

Provider Newsletter

Summer 2026

Aetna Medicare HIDE (HMO D-SNP)



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Quarterly News

Partner with NationsHearing®

NationsBenefits® is the leading supplemental benefits management provider, administering benefits including hearing, flex card, OTC, transportation, vision, meals, nutrition, and PERS to over 12 million health plan members nationally.

NationsHearing remains the only independently owned hearing benefit management organization.

We offer a full portfolio of hearing aids from all leading manufacturers. This ensures patient choice and allows our hearing healthcare partners

the latitude to select the hearing aid that best meets the needs of their patients.

The NationsHearing® Model

There is no charge to participate in the NationsHearing® Provider Network, and our dedicated Provider Network Team ensures that the onboarding process is simple and straightforward. The member contacts NationsHearing®, and our Member Experience Advisors confirm eligibility and benefits. Our team contacts the Provider’s office to schedule the initial hearing test appointment. Following the hearing exam, providers can make a recommendation from our full portfolio of hearing aids from all leading manufacturers. The provider uses the NationsHearing® Provider Portal to order hearing aids, which will ship directly to their office. Upon receiving the hearing aids, the fitting appointment can be scheduled at the Provider’s convenience. Fitting Fees are paid within 60 days of the fitting appointment via ACH or check.

Learning how to work with NationsHearing® can help you attract more patients and grow your practice. Call 800-921-4559 to learn more.

Member Resources

Balance Billing

Providers may not bill members for any Medicare or Medicaid covered services. Members are not responsible for Medicare cost sharing under CMS regulations. Medicare cost sharing includes the deductibles, coinsurance and copays included as part of Medicare Advantage benefit plans.

Reminders

Women’s Health

Women do not need a referral or prior approval to see a women’s health specialist. This includes:

- Gynecologists

- Certified nurse midwives
- Obstetricians

Our members can choose any of these providers in our network for your routine women’s health care.

Routine women’s health care includes:

- Breast exams
- Mammograms
- Pap tests
- Prenatal

Primary Care Providers

Primary care providers (PCP) are the members first stop for all their health care needs. But at some point, they may need to see a specialist to help treat certain injuries or illnesses. Members with special needs or who need long-term services have direct access to specialists.

You can help your patients choose a specialist. You can also give you a referral if needed. But our members don’t need a referral or prior approval to see most specialists in the network (check our [provider directory](#) to see in-network providers). To learn more about what the plan will cover, visit our [provider manual](#).



Krames Online

We believe our patients’ well-being comes first—always. We understand that during clinical encounters, not every question can be addressed in the moment. To support you and your patients beyond the visit, [Krames Online](#) provides 24/7 access to trusted health education resources.

With more than 4,000 topics covering health conditions and medications, Krames Online empowers you to confidently guide patients and their families to reliable answers for both common and complex questions. Providers can easily encourage patients to use the search function to continue learning at their own pace; while continuing to support patients with Limited English Proficiency (LEP), patient education materials are available in Spanish (alternative languages if exist). These resources help ensure patients fully understand their care, treatment options, and self-management instructions. Providers are encouraged to offer these translated materials as part of routine care to promote equitable access, informed decision-making, and improved health outcomes.

This resource reflects our commitment to supporting

your care delivery—ensuring patients receive the information they need, the answers they deserve, and the tools that reinforce informed, high-quality care.

September is Fall Prevention Awareness Month

Each year, between 700,000 to a million fall incidents happen within a hospital setting. Up to a 1/3 of these may be preventable. Aetna Medicare HIDE (HMO D-SNP) wants to provide several tools and resources to prevent falls for members, both inside your offices or in the patient’s home.

Providers can mitigate fall risks by:

- Including fall risk screenings yearly or following a recent fall
- Evaluating patient’s footwear, gait, strength and balance
- Review a patient’s medication and home hazard risks
- Educate patients on their risk factors and community resources

Discuss how to prevent falls at home with patients. You may advise your patients to review the health sheet (also available in Spanish):

Aetna.Kramesonline.com/Search/3,S,87093

Second Opinions

Aetna Medicare HIDE provides a second opinion from an in-network provider or arranges for the member to obtain a second opinion outside the network. If the health plan is unable to provide a necessary and covered service to a member in-network, services must be adequately and timely covered out of network for as long as the health plan is unable to provide them. The health plan will coordinate payment with the out of network provider and ensure the cost to the member is not greater than it would be if the service were provided in network.

Provider Resources

Keep your information current



Keeping your details up to date in our directories helps members find the right information about you and your practice. This also helps ensure that you receive timely payment, communications, reminders and more.

Updating your provider data info

You can update your provider information, including:

- New service locations for an existing contracted TIN
- Change of name, address, phone number, fax and office hours

- Specialty, hospital affiliations, board certifications and other details

Submitting through Availity (Non-LTSS)

Need to update information? The best way to do so is to follow these:

1. Log in to Availity: Access the Availity portal
2. Access Payer Spaces: Select 'Payer Spaces' in the top navigation, then select the Aetna logo.
3. Use Provider Data Management (PDM):
 - a. Select 'Provider Data Management' from the menu to manage your provider roster.
 - b. Select your business profile
 - c. Choose Manage Type 1 Providers to add a new provider or update existing NPI information.
4. Submit changes: Follow the prompts to add the new provider's NPI, address, and specialization, then click 'Save.'

LTSS provider? No problem! Just complete these steps:

1. Email us at COEProviderServices@Aetna.com for a Provider Change Request (PCR) file. In your email, be sure to:
 - Include a copy of your W-9, if applicable. If you're contracted as a group, send a group W-9. Otherwise, just send an individual W-9
2. Complete the PCR file. After you receive your PCR file, be sure to:
 - Complete all required fields within the PCR file
 - Email the file back to us

After you send us your materials and information, we'll process the change or contact you for more details. Need to update your participation in our network? Call us at 1-855-676-5772. Or just [email](#) us to learn more.

Appointment Availability Standards & Timeframes

Providers are required to schedule appointments for eligible members in accordance with the minimum appointment availability standards and based on the acuity and severity of the presenting condition, in conjunction with the enrollee's past and current medical history. Our Provider Services Department will routinely monitor compliance and seek Corrective Action Plans (CAP), such as panel or referral restrictions, from providers that do not meet accessibility standards. Providers are contractually

required to meet the National Committee for Quality Assurance (NCQA) standards for timely access to care and services, considering the urgency of and the need for the services.

Visit our website to review the [appointment wait time standards](#) for Primary Care Providers (PCPs), Obstetrics and Gynecologist (OB/GYNs), high volume Participating Specialist Providers (PSPs), and Mental Health Clinics and Mental Health/Substance Use Disorder (MH/ SUD) providers.

Hours of Operation Parity

Aetna requires the hours of operation that practitioners offer to Medicaid members to be no less than those offered to commercial members and available 24 hours a day, 7 days a week, when medically necessary.

Availity Portal

The Availity Portal offers secure online access to and the ability to manage business transactions through a single, easy to use site. Availity features include buy are not limited to:

- Claim Submission and Status
- Eligibility and Benefits Search
- Authorization Request
- Case Management Link
- Grievance Submission
- Panel Roster

If your organization isn't registered with Availity, get started today at [availity.com/provider-portal-registration](https://www.availity.com/provider-portal-registration)

Operational Resources

We want to support our health care providers as we work together to reach health care goals. We offer a variety of webinars and training opportunities throughout the year to help you, and your staff stay up to date on essential responsibilities. This section includes just some of the resources. Additional tools and resources can be found on your provider manual.

For more information, contact our provider service department at 1-855-676-5772 or our provider [website](#).

Delivery System Supports

Aetna Medicare HIDE wants to support our health care providers as we work together to reach health care goals. We offer a variety of webinars and training opportunities throughout the year to help you, and your staff stay up to date on essential responsibilities. Additional tools and resources can be found in your provider manual.

Reminder: Required Prior Authorization Form

To help us process requests efficiently and ensure members receive timely access to care, please remember to use the Prior Authorization Form available on our website when submitting requests. The form must be fully completed, including the urgency designation (Standard or Expedited). Providing complete and accurate information allows our team to correctly prioritize incoming requests and avoid delays in review. Thank you for your partnership and commitment to supporting high quality, timely care for our shared members.

How to request Prior Authorizations

A prior authorization request may be submitted by:

- Submitting the request through Availity
- Fax the [Prior Authorization Request Form](#) to 1-844-241-2495. Please use a cover sheet with the practice’s correct phone and fax numbers to safeguard the protected health information and facilitate processing
- Through our toll-free number at 1 -855-676-5772



To check the status of a prior authorization you submitted or to confirm that we received the request, please visit the Availity, or call us at 1-855-676-5772.

If response for non-emergency prior authorization is not received within 15 days, please contact us at 1-855-676-5772.

When requesting prior authorization, please provide the following:

- Member’s identification number
- Demographic information
- Requesting provider contact information
- Clinical notes/explanation of medical necessity
- Other treatments that have been tried
- Diagnosis and procedure codes
- DOS

Important Note:

- Emergency services do not require prior authorization; however, notification is required the same day.
- All out of network services must be authorized.
- Unauthorized services will not be reimbursed, and authorizations are not a guarantee of payment.
- If providers do not receive outreach or response to non-emergency authorizations, please reach out to provider services at 1-855-676-5772.

- For post stabilization services, hospitals may request prior authorization by calling 1-855-676-5772.

Decision and Notification Requirements

Decision	Decision/notification timeframe
Urgent pre-service approval/denial	Within seventy-two (72) hours of receipt of request
Non-urgent pre-service approval/denial	Within five (5) calendar days of receipt of request
Post-service approval/denial	Within thirty (30) calendar days of receipt of request

Due to the federal and state guidelines, the turnaround time (TAT) for non-urgent pre-service decisions (5 days). It is critical that you submit complete and accurate information upfront to support your authorization request. This includes the designated point of contact, all required medical documentation, and relevant medical history. Missing or incomplete details can delay the review process and impact timely access to care for members. Ensuring thorough submissions helps us meet regulatory requirements and deliver prompt decisions within the timeframe.

We use the MCG criteria to ensure consistency in hospital-based utilization practices. The guidelines span the continuum of patient care and describe best practices for treating common conditions. The MCGs are updated regularly as each new version is published. UM Criteria is electronically available to practitioners and copies of individual guidelines are available for review upon request.

You can request a copy of the Medical Necessity Criteria. Call us at 1-855-676-5772 or visit our [website](#).

Complex Care Management Referral Options
Empowering members through coordinated care

Aetna Medicare Medicaid Plans offer an evidence-based care management program to help members improve their health and access needed services. Care managers—typically nurses or social workers—develop individualized care plans and support members in meeting their health goals. All members are assigned a care manager, with support levels based on clinical and social needs. Some of the reasons you may want to ask the health plan to have a case manager contact the member are:

- Does the member frequently use the emergency room instead of visiting their providers office for ongoing issues?

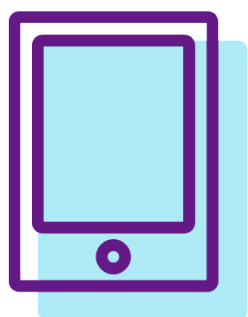
- Has the member recently had multiple hospitalizations?
- Is the member having difficulty obtaining authorizations for medical benefits ordered by providers?
- Has the member been diagnosed with Congestive Heart Failure (CHF) diabetes, asthma, or Chronic Obstructive Pulmonary Disorder (COPD), yet does not comply with the recommended treatment regimen?
- Does the member need help applying for a state-based long-term care program?
- Does the member have HIV?
- Is the member pregnant with high-risk conditions?
- Is the member pregnant and over 35 years of age?
- Has the member received a referral to a specialist, but is unsure of the next steps?
- Does the member need information on available community services and resources not covered by Medicaid (e.g. energy assistance, SNAP, housing assistance)?

A care manager will contact the member—and caregivers when appropriate—to complete an assessment. This helps determine the level of support needed.

The care manager will then work with the member to develop a care plan, provide education, and coordinate services with the member’s healthcare providers. Frequency of outreach varies based on the member’s individual needs.

How to refer

To request care management support, call Provider Services at 1-855-676-5772. A care manager will review and respond within 3–5 business days.



Members can be referred to the complex case management program from a variety of sources, including our medical management programs, discharge planners, members, caregivers, and providers.

To referral a member into case management, call 1-855-676-5772 (TTY: 711) or visit our [website](#).

Provider Collaboration with Care Management

To support collaborative care management with provider partners and reduce care fragmentation. Aetna and participating providers will share responsibility for delivering coordinated, patient-centered care. Each party will work collaboratively to ensure timely communication, clear accountability, and seamless transitions across care settings in support of patient outcomes and experience. Roles and responsibilities are outlined [here](#) and will be reviewed at least annually or when processes change. This collaborative approach is intended to help reduce patient frustration, improve accountability, and support improved health outcomes.

Affirmative Statement

Making sure members get the right care

Our Utilization Management (UM) program ensures members receive the right care in the right setting when they need it. UM staff can help you and our members make decisions about their health care. When we make decisions, it is important to remember the following:

- We make UM decisions by looking at members’ benefits and choosing the most appropriate care and service. Members also must have active coverage.
- We don’t reward providers or other people for denying coverage or care.
- Our employees do not get any incentives to reduce the services members receive.

You can get more information about UM by calling us at call 1-855-676-5772. Language translation for members is provided for free by calling call 1-855-676-5772. Practitioners may freely communicate with patients about all treatment options, regardless of benefit coverage limitations.

Population Health Management (PHM) Strategy

Population health management programs are available to help support members in their health care journey. We have special programs available for members who are managing conditions or just trying to stay healthy.

Diabetes Management - We have a disease management program for members diagnosed with diabetes. Connect with us if your patient has diabetes. We’ll work with your patients to learn more about their condition and put together a plan of care to address any high-risk needs.

Chronic Condition (Hypertension) Management - A

care manager is here to help the patient find the care and services they will need. They'll get a call from their care manager soon after they are enrolled. The care manager works with the members, their providers, to make sure they understand their hypertension and how to best manage it.

Our goal is to build a care plan that will help our members live a healthier life.

Medication Safety - substance use disorders or substance misuse happen when the repeated use of alcohol or drugs causes impairment. This includes:

- Health problems
- Disability
- Failure to meet major responsibilities at work, school or home

These illnesses are common, serious and tend to repeat. But many people recover with treatment.

Acute Care and ED Utilization (Physical and Behavioral Health) – Many illnesses don't need to be treated at the emergency room. Our Care Management team can provide education and guidance to help all members determine when to contact their physician and when to go to the emergency room. In addition, when a hospitalization is necessary, a care manager will be in contact to help members:

- Schedule follow up appointments
- Obtain prescribed medications
- Understand discharge instructions
- Coordinate any other needed services

Transition of Care – Prior to discharge, a care manager will contact the member to provide support in discharge planning and post-admission care. Additionally, they will assist in coordination transition services to another facility or to a home care setting. You can learn about these programs [online](#) or in your provider handbook. You can also call 1-855-676-5772 (TTY: 711).

Guidelines

Respected medical professional and public health organizations create clinical practice guidelines that document best practices and recommendations for care. The organization uses clinical practice guidelines to help practitioners make decisions about



appropriate health care for specific clinical circumstances and behavioral healthcare services. Aetna adopts at least four evidence-based clinical practice guidelines, approved by its Quality Improvement (QI) committee, that:

1. Are based on valid and reliable clinical evidence or a consensus of practitioners in the particular field.
2. Consider the needs of the organization's members.

3. Are adopted in consultation with contracted health care professionals.
4. Are reviewed and updated at least every two years, as applicable

We make decisions for member education that are consistent with its practice guidelines. To learn more about our practice guidelines, please visit our [website](#).