Claims Filing Guidelines

Claims	Timely Filing Guideline
Plan Participating Providers	Provider shall mail or electronically transfer (submit) the claim within **180** days from the date of service (DOS) **Inpatient Services –** 180 days from the date of discharge
Non-Participating Providers	Provider shall mail or electronically transfer (submit) the claim within **365** days from the date of service (DOS) **Inpatient Services –** 365 days from the date of discharge
Plan as Secondary Payor	When the Managed Care Plan is the secondary payer, the provider must submit the claim within **ninety (90) calendar days** after the final determination of the primary payer.
Medicare Crossover	When the Managed Care Plan is the secondary payer to Medicare, and the claim is a Medicare cross over claim, these must be submitted within **36 months** of the original submission to Medicare.
Corrected Claims	Provider shall mail or electronically transfer (submit) the corrected claim within **180 days** from the date of service or discharge from an inpatient admission.
Return of requested additional information (itemized bill, ER records, med records, attachments)	A provider must submit any additional information or documentation as specified, within **thirty-five (35) days** after receipt of the notification. Additional information is considered received on the date it is electronically transferred or mailed. Aetna Better Health cannot request duplicate documents.

Appeals Filing Guidelines

Appeals	Par/Non-Par	Timely Filing Guideline
Provider Appeals related to Medical Necessity	Par	60 days from Notice of Adverse Benefits Determination (NABD)
	Non-Par	60 days from Notice of Adverse Benefits Determination (NABD)
Provider Appeals related to billing disputes, not related to authorizations The exception to this is underpayment disputes, they all have 365 days to dispute	Par	90 days from Explanation Of Benefits/ Explanation Of Payment/ Remit (EOB/EOP)
	Non-Par	180 days from Explanation Of Benefits/ Explanation Of Payment/ Remit (EOB/EOP)
Provider Appeals- claim appeals (related to authorization) requesting authorization after the claims is filed and EOB went out stating claim was denied for no authorization	Par	90 days from Explanation Of Benefits/ Explanation Of Payment/ Remit (EOB/EOP)
	Non-Par	180 days from Explanation of Benefits (EOB)

Note: This document outlines Aetna Better Health of Florida (ABHFL) standard timeframes. Other timeframes may apply under certain contract agreements. For additional information please refer to your specific provider agreement.