

June 2026

OfficeLink Updates™



Welcome to the latest edition of OfficeLink Updates (OLU). As always, we provide you with relevant news for your office.



HIGHLIGHTS IN THIS ISSUE

[Get credentialed with us faster](#)

We're working on reducing the time it takes for you to get credentialed or re-credentialed with us. One thing that tends to slow that process down is when we can't reach you to ask questions or request additional information.

[Navigate prior authorization \(PA\) like a pro](#)

PA doesn't have to slow you down or add costs. Our new downloadable resources tip sheet brings together tools, training and best practices from Aetna® and EviCore healthcare to help your team save time and reduce overhead.

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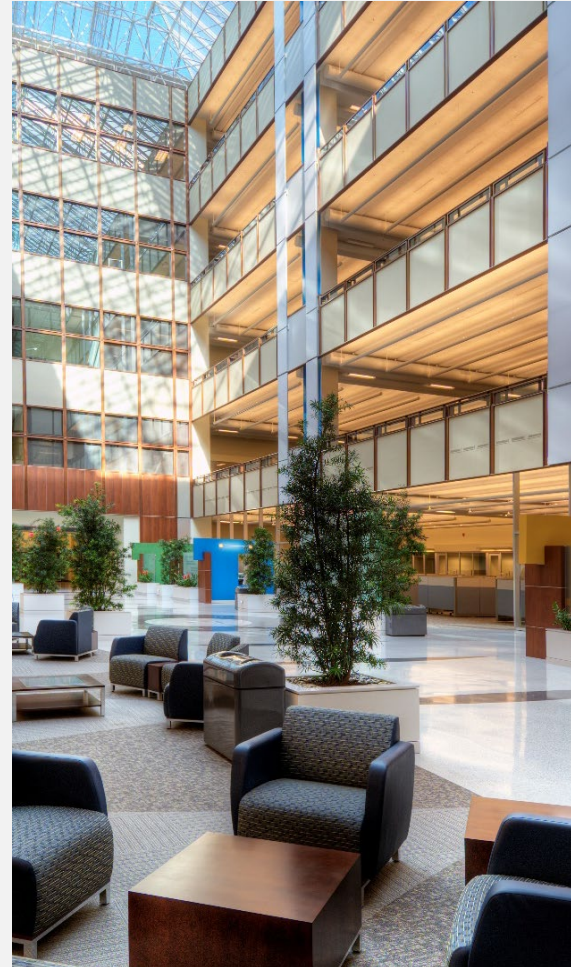
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Behavioral health

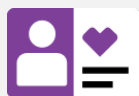
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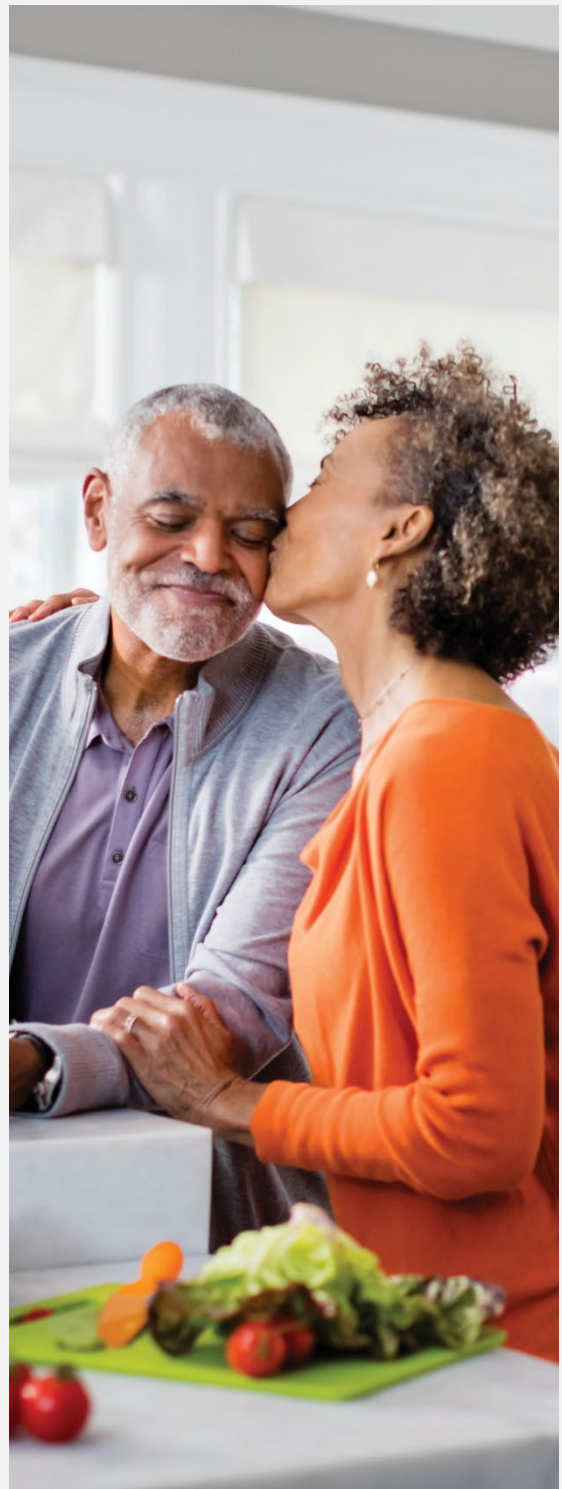
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Important policy updates (including pharmacy)

We regularly adjust our clinical, payment and coding policy positions as part of our ongoing policy review processes. Our standard payment policies identify services that may be incidental to other services and, therefore, ineligible for payment.

We're required to notify you of any change that could affect you either financially or administratively. These changes may not be considered material changes in all states.

Unless otherwise stated, policy changes apply to both Commercial and Medicare lines of business.

Claim and Code Review Program (CCRP) update

Starting September 1, you may see new claim edits.

This update applies to our commercial, Medicare and Student Health members.

Our program evaluates claims against industry coding guidelines such as those from the Centers for Medicare & Medicaid Services (CMS), American Medical Association Current Procedural Terminology (CPT®) coding standards and evidence-based guidelines from nationally recognized professional health care organizations and public health agencies.*

Beginning September 1, 2026, you may see new claim edits. These are part of our CCRP. These edits support our continuing effort to process claims accurately for our commercial, Medicare and Student Health members. You can view these edits on our [provider portal on Availity](#).**

For coding changes, go to Aetna Payer Spaces > Resources. In the search bar, search for "expanded claim edits."

Except for Student Health, you'll also have access to our code edit lookup tools. To find out if our new claim edits will apply to your claim, log in to Availity®. You'll need to know your Aetna® provider ID number (PIN) to access our code edit lookup tools.

We may request medical records for certain claims, such as high-dollar claims, implant claims, anesthesia claims, and bundled services claims, to help confirm coding accuracy.

*CPT® is a registered trademark of the American Medical Association. 2025 All rights reserved.

**Availity® is available only to providers in the U.S. and its territories.

Note to Washington State providers: For commercial plans, your effective date for changes described in this article will be communicated to you following regulatory review.

Note to Texas providers: Changes described in this article will be implemented for fully insured plans written in the state of Texas only if such changes are in accordance with applicable regulatory requirements. Changes for all other plans will be as outlined in this article.

Note to Maine and Vermont providers: For commercial plans, your effective date for routine changes described in this article will be the statutory date of January 1, April 1, July 1 or October 1, whichever date follows the effective date(s) referred to in this article. Changes required by state or federal law, or pursuant to revisions of Current Procedural Terminology (CPT®) codes published by the American Medical Association, may be effective outside the statutory dates outlined above.

Upcoming payment change for certain radiology services billed with modifier CT

This change applies to both our commercial and Medicare members.

What's changing

Effective September 1, 2026, we'll apply a 15% payment reduction to certain radiology services billed with modifier CT, consistent with the Centers for Medicare & Medicaid Services (CMS) reimbursement guidelines.

This reduction will apply to:

- The technical component (TC) of the service
- The TC portion of global billing
- Computed tomography (CT) imaging services
- Both the Medicare Physician Fee Schedule (MPFS) and the Outpatient Prospective Payment System (OPPS)

What this means for you

You can continue to report modifier CT when applicable, but know that services billed with modifier CT will receive a 15% reduction to the TC.

About modifier CT

Modifier CT is required when CT imaging is performed using equipment that doesn't meet the National Electrical Manufacturers Association (NEMA) XR 29-2013 "Smart Dose" standards.

CMS requires a 15% reduction for CT services billed with this modifier, and we're aligning our payment approach accordingly.

More information

Beginning September 1, 2026, you can find more details in the Multiple Procedure Reductions for Imaging and Diagnostic Procedures Payment Policy on our [provider portal on Availity](#).*

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Maternity care services coding restructure

The American Medical Association (AMA) and the American College of Obstetricians and Gynecologists (ACOG) are replacing the global maternity CPT® (Current Procedural Terminology) codes with Evaluation and Management services codes for antepartum and post-partum care, new labor management codes and updated delivery codes. These will be effective January 1, 2027. We're working to implement these codes and are committed to communicating these implementation updates to you as soon as they're available.

Upcoming changes to commercial drug lists

Find out about drug list changes and how to request drug prior authorizations (PAs).

On October 1, 2026, we'll update our pharmacy drug lists. These changes may include things like:

- Adding or removing specialty, brand-name and generic drugs
- Changing preferred or non-preferred drugs
- Changing PA, quantity limits and step-therapy requirements

You'll be able to view the changes as early as August 1, 2026. They'll be on our [Formularies and Pharmacy Clinical Policy Bulletins](#) page.

Ways to request a drug PA

- Submit your PA through [CoverMyMeds](#).
- For requests for non-specialty drugs, call [1-800-294-5979 \(TTY: 711\)](#). Or fax your [authorization request form \(PDF\)](#) to [1-888-836-0730](#).
- For requests for drugs on the Aetna Specialty Drug List, submit precertification requests online at least two weeks in advance. You can submit specialty drugs with Novologix® through our [provider portal on Availity](#) or you can call [1-866-814-5506 \(TTY: 711\)](#).*

Medications on the Aetna Drug Guide and on the precertification, step-therapy and quantity-limits lists are subject to change.

More information

For more information, refer to the [Contact Aetna](#) page.

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Important pharmacy updates

Read the updates for [Medicare, Medicare Part B step therapy and commercial](#).

Medicare

Visit our [Medicare drug list](#) page to view the most current Medicare plan formularies (drug lists). We update these formulary documents regularly during the benefits year as we add or update additional coverage each month.

Visit our [Medicare Part B step therapy](#) page to view the most current Preferred Drug Lists for Medicare Advantage (MA) and Medicare Advantage with prescription drug coverage (MAPD) members. We update these lists regularly throughout the plan year.

Commercial — notice of changes to prior authorization (PA) requirements

Visit our [Formularies and Pharmacy Clinical Policy Bulletins](#) page to view:

- Commercial pharmacy plan drug guides with new-to-market drugs we add monthly
- Clinical policy bulletins with the most current PA requirements for each drug

Student Health

Visit [Aetna Student Health](#) to view the most current Aetna Student HealthSM plan formularies (drug lists). Follow these steps:

1. Select your college or university and click “View your school.”
2. Select the “Members” link at the top of the page.
3. Click the “Prescriptions” link under Resources for Members.
4. Scroll down to the Aetna Pharmacy Documents section.

Aetna[®] federal employee plans

Visit our [Aetna Federal Plans](#) website to view the most current formularies (drug lists).



State-specific updates

Here you'll find state-specific updates on programs, products, services, policies and regulations.

Updates to office notice addresses for contract notifications

New addresses are effective immediately.

This article applies to the following states: Delaware, Pennsylvania and West Virginia.

We have migrated our office-based provider notice addresses to a specific P.O. box as we move to a digital mail system.

If you've been using any of the following old addresses for commercial and Medicare medical contract notifications, please start using the new address effective immediately.

Delaware address

Old address: 750 Prides Crossing, Suite 200, Newark, DE 19713
New address: Aetna Network Management
P.O. Box 818047, Cleveland, OH 44181-8047

Pennsylvania address

Old address: 1425 Union Meeting Road, Blue Bell, PA 19422
New address: Aetna Network Management
P.O. Box 818047, Cleveland, OH 44181-8047

Old address: 3721 Tec Port Drive, Harrisburg, PA 17111
New address: Aetna Network Management
P.O. Box 818047, Cleveland, OH 44181-8047

West Virginia address

Old address: 2222 Ewing Road, Moon Township, PA 15108
New address: Aetna Network Management
P.O. Box 818047, Cleveland, OH 44181-8047

All behavioral health contract notifications:

Old address: 1425 Union Meeting Road, Blue Bell, PA 19422
New address: Aetna Behavioral Health

P.O. Box 818047, Cleveland, OH 44181-8047

For new addresses for Alaska, Arizona, California, Colorado, Idaho, Kansas, Maine, Michigan, Nebraska, Nevada, New Jersey, Oregon, Texas, Utah, Virginia and Washington, refer to page 10 of the [December 2025 quarterly issue of OLU](#).

Notice of material amendment/change to contract

This article applies to the following states: Colorado and Ohio.

For important information that may affect your payment, compensation or administrative procedures, refer to the [Important Policy Updates](#) section of this newsletter.

Aetna® Market Fee Schedule (AMFS) update

This article applies to the following states: Illinois, Indiana, Georgia, Michigan, Minnesota, Missouri and Wisconsin.

We're updating our AMFS for plans in your service area. These changes will affect the services we pay you for based on AMFS. You can find these services in the compensation section of your contract. The following states will see these changes:

- Effective September 1, 2026: Michigan, Minnesota and Wisconsin
- Effective October 1, 2026: Illinois, Indiana and Missouri
- Effective October 15, 2026: Georgia

How we determine our fee schedule

We look at industry standards and other sources, such as the Resource-Based Relative Value Scale (RBRVS) on the Centers for Medicare & Medicaid Services (CMS) website.

- For codes using RBRVS, we use the site-of-service differential. This lets us make additional payments for certain codes based on the service location.
- For codes where RBRVS is either not used or not available, we use sources like external vendor pricing models, Medicare fee schedules and nationally contracted rates.

View the fee schedules

The updated fee schedules could be available to view as early as:

- September 1, 2026, for Michigan, Minnesota and Wisconsin

- October 1, 2026, for Illinois, Indiana and Missouri
- October 15, 2026, for Georgia

You can view them on our [provider portal on Availity](#).* Or go to [Aetna.com](#). Choose “more Aetna” then “medical providers.” Then choose “claims.”

We’re here to help

If you have questions, refer to our [Contact Aetna](#) page.

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California : New health care privacy requirements

Certain geofencing and location-tracking practices around in-person health care facilities are restricted.

Updated Confidentiality of Medical Information Act (CMIA) requirements

Effective September 20, 2025, [California Senate Bill 81 \(SB 81\)](#) strengthens patient privacy and access to care by limiting immigration enforcement activities in health care settings. The law expands the definition of protected medical information to include a patient’s immigration status and place of birth and generally prohibits sharing this information for immigration enforcement purposes without patient authorization or a valid judicial warrant or court order.

SB 81 also restricts immigration enforcement access to patients and nonpublic areas of health care facilities and requires providers to establish procedures and staff training for responding to enforcement requests. These changes are intended to ensure that patients can seek care without fear and to reinforce existing confidentiality obligations under California law.

Privacy around health care facilities

Effective January 1, 2026, [California Assembly Bill 45 \(AB 45\)](#) enhances privacy protections for individuals seeking health care services by limiting the collection, use and sharing of personal and location-based information. The law restricts certain geofencing and location-tracking practices around in-person health care facilities, including family planning centers, and generally prohibits the use of personal information obtained through these practices except in limited circumstances.

AB 45 also expands enforcement by allowing civil actions for violations.

These changes are intended to help ensure that individuals can access care without concern about surveillance or misuse of sensitive information.

These new privacy requirements apply to all California contracted providers and health care facilities.

California: Use our interpretation service at no cost

This program is for both providers and members, and our hotlines and help centers can provide translations of important medical documents.

Need help giving care to non-English-speaking Aetna® members? Just use our Language Assistance Program (LAP). There's no charge for this interpretation service.

You can call [1-800-525-3148](tel:1-800-525-3148) (TTY: [711](tel:711)) to reach a qualified interpreter directly.

Members can also request interpretation services from our LAP by calling the number on their ID card. They can contact our LAP for general questions, to file a grievance or to get a grievance form.

Questions?

Get help from your state. Just call the:

- [CA Department of Insurance](#) Hotline at [1-800-927-4357](tel:1-800-927-4357) for traditional plans
- CA Department of Managed Health Care Help Center at [1-888-466-2219](tel:1-888-466-2219) (TDD: [1-877-688-9891](tel:1-877-688-9891)) for HMO and DMO plans

You can reach the [California Department of Managed Care Help Center](#) 24/7. The department's internet web site is www.dmhc.ca.gov. It provides written translation of independent medical review and complaint forms in Spanish, Chinese and other languages. You can get paper copies of the forms by submitting a written request to:

California Department of Managed Health Care
Help Center
980 9th Street, Suite 500
Sacramento, CA 95814-2725

Or, for traditional plans, visit the [California Department of Insurance](#) at www.insurance.ca.gov/01-consumers/101-help/index.cfm.

California: Make member grievance forms available at your office

You can get these forms, which allow members to file grievances with numerous entities, in English or Spanish.

California regulations require you to make [member grievance forms](#) for health plans available at all office or facility locations.

Our members may file a grievance with us, the California Department of Managed Health Care (DMHC), or the California Department of Insurance (CDI) for any reason, including delays in timely access to care or timely referrals.

You can download the California HMO and California DMO grievance forms, which include information about member rights and responsibilities, in English and Spanish.

California: Access standards

These standards cover [appointment availability, exceptions to appointment time frames and criteria for rescheduling](#).

California law has established appointment availability standards to ensure timely access to necessary health care services. Our members have the right to schedule an appointment within the following time frames:

Appointment type	Time frame
Urgent care services that don't require prior authorization	48 hours from request
Urgent care services that require prior authorization	96 hours from request
Non-urgent doctor appointment (primary care physician)	10 business days
Non-urgent doctor appointment (specialty physician)	15 business days
Non-urgent mental health appointment (non physician)	10 business days
Non-urgent appointment (ancillary provider)	15 business days
Non-urgent follow-up appointments with a non-physician mental health care or substance use disorder provider	10 business days for those undergoing a course of treatment for an ongoing mental health or substance use disorder condition

Note: A referral to a specialist by a primary care provider or another specialist is subject to the relevant time-elapsing standards listed above.

Exceptions to the above appointment time frames

- The above time frames may be extended if the referring or treating provider determines and notes in the appropriate record that a longer wait time won't have a negative impact on the member's health.
- Preventive care services and follow-up care may be scheduled in advance as determined by the treating licensed health care provider.

Rescheduling appointments

If it's necessary for you or a member to reschedule an appointment, the appointment must be promptly rescheduled in a manner that's appropriate for the member's health care needs and that ensures continuity of care consistent with good professional practice.

We don't delegate monitoring and assessment of these standards to any of our contracted provider groups. We'll assess our contracted provider network against these standards by conducting an annual provider survey to assess appointment availability and a provider satisfaction survey to solicit concerns and perspectives.

California: 2026 Provider Appointment Availability Survey (PAAS)

We might contact your office with our brief survey questions, and we're required to send your responses to the DMHC and the CDI.

California law requires that health plans survey their network providers annually to ensure that they comply with California time-elapsed standards for urgent and non-urgent appointments.

We've contracted with Sutherland Healthcare Solutions to administer the PAAS for 2026. We'll assess compliance through the PAAS and report the results to the California Department of Managed Health Care (DMHC) and to the California Department of Insurance (CDI).

Your office may be contacted via fax, email or phone for the purposes of this assessment. This survey should take only a few minutes of your time and will be conducted during normal business hours. We appreciate your cooperation in complying with this regulation.

Providers to be surveyed

- Primary care physicians (PCPs)
- Specialty physicians
- Psychiatrists

- Non-Physician Mental Health (NPMH) providers and Substance Use Disorder (SUD) providers
- Ancillary providers who offer mammogram appointments and ancillary providers who offer physical therapy appointments

Survey questions

- Urgent appointments: Is the appointment date and time within 48 hours (for a PCP/ specialist/psychiatrist/NPMH or SUD visit request)?
- Non-urgent appointments: Is the appointment date and time within 10 business days (for a PCP/NPMH visit request or a SUD visit request) or within 15 business days (for a specialist/psychiatrist/ancillary visit request)?

Note that both in-person visits and telehealth visits qualify as appointments.

The importance of your response

Because you're a contracted provider, you must respond to the survey. Your response should accurately reflect your appointment availability for our members. We'll report all responses, including non-responses, to the DMHC and CDI. If your office doesn't respond to the survey, we'll issue a corrective action plan.

Colorado: Prior authorization (PA) exemption program (Gold Carding)

We'll review eligibility for new exemptions annually.

Effective May 1, 2026, we're offering a PA exemption program ("Gold Carding") that will apply to fully insured Colorado commercial plan members (identified by "CO DOI" on the ID card) consistent with Colorado law (C.R.S. §§ 10-16-112.5 and 10-16-124.5).

If you submitted at least five PA requests in the prior calendar year for a specific health care service or drug and had a 90% or higher approval rate for those requests, you qualify for an exemption from requesting PAs for that service or drug.

We sent letters in April to tell you whether you qualified for an exemption. We'll review eligibility for new exemptions annually and may audit claims to confirm that you continue to meet exemption requirements.

If you have questions, call the credentialing phone number on the [Contact Aetna](#) page.

Nevada: Prior authorization (PA) update for SNF and IRF episode management

This change affects Medicare Advantage (individual and group) and Dual Eligible Special Needs Plan (D-SNP) members only.

Effective August 1, 2026, WellSky™ will manage all PA requests for Skilled Nursing Facility (SNF) and Inpatient Rehabilitation Facility (IRF) episode management.

Long-Term Acute Care Hospital (LTACH) PA requests will continue to be submitted directly to us.

How to contact WellSky

- Call the WellSky provider line at [1-855-739-0742](tel:1-855-739-0742).
- Submit PA through the [WellSky™ provider portal](#).

More information

If you have questions, please contact Aetna Medicare at [1-855-335-1407](tel:1-855-335-1407) (TTY: [711](tel:711)) and choose option 4 for providers.

Nevada: Changes to the Aetna Medicare Advantage (MA) home health program

Find out how to participate, and learn more about claims payments and pre-approvals.

Effective September 1, 2026, we'll use tango™ as our home health care network. Tango works with payers and providers to ensure that patients receive high-quality care at home. The tango home health network is for MA members living in Nevada.

How to participate

If you have a tango contract, you'll automatically participate for our Nevada MA members under their tango contract. The tango rates and terms of that contract will apply, and tango will pay directly for covered services. You'll continue to collect applicable copayment and coinsurance amounts directly from patients, and covered services will continue to apply toward deductibles.

If you're not participating with tango, you'll need to sign an agreement with tango. Otherwise, you'll be out of network. You can contact tango directly by:

- Visiting the [tango contracting](#) page

- Emailing [Provider Relations](#)
- Calling [1-888-705-5274](tel:1-888-705-5274)

Claims payment changes

Tango will pay claims for covered home health services filed with an authorization. Claims for home health visits with dates of service on or after September 1 should be billed to tango. They'll be paid under the rates and terms of your tango contract.

Find out more about [how to send claims to tango](#).

Pre-approvals

Tango requires pre-approval for the following services whether they are administered in a home or residence:

- In-home skilled nursing
- Physical therapy
- Occupational therapy
- Speech therapy
- Home health aide services
- Medical social work

These services will be listed before September 1 on [Aetna.com](https://www.aetna.com).

How to send pre-approval requests:

1. Register at [tango](#).
2. Fax the [authorization request form \(PDF\)](#) to **1-877-612-7066**.

For authorization inquiries:

- Register at [tango](#) and submit a FreshDesk ticket.
- Call tango (Monday through Friday, 8 AM to 8 PM ET) at [1-888-705-5274](tel:1-888-705-5274).
- [Email a network representative](#).

More information

If you have questions, please contact Aetna Medicare at [1-855-335-1407](tel:1-855-335-1407) (TTY: 711) and choose option 4 for providers. You can also [email the tango provider network team](#) or call tango at [1-888-705-5274](tel:1-888-705-5274).



News for you

You'll find information — new services, tools and reminders — to help your office comply with regulations and administer plans.

Federal Employee Health Benefits and Postal Service Health Benefits Program telehealth services

The Centers for Medicare & Medicaid Services (CMS) released an updated telehealth toolkit, which includes strategies for delivering services via telehealth.

Telehealth delivers clinical care remotely using telecommunications technology to improve health care access. CMS recently released its updated [telehealth toolkit \(PDF\)](#), which can help you serve specific populations, including children and youth, and provide maternal and behavioral health services.

If you offer telehealth visits, note that:

- You should always get consent for audio and video recordings of visits, as required by federal and state law
- You must keep Protected Health Information (PHI) confidential
- You must comply with the [Health Insurance Portability and Accountability Act \(HIPAA\) Privacy Rule](#).

New provider onboarding webinar for providers and their staff

Take our “Doing business with Aetna” webinar to get lots of your questions answered.

New to Aetna®? Or do you simply want to see what's new? Join us in our new provider onboarding webinar — Doing business with Aetna — to discover tools, processes and resources that'll make your day-to-day tasks with us simple and quick.

We'll show you how to:

- Locate provider manuals, clinical policy bulletins and payment policies
- Access online transactions such as those related to eligibility, benefits, precertifications and claim status/disputes
- Locate Help & Training on Availity®
- Access our online forms
- Navigate to our provider referral directory and Medicare directory
- Update your provider data and much more

Register today

The [new provider onboarding webinar](#) — Doing business with Aetna — is offered on the second Tuesday and third Wednesday of every month, from 1 PM to 2:30 PM ET.

Questions?

Just [email us](#) with any questions that you may have. We look forward to seeing you in an upcoming session.

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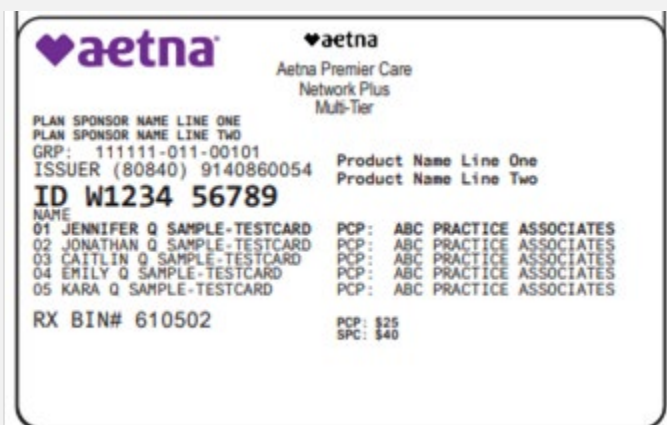
Verifying patient eligibility for Aetna® Premier Care Network (APCN) Plus Multi-Tier plan

[Find out how to identify patients in the multi-tier program and view examples of ID cards.](#)

Some of your patients might be in our new APCN Plus Multi-Tier program. This program is a national performance network offering. Multi-tiered programs sort providers and facilities into tiers based on their performance and the ability for the patient to save money. The highest performing and most efficient providers are in Tier 1.

How to identify patients in the multi-tier program

The member ID card will say “Aetna Premier Care Network Plus Multi-Tier.” ID cards for members enrolled in the Aetna Whole Health (AWH) network will also include the name of the AWH. Example ID cards are shown below.




Use www.aetna.com to choose providers in your plan.

MEDICAL INDIVIDUAL	Tier 1	Tier 2	FAMILY	Tier 1	Tier 2
INN DED	\$\$\$\$\$\$	\$\$\$\$\$\$		\$\$\$\$\$\$	\$\$\$\$\$\$
INN OOP MAX	\$\$\$\$\$\$	\$\$\$\$\$\$		\$\$\$\$\$\$	\$\$\$\$\$\$
OON DED	\$\$\$\$\$\$			\$\$\$\$\$\$	
OON OOP MAX	\$\$\$\$\$\$			\$\$\$\$\$\$	

MEMBER/PROVIDER SERVICES 1-888-888-8888
 RX MEMBER SERVICES 1-888-888-8888
 MENTAL/BEHAVIORAL HEALTH 1-888-888-8888

See your plan documents for all plan requirements, including precertification. In an emergency, seek care immediately or call 911. This card does not guarantee coverage.
www.aetna.com




Product Name Line One
 Product Name Line Two

PLAN SPONSOR NAME LINE ONE
 PLAN SPONSOR NAME LINE TWO

ID W1234 56789
01 AUDREY Q SAMPLE-TESTCARD
 PCP: ABC PRACTICE ASSOCIATES
02 JESSIE Q SAMPLE-TESTCARD
 PCP: ABC PRACTICE ASSOCIATES
03 CAITLIN Q SAMPLE-TESTCARD
 PCP: ABC PRACTICE ASSOCIATES
04 EMILY Q SAMPLE-TESTCARD
 PCP: ABC PRACTICE ASSOCIATES
05 KARA Q SAMPLE-TESTCARD
 PCP: ABC PRACTICE ASSOCIATES

PAYER NUMBER 60054 NNNN
 GRP: 888888-011-00101

Medical Legal Entity Prints Here
 Submit Claims To: PO BOX 981106
 EL PASO TX 79998-1106

Aetna Whole HealthSM
New Jersey 

AWH New Jersey - www.aetna.com

MEDICAL INDIVIDUAL	Tier 1	Tier 2	FAMILY	Tier 1	Tier 2
INN DED	\$\$\$\$\$\$	\$\$\$\$\$\$		\$\$\$\$\$\$	\$\$\$\$\$\$
INN OOP MAX	\$\$\$\$\$\$	\$\$\$\$\$\$		\$\$\$\$\$\$	\$\$\$\$\$\$
OON DED	\$\$\$\$\$\$			\$\$\$\$\$\$	
OON OOP MAX	\$\$\$\$\$\$			\$\$\$\$\$\$	

MEMBER/PROVIDER SERVICES 1-888-888-8888
 RX MEMBER SERVICES 1-888-888-8888
 MENTAL/BEHAVIORAL HEALTH 1-888-888-8888

See your plan documents for all plan requirements, including precertification. In an emergency, seek care immediately or call 911. This card does not guarantee coverage.
www.aetna.com

Eligibility

- Run an Eligibility and Benefits (E&B) inquiry to check if the patient is eligible based on your tier.
- To check your participation and tier status, review the limitations section of the E&B response or use our [Provider Referral Directory](#).

Tier 1 participation

- If you're a Tier 1 provider or facility, "maximum savings" will be displayed.

- This tier is APCN Plus, which is covered at the highest benefits level.

Tier 2 participation

- If you're a Tier 2 provider or facility, "standard savings" will be displayed.
- Facilities may be listed with both "maximum savings" and "standard savings" due to the facility and providers being included under the same tax ID. We refer to this as "mixed participation" status.
- This tier is our broad network and is covered at a reduced benefits level. Most providers and facilities contracted with us but aren't designated as Tier 1 will be covered at the Tier 2 benefits level.

Out of network

- If you're out of network, the system will display this for the APCN Plus plan, it'll display as: "We are unable to determine your participation status... Services rendered by providers that are not part of the patient's network are not covered."
- A member might still be covered for out-of-network benefits.

Questions?

If you have questions, refer to our [Contact Aetna](#) page.

A simpler way to request fee schedules

This new streamlined process will improve your experience when working with us.

Effective June 1, 2026, the [fee schedule mailbox](#) will be retired. You can begin using the new, streamlined process today and it'll be required after this date.

Here's what you need to know:

- 10 codes or fewer: Requests can still be handled by phone or in writing.
- 11 or more codes or full fee schedules:
 - Medical doctors (MDs) and doctors of osteopathic medicine (DOs) with direct contracts with us can quickly access fee schedules through our [provider portal on Availity](#).*
 - All other providers should submit a request using the "Contact Us" form on Availity® or [Aetna.com](#) (select Fee Schedule). Include:
 - Provider's service address (include all locations, if applicable)
 - TIN(s), as applicable
- Fee schedules will be delivered via email.

This update helps reduce wait times and offers more convenient self-service options. Thank you for partnering with us as we continue to improve your experience.

*Availity® is available only to providers in the U.S. and its territories.

How to fax medical records to us

Sending one fax per member will reduce delays.

Because we can attach faxes only to one patient's record, you'll experience delays if you fax medical records that include information for multiple patients.

What to include with each fax

When you submit clinical documentation, continue using your standard fax cover sheet and ensure that it includes:

- The full case reference number, including all digits (and any zeros provided by us); if the patient has more than one reference number, list only the most recent one
- The member ID number
- Clear, typed information to support accurate matching

Update to P.O. boxes used for claims-related correspondence

In the past, we stopped using two claims P.O. boxes in Lexington, Kentucky: 14088 and 14089. These boxes are open again. But they don't accept Aetna® claims or claims-related mail.

What you need to know

We're no longer accepting medical or dental claims or claims-related mail to P.O. boxes 14088 and 14089 in Lexington, Kentucky.

Claims and claims-related mail includes but isn't limited to:

- Initial claims
- Corrected claims
- Resubmissions
- Appeals
- Requests for reconsideration
- Supporting documentation for all of the above

Please use the following P.O. boxes:

- Medical claims and claims-related correspondence: P.O. Box 14079, Lexington, Kentucky 40512-4079
- Dental claims and related correspondence: P.O. Box 14094, Lexington, Kentucky 40512-4094

Note that P.O. Box 981106, El Paso, TX 79998-1106 remains open and active for claims and claims-related correspondence.

If you use a biller or third-party administrator (TPA), please notify them or their office of this change.

Navigate prior authorization (PA) like a pro

Streamlined workflows reduce administrative delays and help lower operational costs, freeing up time and resources for patient care.

PA doesn't have to slow you down or add costs. Our new downloadable resources tip sheet brings together tools, training and best practices from Aetna® and EviCore healthcare to help your team save time and reduce overhead.

What's available?

- **EviCore** Providers' Hub: Access training guides like "How to Speed Up Prior Authorization" and "Keys to Avoiding Peer-to-Peer Calls." Plus, use tools to schedule peer-to-peer discussions, upload clinical information and check case status online.
- Our **Clinical Policy Bulletins**: Gain clarity on coverage guidelines for medical and pharmacy services.
- Precertification tools: Use our **code lookup tool** and forms to ensure smooth submissions.
- Education and training: Join webinars, explore Availity® demos and learn how to submit drug PA requests through Novologix®.*

More information

Visit our **provider portal on Availity**. Go to Aetna Payer Spaces > Resources. In the search bar, search for "Prior authorization resources."

*Availity® is available only to providers in the U.S. and its territories.

Help improve communication between treating providers

Use our forms to make it easier to communicate with other practitioners.

Based on the results of a recent survey, we know that primary care physicians (PCPs) are concerned about how they don't get regular reports about their patients' ongoing evaluation and care from other treating providers.

This breakdown in communication can pose a threat to quality patient care. We understand that coordinating care with many physicians, facilities and behavioral health care professionals can be a challenge.

Use our tools to share information

Comprehensive patient care includes communicating with your patients' other treating health care professionals. To promote collaboration and comprehensive care, it's critical that PCPs and specialists talk openly with each other.

You can use [our forms and applications](#) to help.

Thank you for your efforts to improve how you communicate with other providers.

The chronic condition improvement program (CCIP)

Learn more about how the CCIP is designed to improve your patients' quality of life.

Every year, our Quality Management Department implements the CCIP. We do this in accordance with Centers for Medicare & Medicaid Services (CMS) requirements.

The CCIP is a clinical effort designed to improve your patients' quality of life.

What does the CCIP do?

The CCIP promotes effective management of enrollees' chronic diseases over a three-year period. The program goals are to:

- Slow disease progression
- Prevent complications
- Inhibit development of comorbidities
- Reduce preventable emergency room (ER) encounters
- Decrease inpatient stays
- Improve the health of a specific group of enrollees with chronic conditions

How does the CCIP improve health outcomes?

The quality improvement model we use is based on the Plan-Do-Study-Act (PDSA) quality improvement model. In accordance with the CMS CCIP Resource Document, PDSA is cyclical in nature and includes planning, implementing, and studying a change and acting on the result of that change. Care management incorporates the PDSA model into the CCIP interventions.

What you can do

Urge your patients to take part in the program so we can help manage their chronic diseases.

Resources

Learn more about our [care management initiatives](#) and refer to your [provider manual \(PDF\)](#).

Help improve the health care transition for adolescents and young adults

Use the resources listed in this article to give your young patients the help they need.

We know that adolescents and young adults are a vulnerable population with evolving health conditions, high rates of behavioral health risks and low use of health care services. Health care clinicians play a crucial role in supporting the transition from pediatric to adult health care. For optimal health outcomes, transitioning adolescents need supportive primary care providers and specialists.

We're here to help

To support our youth and help facilitate an effective transition, we provide resources you can use when you talk with your patients:

- The health plan's website to learn more about available plan benefits and special programs
- The Aetna HealthSM app, so you can keep a safe and handy health record online
- The Health Risk Assessment, which helps provide personalized health results that can be shared with clinicians confidentially
- Access to Aetna[®] nurses, who can help navigate the health care system and find needed resources
- Access to behavioral health counselors to help arrange mental health or substance use disorder care and connections to community resources
- Access to telehealth services, which offer flexible ways to get care

Our annual transition to the new edition of the MCG

We use evidence-based clinical guidelines from nationally recognized authorities, such as MCG, to make utilization management (UM) decisions.

Every year, we coordinate with MCG to update to their new edition. On June 5, 2025, we'll start using the 30th edition of the MCG and will use it for designated reviews.

Get credentialed with us faster

[Make sure we have an updated, credentialing-specific email address.](#)

We're working on reducing the time it takes for you to get credentialed or re-credentialed with us. One thing that tends to slow that process down is when we can't reach you to ask questions or request additional information.

We know that you give us a credentialing email address on the application, but sometimes that address changes.

To make sure we have an updated address, you can get in touch with your Aetna® network representative, if you have one. If not, another good time to update us is during contract renewal.



Behavioral health

Stay informed about behavioral health coverage updates so you can deliver the best possible treatment to your patients.

Behavioral health clinical criteria

[Read about how we determine coverage and where to go for more information.](#)

How we determine coverage

Our medical directors make all coverage denial decisions based on behavioral health clinical criteria. Only our medical directors, psychologists, board-certified behavior analysts-doctoral (BCBA-D) and pharmacists make denial decisions for reasons related to medical

necessity. (Licensed pharmacists and psychologists review coverage requests as permitted by state regulations.)

Where state law mandates, utilization review coverage denials are made, as applicable, by a physician or pharmacist licensed to practice in that state.

Behavioral health staff use evidence-based clinical guidelines from nationally recognized authorities to guide utilization management decisions involving precertification, inpatient review, discharge planning and retrospective review. Staff use the following criteria as guides in making coverage determinations, which are based on information about the specific member's clinical condition:

More information about our behavioral health clinical criteria

- [**Aetna clinical policy bulletins**](#)
- [**Guidelines for coverage determination**](#)
- [**Centers for Medicare & Medicaid Services \(CMS\):**](#)
 - National Coverage Determinations (in the blue box at the top of the page)
 - Local Coverage Determinations (under Coverage Process)
 - Medicare Benefit Policy Manual (under Related Instructions)
- [**The American Society of Addiction Medicine \(ASAM\) Criteria:**](#) textbook, third edition (applies only to our commercial line of business starting on January 1, 2024. The ASAM criteria content is copyrighted. Contact the [**American Society of Addiction Medicine**](#) for information on how to purchase it. Substance use disorder care in New York state: [**Level of Care for Alcohol and Drug Treatment Referral \(LOCADTR\)**](#)
- [**LOCUS® and CALOCUS-CASII®**](#)
- [**\(CMS\) Medicare Prescription Drug Benefit Manual**](#)
- [**\(CMS\) Medicare Managed Care Manual**](#)

States may also mandate the use of other criteria and guidelines.

Hard copies

Need hard copies of a specific criteria for a specific determination? We're here to help. Visit our [**Contact Aetna**](#) page.

The behavioral health section of our provider manual keeps you informed

Learn more about clinical management and delivery, medical record documentation requirements and our behavioral health case management program.

Visit us online to view a copy of the [Office Manual for Health Care Professionals \(PDF\)](#). If you don't have Internet access, call our Provider Contact Center at [1-888-MD AETNA \(1-888-632-3862\)](#) (TTY: [711](#)) to get a paper copy.

What's in the manual

The manual contains information on the following:

- Our behavioral health guiding principles
- Behavioral health medical record documentation requirements
- Our behavioral health case management program and how to refer your patients
- Member rights and responsibilities
- Telehealth services
- Clinical management and delivery, including coordination of care
- Behavioral health screening programs
- Our behavioral health quality program

More information

If you have questions, refer to our [Contact Aetna](#) page.

Aetna® behavioral health appointment timeliness and after-hours availability standards

Review our [Network Participation Criteria Manual](#) for more information about these standards.

We want to ensure timely access to care and safety for our members. We complete yearly surveys of our behavioral health network providers to assess compliance.

Appointment timeliness standards

Each behavioral health care provider must schedule appointments with members, at a minimum, within the following timeframes:

- Emergency/urgent care: Must be seen immediately (or referred to emergency room/urgent care/crisis center, as appropriate)
- Symptomatic/non-urgent acute care: Within seven business days

- Routine and preventive care: Within 10 business days
- Follow-up care:
 - Non-prescribers of medication: Within three weeks
 - Prescribers of medication: Within five weeks

After-hours availability standards

Each behavioral health care provider must have, at minimum, a voicemail system in place 24-hours-per-day, 7-days-per-week, which directs patients to go to the nearest emergency department and/or to call 911/988 in a crisis.

Please see the [Network Participation Criteria Manual](#) for the most up-to-date information about these standards.

We thank you for keeping these measures in place to ensure the safety of your patients and clients.

If you have questions, refer to our [Contact Aetna](#) page.



Get Medicare-related information, reminders and guidelines.

Complete your required Medicare compliance training and attestation by October 31, 2026

You received an email via Adobe Acrobat Sign this spring reminding you about the annual training and attestation that the Centers for Medicare & Medicaid Services (CMS) requires. If we don't have your compliance email address, you'll receive a postcard reminder.

If you're participating in our Medicare Advantage (MA) plans, you must meet CMS compliance requirements for first-tier, downstream and related entities (FDR). If you're caring for Special Needs Plan (SNP) members, you must also complete your annual Model of Care (MOC) training.

To learn more about our MA plans, including SNPs, view our [Medicare Advantage quick reference guide \(PDF\)](#).

How to submit your attestation

Visit the [Medicare compliance and attestation](#) page to review the training materials and submit your attestation by October 31, 2026, to remain compliant.

Reminder: Updated Medicare Hospital CMS OMB MOON, IM, DND Patient Notices

Prior versions of the MOON, IM and DND are no longer accepted.

The Centers for Medicare & Medicaid Services (CMS) released updated, Office of Management and Budget (OMB)-approved versions of the following beneficiary notices applicable to Medicare Advantage (MA) members. As of the dates outlined below, you should already be using the updated forms. Please ensure you use the updated versions and share them with your staff.

- You should have started using the updated Medicare Outpatient Observation Notice (MOON) (Form CMS-10611) on April 21, 2026.
- You should have started using the Important Message from Medicare (IM) (Form CMS-10065) and Detailed Notice of Discharge (DND) (Form CMS-10066) on May 15, 2026.

Reminder: Providers are covered entities responsible to provide language assistance to limited English proficiency (LEP) individuals and alternate formats such as large print, Braille or audio consistent with section 1557 of the Affordable Care Act and section 504 of the Rehabilitation Act of 1973. Below are links to the CMS website/Beneficiary Notices Initiative (BNI) webpage where these notices are posted in both English, Spanish and Large Print.

MOON, IM and DND delivery, explanation, documentation and compliance remain the responsibility of the provider, consistent with CMS requirements.

This reminder is provided for awareness only and doesn't change existing CMS obligations.

Additionally, below are links to the Notice of Availability (NOA) of Language Assistance Services and Auxiliary Aids and Services translated into 46 languages.

CMS resources

- [Beneficiary Notices Initiative \(BNI\)](#)
 - Official CMS OMB MOON, IM, DND forms, Instructions, FAQs, available in Spanish and Large Print
- Notices of Availability (NoAs), translated into 46 languages, visit [Marketing Models, Standard Documents, and Educational Material | CMS](#), then click on "[CY 2026 Model Materials — updated \(ZIP\)](#)," then click "Translated NoA zip."

- MLN Connects Newsletters
 - [MOON 2/26/26](#)
 - [IM & DND 3/19/26](#)
- [Medicare Claims Processing Manual — Chapter 30](#)
 - MOON requirements — Section 400
 - Expedited Determinations of Inpatient Hospital Discharges — Section 200

Caring for Dual Eligible Special Needs Plan (D-SNP) members from out of state

[Find out how to receive payment for treating an out-of-state D-SNP member.](#)

In accordance with the Centers for Medicare & Medicaid Services (CMS) guidelines, Medicare Advantage (MA) members enrolled in a D-SNP have access to any provider who participates with their carrier's plan and who is located within a reasonable distance from the member's residence.

D-SNP members living near state borders may choose to receive services from a provider located outside of their residential state.

Register with Medicaid in bordering states to receive payment

To receive payment for treating an out-of-state D-SNP member, you must be registered to accept Medicaid within the state where the member resides. Failure to register for Medicaid in the member's residential state can result in delayed or denied payments.

The registration process for each state varies. For assistance with out-of-state Medicaid enrollment processes, you can contact the Department of Health and Human Services for each bordering state.

Registering with the state's Medicaid program doesn't obligate you to accept Medicaid patients.

Don't bill Qualified Medicare Beneficiaries (QMBs) for cost sharing

[Most dual-eligible beneficiaries are cost-share protected, which means you must accept the Medicare and Medicaid \(if applicable\) payments as payment in full.](#)

QMBs are dual-eligible individuals who qualify for both Medicare and Medicaid due to their low-income status. The QMB program requires state Medicaid programs to cover Medicare premiums, deductibles, coinsurance amounts and copayments for eligible beneficiaries.

QMBs have no legal responsibility for Medicare Part A and B cost-sharing amounts. Medicare and Medicaid payments combined must be accepted as full reimbursement. As outlined in the Aetna Medicare Provider Manual, you're prohibited from billing QMBs or treating them as private pay patients.

QMBs and billing

Refer to the charts below to understand QMBs and their billing protections:

Dual-eligible category	Description	Billing protections
QMB	Eligible for QMB benefits only; Medicaid pays Medicare cost-sharing	Can't be billed for Medicare A/B cost-sharing
QMB+	Eligible for both QMB and full Medicaid benefits	Can't be billed for Medicare A/B cost-sharing
SLMB	Specified Low-Income Medicare Beneficiary; Medicaid pays Part B premiums only	Can be billed for cost-sharing not covered by Medicaid

SLMB+	Eligible for SLMB and full Medicaid benefits	May have billing protections based on full Medicaid coverage*
QI	Qualifying Individual; Medicaid pays Part B premiums only	Can be billed for cost-sharing not covered by Medicaid
QDWI	Qualified Disabled and Working Individual; Medicaid pays Part A premiums only	Can be billed for cost-sharing not covered by Medicaid
FBDE	Full Benefit Dual-Eligible; eligible for full Medicaid benefits	Can't be billed for Medicare A/B cost-sharing

*If Medicaid covers the service and if the provider accepts Medicaid.

Identifying QMBs

Timely access to QMB status information is crucial for compliance. The Centers for Medicare & Medicaid Services (CMS) provides resources for confirming dual-eligible status:

- Medicare Advantage Medicaid Status Data File: Monthly updates that include dual status codes (e.g., "01" and "02")

- Monthly Membership Detail Data Report (MMR): A report produced by the MARx system, showing QMB status in Field 84

You can also check member eligibility, including QMB status, through our [provider portal on Availity](#),* which offers detailed eligibility and claims information.

For further details, refer to the [Aetna Provider Manual](#) and CMS guidance on the prohibition of billing QMBs on the [CMS Medicare Learning Network](#).

*Availity® is available only to providers in the U.S. and its territories.

Advance Beneficiary Notice of Noncoverage (ABN) documents and the organization determination (OD) notice of denial

An ABN document isn't a valid denial notice for a Medicare Advantage (MA) member. The Original Medicare program uses ABN documents — sometimes called “waivers.” But you can't use them for patients in Aetna MA plans, since the Centers for Medicare & Medicaid Services (CMS) prohibits them.

What Aetna MA plans cover

Aetna MA plans must cover everything Original Medicare does. In some cases, they may provide coverage that's more generous or benefits that go beyond what's covered by Original Medicare. We urge you to call us to verify coverage.

Organization determination (OD) notice of denial

Providers in MA plans can't charge a MA member for a service not covered under their plan unless that member gets a preservice OD notice of denial from us before getting such services. If the member doesn't have a preservice OD notice of denial from us, you must hold the member harmless for the noncovered services. You can't charge them any amount beyond the normal copayments and coinsurance amounts.

If a service is never covered under Original Medicare or is a clear exclusion in the plan documents, a preservice OD isn't needed. You may hold the member financially liable for such noncovered services. Note that services or supplies that aren't medically necessary or aren't covered in the clinical criteria aren't “clear exclusions.” In such cases, the member isn't likely to know if a service is medically necessary.

You or the member can initiate an OD notice of denial. This will help determine if the member has coverage for a service before they receive care. This will also help everyone know the status of benefits before setting up a lab or diagnostic test.

You'll be able to hold an Aetna® Medicare member financially responsible for a noncovered service only if:

- A service or supply is never covered under Original Medicare
- The member has a preservice OD notice of denial from us and decides to proceed with the service knowing they'll have to pay the full cost

EyeMed is the exclusive provider for Routine Vision benefits for Aetna® Medicare Advantage (MA) and Allina Health | Aetna Individual plan members

[Find out how to join the EyeMed network, check eligibility and get claims paid.](#)

This article does not apply to the following:

- Florida
- Select integrated D-SNPs, including the Aetna Medicare FIDE (HMO D-SNP) in Illinois, New Jersey, and Virginia and Aetna Medicare HIDE (HMO D-SNP) in Michigan
- Aetna Group MA plan members

Effective January 1, 2026, Aetna MA Individual plan members must see an EyeMed provider for their routine vision benefits (exams and prescription eyewear) for those benefits to be considered in-network.

Always check eligibility

Some members have plans that provide only in-network benefits, while others have plans that provide both in- and out-of-network vision and eyewear coverage.

Remember to verify benefits and eligibility via Availity® or your preferred vendor or clearinghouse.*

Reimbursement

Aetna and Allina Health | Aetna MA Individual plan members (HMO/PPO) have access to the Aetna MA contracted network for Medicare-covered (medical/diagnostic) eye care services. Providers not contracted with EyeMed will only be reimbursed up to \$50 for any routine (non-Medicare covered) eye exam services rendered for PPO members.

Consult the chart below for 2026 routine eye exam and eyewear benefits (non-Medicare covered).

Plan type	EyeMed provider	Non-EyeMed provider
HMO plan members	<p>\$0 copay for one non-Medicare covered routine eye exam. Refraction should be billed as inclusive to the routine eye exam.**</p> <p>\$0 copay for prescription eyewear up to a benefit maximum. Members are responsible for any billed amount over the benefit maximum.</p>	Not covered
PPO plan members	<p>\$0 copay for one non-Medicare covered routine eye exam. Refraction should be billed as inclusive to the routine eye exam.**</p> <p>\$0 copay for prescription eyewear up to a benefit maximum. Members are responsible for any billed amount over the benefit maximum.</p>	<p>\$0 copay for one non-Medicare covered routine eye exam and refraction up to \$50.** Members are responsible for any billed amount over \$50.</p> <p>\$0 copay for prescription eyewear up to a benefit maximum. Members are responsible for any billed amount over the benefit maximum.</p>

Claims

Submit your claims electronically.

- Submit routine supplemental Medicare vision claims (eye exams and eyewear) directly to EyeMed for faster processing and payment.
- Claims for routine vision exams and eyewear should be submitted to EyeMed directly. Do not submit routine vision claims to Aetna medical.

Non-EyeMed providers should mail claim forms to:

First American Administrators, Inc.
 Attn: OON Claims

P.O. Box 8504
Mason, OH 45040

For non-routine services or claims with a medical diagnosis, follow standard medical billing guidance. Note that refractions should not be billed with medical claims but should be included as part of the routine/comprehensive exam.

Verify whether you're an EyeMed provider

To verify, you can visit our [Vision Benefit page](#). If you'd like to become an EyeMed provider, fill out this [EyeMed provider form](#). Be sure to check the "Join EyeMed as New Provider" box.

*Availity® is available only to providers in the U.S. and its territories.

**If members receive additional services during the routine eye exam, such as but not limited to lab, diagnostic testing, and/or specialist treatment, they may also be responsible for the cost for the additional services received.

Medicare Advantage — billing

This is a reminder to bill us the same way you bill traditional Medicare.

Keep your data updated in NPPES

[Accurate provider directories help Medicare patients identify and locate providers and make health plan choices.](#)

Use the National Plan and Provider Enumeration System (NPPES) to correct your data and improve provider directory accuracy.

CMS suggests updating NPPES

The Centers for Medicare & Medicaid Services (CMS) suggests using the NPPES to review, update and attest to your NPPES data. We join with CMS to remind providers to keep their data up to date.

For more information, refer to these [frequently asked questions \(PDF\)](#).

We submitted the 2026 HEDIS® medical record collection project results

We're working to close data and care gaps for an enhanced provider and patient experience.

Annually, we collect HEDIS® (Healthcare Effectiveness Data and Information Set) data from claims, encounters, administrative data and medical records. We support a consumer-obsessed culture — one that enhances member health and quality of life, expands provider relationships to support an enhanced patient experience and closes data and care gaps.

We submitted our 2025 data in accordance with the National Committee for Quality Assurance (NCQA) reporting requirements.

We want to thank staff members who provided medical records in support of our HEDIS efforts.

*HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

PathForward supports CAHPS and HOS goals

[Learn more about how you can use PathForward to support your patients.](#)

PathForward gives your team tools that help patients feel supported and guided at key points in their care. The tools focus on daily habits that build trust and reduce confusion.

You can use PathForward to:

- Build clear and kind communication
- Set strong first impressions
- Support patients when care is delayed
- Create warm and welcoming spaces
- Guide patients from one step of care to the next
- Support conversations about physical health, mental health and the functional needs that affect daily living

Each tool is designed to support improvement across the measures that matter most. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey assesses the patient's experience with their care, emphasizing getting care quickly, getting needed care, care coordination, customer service and the overall rating of care.

The Health Outcomes Survey (HOS) evaluates longitudinal changes in physical and mental health, with emphasis on provider assessment, discussion and management related to fall risk, bladder control and physical activity.

PathForward turns everyday behaviors into measurable improvements, helping patients feel informed, confident and well supported at every touchpoint.

Visit our [provider portal on Availity](#) to download your complimentary toolkit.* Once you log in, select Payer Spaces from the gray navigation bar. Choose Aetna (or one of our joint ventures, if applicable), then go to the Resources section and look in the Provider Education category for these documents:

- Positive first impressions guide
- Why compassionate communication matters
- Creating a welcoming space for your patients
- Create comfort, build trust and support healing with our healing environment checklist
- Patient Passport letter template
- Service recovery guide
- Service standards and behavior
- Survey 101 – HOS, CAHPS, Medicare Post Visit Survey

* Availity® is available only to providers in the U.S. and its territories.

Reminder: Submission of information and CMS turnaround time requirements for ODs

[Be sure to submit requests accurately and in a timely manner.](#)

Timely and complete submission of clinical documentation is essential to ensure smooth processing of Organizational Determinations (ODs). The Centers for Medicare & Medicaid Services (CMS) requires all Medicare Advantage plans and contracted providers to adhere to specific turnaround time (TAT) standards when requesting authorization for services. Below is a summary of the required timelines and corresponding review processes.

Expedited ODs— 72 hours

Expedited requests are appropriate when a delay in care could seriously jeopardize the member's health, life or ability to regain maximum function.

- Required TAT: within 72 hours of receiving the request
- Peer-to-peer opportunity: if the request is denied, providers will be offered an opportunity for an immediate peer-to-peer review before a final decision is issued

Standard ODs — 7 calendar days

Standard requests apply when the member's health condition doesn't meet the threshold for expedited review.

- Required TAT: within 7 calendar days of receiving the request
- Peer-to-peer opportunity: if the request is denied, providers will have access to a peer-to-peer review prior to final determination

Clinical documentation requirements

To avoid delays and support timely decision-making, ensure that all relevant clinical information accompanies the initial request. Incomplete submissions can slow down the review process and may increase the likelihood of denial.

We appreciate your partnership in ensuring that members receive timely, appropriate care. Submitting complete clinical documentation and selecting the correct request type helps support faster, more accurate determinations for our shared patients.

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