of network services must be authorized except for emergency services.

Interested providers (provider enrollment)

If you are interested in applying for participation in our Aetna Better Health of New Jersey network, please visit our website at aetnabetterhealth.com/nj and complete the provider application forms (directions available online).

If you would like to speak to a representative about the application process or the status of your application, please contact our Provider Services Department at **1-855-232-3596**, these inquiries will be routed to the Network team. To determine if Aetna Better Health of New Jersey is accepting new providers in a specific region, please contact our Provider Services Department at the number located above.

If you would like to mail your application, please mail to:

Aetna Better Health of New Jersey
Attention: Provider Services
3 Independence Way, Suite 400
Princeton, NJ 08540

Please note this is for all medical type of providers including (HCBS, MLTSS, Ancillary, Hospital etc.). Please contact LIBERTY Dental Plan if you are a dental provider and are interested in becoming part of their network. See page 9 for LIBERTY Dental Plan contact information.

Provider inquiries

Providers may contact us at, **1-855-232-3596** from 8 a.m. and 5 p.m., Monday through Friday, or email us AetnaBetterHealth-NJ-ProviderServices@aetna.com for any and all questions including checking on the status of an inquiry, complaint, grievance, and or appeal that has been filed on behalf of a member. Our Provider Services Staff will respond within 48 business hours.

Sample ID Cards

MLTSS FRONT

Aetna Better Health® of New Jersey 

NJ FamilyCare Managed Long Term Services and Support (MLTSS)

Member ID # XXXXXXXXXXXXX Date of Birth 00/00/0000
 Member Name Last Name, First Name Sex X

PCP Last Name, First Name
 PCP Phone 000-000-0000 Effective Date 00/00/0000

Dental Benefit*
 CO-PAYS

PCP \$0	Brand \$0	RxBIN: 610591	
ER \$0	Generic \$0	RxPCN: ADV	
		RxGRP: RX8829	
Pharmacist Use Only: 1-855-319-6286			

AetnaBetterHealth.com/NewJersey
 THIS CARD IS NOT A GUARANTEE OF ELIGIBILITY, ENROLLMENT OR PAYMENT. NJMED1

A FRONT

Aetna Better Health® of New Jersey 

NJ FamilyCare A

Member ID # XXXXXXXXXXXXX Date of Birth 00/00/0000
 Member Name Last Name, First Name Sex X

PCP Last Name, First Name
 PCP Phone 000-000-0000 Effective Date 00/00/0000

Dental Benefit*
 CO-PAYS

PCP \$0	Brand \$0	RxBIN: 610591	
ER \$0	Generic \$0	RxPCN: ADV	
		RxGRP: RX8829	
Pharmacist Use Only: 1-855-319-6286			

AetnaBetterHealth.com/NewJersey
 THIS CARD IS NOT A GUARANTEE OF ELIGIBILITY, ENROLLMENT OR PAYMENT. NJMED1

B FRONT

Aetna Better Health® of New Jersey 

NJ FamilyCare B

Member ID # XXXXXXXXXXXXX Date of Birth 00/00/0000
 Member Name Last Name, First Name Sex X

PCP Last Name, First Name
 PCP Phone 000-000-0000 Effective Date 00/00/0000

Dental Benefit*
 CO-PAYS

PCP \$0	Brand \$0	RxBIN: 610591	
ER \$0	Generic \$0	RxPCN: ADV	
		RxGRP: RX8829	
Pharmacist Use Only: 1-855-319-6286			

AetnaBetterHealth.com/NewJersey
 THIS CARD IS NOT A GUARANTEE OF ELIGIBILITY, ENROLLMENT OR PAYMENT. NJMED1

C FRONT

Aetna Better Health® of New Jersey 

NJ FamilyCare C

Member ID # XXXXXXXXXXXXX Date of Birth 00/00/0000
 Member Name Last Name, First Name Sex X

PCP Last Name, First Name
 PCP Phone 000-000-0000 Effective Date 00/00/0000

Dental Benefit*
 CO-PAYS

PCP \$5	Brand \$5	RxBIN: 610591	
ER \$10	Generic \$1	RxPCN: ADV	
		RxGRP: RX8829	
Pharmacist Use Only: 1-855-319-6286			

AetnaBetterHealth.com/NewJersey
 THIS CARD IS NOT A GUARANTEE OF ELIGIBILITY, ENROLLMENT OR PAYMENT. NJMED1

D FRONT

Aetna Better Health® of New Jersey 

NJ FamilyCare D

Member ID # XXXXXXXXXXXXX Date of Birth 00/00/0000
 Member Name Last Name, First Name Sex X

PCP Last Name, First Name
 PCP Phone 000-000-0000 Effective Date 00/00/0000

Dental Benefit*
 CO-PAYS

PCP \$5	Rx \$5	RxBIN: 610591	
ER \$35	Rx>34 days \$10	RxPCN: ADV	
		RxGRP: RX8829	
After hours \$10 Pharmacist Use Only: 1-855-319-6286			

AetnaBetterHealth.com/NewJersey
 THIS CARD IS NOT A GUARANTEE OF ELIGIBILITY, ENROLLMENT OR PAYMENT. NJMED1

BACK

Member Services / Servicios al Miembro (24/7): 1-855-232-3596, TTY 711, 24/7
 Urgent Care: Call your primary care provider (PCP)
 Atención de Urgencia: Llame a su proveedor de cuidado primario (PCP)
 *LIBERTY Dental Plan Dental Services / Servicios de Dental: 1-855-225-1727

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.
 Atención de Emergencia: Si tiene una emergencia, llame al 911 o vaya al hospital más cercano. No necesita aprobación previa para el transporte de emergencia o la atención de emergencia en el hospital.

Prior authorization is required for all inpatient admissions and selected outpatient services. To notify of an admission, please call 1-855-232-3596.
 Se requiere autorización previa para todas las admisiones de internación y para ciertos servicios ambulatorios. Para notificar una admisión, llame al 1-855-232-3596.

Send Medical Claims: Aetna Better Health of New Jersey
 PO Box 61925, Phoenix, AZ 85082-1925

To verify member eligibility: 1-855-232-3596
 Electronic Claims: Payer ID 46320

NJMED1

Coordination of Benefits (COB) Frequently Asked Questions

What is the contact information for questions related to COB?

Providers can call us at **1-855-232-3596** between the hours of 8 a.m. and 5 p.m., Monday through Friday, or e-mail us at: **AetnaBetterHealth-NJ-ProviderServices@aetna.com**.

If a member is dually eligible or has a TPL policy how often does the provider have to submit a denial from Medicare and/or the TPL insurer?

Aetna Better Health of New Jersey is the payer of last resort. We require an annual EOB from MLTSS members for services not covered by the primary insurer Medicare Advantage. A new EOB will not be required for subsequent claims during the year from the same payer, provider, member, and service code. Services paid by TPL, which have been exhausted should be submitted with an EOB stating the benefit is exhausted before Aetna Better Health of NJ will pay for the service.

Does the Provider submit the denial from the Medicare and/or Commercial Insurance provider electronically or hard copy?

Hard copy with a copy of explanation of payment from Primary carrier.

If the EOB denial can be submitted in hard copy what is the address for submission?

Please use the following address when submitting claims to:

Aetna Better Health of New Jersey

P.O. Box 61925

Phoenix, AZ 85082-1925

How do providers track progress of paper copies of the EOB for individual members?

Participating providers may review the status of a claim by checking the Secure Provider Web Portal located on our website or by calling our Claims Investigation and Research Department (CICR) at **1-855-232-3596**.

What is required for Providers to submit to the Managed Care Plan if member has Medicare and/or Commercial Insurance and the Provider does not participate in the Medicare and/or Commercial Network?

The NJ FamilyCare MCO should require an EOB annually. When an EOB is received that indicates that the service is not covered by the primary insurer, the NJ FamilyCare MCO will pay for the service as the primary payer. A new EOB should not be required for subsequent claims during the calendar year for the same payer, provider, member, and service code. Services paid by a third party carrier may become a non-paid service if the member's benefits are exhausted. If this is the case, the provider should submit an EOB stating the benefit is exhausted before the

managed care organization pays for the service. When a NJ FamilyCare member has TPL through a commercial carrier, it may be necessary for Health Plan staff to investigate and verify third party coverage eligibility and/or benefits on behalf of the member.

Who do providers contact for technical assistance regarding claims submission and coordination of benefits for dually eligible members and members with Commercial Insurance?

Claims Investigation and Research Department (CICR) at **1-855-232-3596**.

Who do providers contact regarding Electronic Funds Transfer (EFT) and Electronic Remittance Advices (ERA/835 files)?

Call us at **1-855-232-3596** from 8 a.m. and 5 p.m., Monday through Friday, or e-mail us at **AetnaBetterHealth-NJ-ProviderServices@aetna.com**.