**Aetna Better Health® of California**
1-855-772-9076

# 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 California provider manual located at **aetnabetterhealth.com/california.**

**Eligibility verification**
Please contact us at **1-855-772-9076** or log into our Secure Web Portal to verify eligibility.

## Tools & Resources

**Website**

- Provider manual
- Member handbook
- 24/7 Secure Web Portal (*See below for full details)*
- Clinical guidelines
- Forms
- Provider education

**Secure Web Portal (24/7)**
The Secure Web Portal allows participating providers to perform a variety of tasks such as:

- Verifying eligibility
- Download various forms used to submit authorization requests
- Submission and verification of prior authorization requests, including status checks
- Review prior authorization requirement search tool
- Checking claims status
- Pull PCP roster of assigned members

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

**aetnabetterhealth.com/california**

## Claims

**Claim inquires**
Participating providers may review the status of a claim by checking the Secure Provider Web Portal located on our website at **aetnabetterhealth.com/california** or by calling our Claims Investigation and Research Department (CICR) at **1-855-772-9076.**

**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 90 day from the determination.

**Electronic claims submission**
We encourages participating providers to electronically submit claims through Change Healthcare (formerly Emdeon). Use **Payer ID# 128CA** when submitting claims to Aetna Better

Health of California.

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, correspondence, and/or resubmissions** Please use the following address when submitting paper claims use:

**Aetna Better Health of California Inc.**
**P.O. Box 982971**
**El Paso, TX 79998-2971**

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 our secure web portal**

We encourage providers to take advantage of using our 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 our website. Providers must register to use our portal. Please see Chapter 4 of the provider manual for additional details surrounding the secure web 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 our secure 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, which can be found on the **aetnabetterhealth.com/california.**

## Prior Authorizations

**How to request prior authorizations**

A prior authorization request may be submitted by:

- Submitting the request through the 24/7 secure web portal located on our website at **aetnabetterhealth.com/california.**
- 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 numbers
  **Sacramento 1-866-489-7441**
  **San Diego 1-844-584-4450**

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

request, visit the secure web portal at **aetnabetterhealth.com/california**, or call us at **1-855-772-9076**. The portal will allow you to check status, view history, and or email a case manager for further clarification if needed.

For further information about the secure web portal, 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 **1-855-772-9076.**

**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 faxing to the following number:
  **San Diego 1-844-584-4450**
- 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 | Seventy-two (72) hours from receipt of request |
| Urgent pre-service denial | Seventy-two (72) hours from receipt of request |
| Non-urgent pre-service approval | Five (5) calendar days from receipt of the request |
| Non-urgent pre-service denial | Five (5) calendar days from receipt of the request |
| 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/california**

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

### Sample ID Cards (Front & Back):