Aetna Better Health of Illinois

Redetermination claims process

Aetna Better Health® of Illinois wants to support providers with claims-related issues during the redetermination process. This information is intended to assist providers with claims submittals for members during their redetermination window.

Before providing service

Medicaid eligibility should always be confirmed at the time of service in the **HFS MEDI platform (Recipient Eligibility Verification System)**. This platform is the most current source for member coverage status. If a member is assigned to a managed care organization (MCO), the name of the MCO and eligibility dates used during the search will be listed in the "Managed Care Section." If a member has been removed from Medicaid eligibility, MEDI will not show an MCO assignment.

When does Aetna® Medicaid process claims?

Aetna will process claims for members who are currently assigned and deemed eligible for Medicaid by HFS and those who are within the first 60 days of their redetermination period. This includes:

- Members who return their redetermination form to HFS during the original 30-day period and are determined to remain eligible for Medicaid
- Members who do not return their redetermination form within the original 30 days and are granted a 30-day grace period to submit the form
- Members who return the redetermination form to HFS within the 30-day grace period and are determined to remain eligible for Medicaid

When does HFS process claims?

Members who have not returned their redetermination form to HFS by the end of the 30-day grace period (first 60 days of the redetermination period) will have their coverage termed with the MCO. They will enter a 90-day reinstatement period.

If a member returns their redetermination form within the 90-day reinstatement period and is determined to remain eligible for Medicaid, HFS will process any claims for services until the member can be assigned back to their original MCO.

Providers should submit claims to HFS for any services rendered during the reinstated coverage period.

What if a member is no longer eligible?

If a member is determined to no longer be eligible for Medicaid at any point during the redetermination process, their Medicaid coverage will be terminated. In those cases, providers should follow the standard billing procedure for a non-Medicaid patient.