

September 30, 2021

Change in Prior authorization requirement

Coordination of Benefits – Secondary insurance requests

Effective October 1, 2021 Aetna Better Health (ABH) will no longer require prior authorization when ABH is secondary except for in the following authorization request types which will be reviewed through the prior authorization process for medical necessity:

- Pharmacy Requests
- Home health services,
- Pediatric home shift care services
- Admissions to pediatric long-term care facilities

Aetna Better Health of Pennsylvania is responsible to pay co- pays and deductibles when the plan is the secondary payer for covered services.

For members who have primary insurance coverage from a source other than Medicaid, Aetna Better Health honors coverage and utilization management decisions made by the primary carrier for those services in the primary carrier's benefits package. If Aetna Better Health is responsible for Medicaid services that are carved out of the primary carrier's benefit package, Aetna Better Health has utilization management responsibility for those carved out services.

When Aetna Better Health is the member's secondary insurer, please submit your request to claims along with an EOB or document showing the primary insurance has made a determination in order to receive secondary payment for those services.

If through Coordination of benefits it is determined additional coverage is required by Aetna, please submit your records with a letter of request for retrospective medical necessity review to:

Aetna Better Health Claims Dept P.O. Box 62198 Phoenix, AZ 85082-2198

A determination will be made within 30 days and communicated via written letter to the requesting provider.

If you have any questions about our claim submission process you can contact our Provider Relations Department by calling 1-866-638-1232.

Thank you,
Aetna Better Health of Pennsylvania Provider Relations