

September 14, 2023

## **Notice of New Aetna Better Health® of New Jersey Medicaid Claims and Encounters Front End Edits**

As of 08/01/2023, Aetna Better Health® of New Jersey is change its existing taxonomy requirement denial edits and will move these edits to the EDI Gateway, as rejections. Aetna Better Health® will require a taxonomy code on each claim submitted having NPI's submitted in the following Provider Loops:

- Billing 2000A-PRV/Box 33b on CMS-1500/Box 81a on the UB-04,
- Rendering 2310B-PRV/Box 24J Shaded, (needed when different from the Billing Taxonomy)
- Attending 2310A-PRV/Box 76 UB-04 providers having NPI's.

**Note:** Providers submitting paper claims should use the **ZZ** qualifier to identify the taxonomy cited in the paper claim form boxes above.

Claims not having a taxonomy for the associate NPI in the Billing Loops submitted will be rejected. Please follow the taxonomy billing guidelines outlined in:

- [www.wpc-edi.com](http://www.wpc-edi.com) when submitting EDI 837I/837P Claims
- [www.nucc.org](http://www.nucc.org) when submitting Professional CMS-1500 Claim Forms
- [www.nubc.org](http://www.nubc.org) when submitting Institutional UB-04 Claim Forms

To avoid claims adjudication rejections, billers should compare the identification values on the claim to the information registered with State of New Jersey for accuracy via <https://www.njmmis.com/providerDirectory.aspx>

Alignment to identification values as listed below are imperative to timely adjudication:

- Billing: NPI, Taxonomy, Billing Address (ZIP -5 or ZIP -9),
- Rendering: NPI, Taxonomy (if Rendering is different from Billing Provider),
- Attending: NPI, Taxonomy
- Provider Type
- Provider Specialty
- If Atypical, ensure the Medicaid ID is registered and effective for the date of service, Billing Address (ZIP -5 or ZIP -9)

If you have any questions about our claim submission processes, please contact our Claims

**Aetna Better Health® of New Jersey**

3 Independence Way, Suite 104  
Princeton, NJ 08540



Inquiry/Claims Research (CICR) Department by calling **1-855-232-3596**.

Thank you,

Provider Relations

Aetna Better Health® of New Jersey

[aetnabetterhealth.com/new-jersey](https://aetnabetterhealth.com/new-jersey)



**Paper CMS-1500 (02-12) Guidance:**

**Submit Form**



**HEALTH INSURANCE CLAIM FORM**

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

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1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BOX (LUNG) <input type="checkbox"/> OTHER <input type="checkbox"/>												1a. INSURED'S I.D. NUMBER (For Program in Item 1)																																																																																															
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)												3. PATIENT'S BIRTH DATE MM   DD   YY SEX M <input type="checkbox"/> F <input type="checkbox"/>												4. INSURED'S NAME (Last Name, First Name, Middle Initial)																																																																																			
5. PATIENT'S ADDRESS (No., Street)												6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>												7. INSURED'S ADDRESS (No., Street)																																																																																			
CITY STATE												8. RESERVED FOR NUCC USE												CITY STATE																																																																																			
ZIP CODE TELEPHONE (Include Area Code)												9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)												10. IS PATIENT'S CONDITION RELATED TO:												11. INSURED'S POLICY GROUP OR FECA NUMBER																																																																							
a. OTHER INSURED'S POLICY OR GROUP NUMBER												a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/>												a. INSURED'S DATE OF BIRTH MM   DD   YY SEX M <input type="checkbox"/> F <input type="checkbox"/>																																																																																			
b. RESERVED FOR NUCC USE												b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State)												b. OTHER CLAIM ID (Designated by NUCC)																																																																																			
c. RESERVED FOR NUCC USE												c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>												c. INSURANCE PLAN NAME OR PROGRAM NAME																																																																																			
d. INSURANCE PLAN NAME OR PROGRAM NAME												10d. CLAIM CODES (Designated by NUCC)												d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> if yes, complete Items 9, 9a, and 9d.																																																																																			
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.																								13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.																																																																																			
SIGNED _____ DATE _____												SIGNED _____												SIGNED _____																																																																																			
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM   DD   YY QUAL.												15. OTHER DATE MM   DD   YY												16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM   DD   YY TO MM   DD   YY																																																																																			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE												17a. _____												17b. NPI _____												18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM   DD   YY TO MM   DD   YY																																																																							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES												21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. _____																																																																																			
A. _____ B. _____ C. _____ D. _____												E. _____ F. _____ G. _____ H. _____												I. _____ J. _____ K. _____ L. _____																																																																																			
24. A. DATE(S) OF SERVICE From MM   DD   YY To MM   DD   YY												B. PLACE OF SERVICE												C. EMG												D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER												E. DIAGNOSIS POINTER												F. \$ CHARGES												G. DAYS OR UNITS												H. FROM FROM (1st)												I. RENDERING PROVIDER ID, #											
1												2												3												4												5												6																																															
25. FEDERAL TAX ID, NUMBER SSN EIN												26. PATIENT'S ACCOUNT NO.												27. ACCEPT ASSIGNMENT? (For 28K, 28L, 28M, 28N) YES <input type="checkbox"/> NO <input type="checkbox"/>												28. TOTAL CHARGE \$												29. AMOUNT PAID \$												30. Rsvd for NUCC Use																																															
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE(S) OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)												32. SERVICE FACILITY LOCATION INFORMATION												33. BILLING PROVIDER INFO & PH # ( )																																																																																			
SIGNED _____ DATE _____												a. NPI _____												b. NPI _____																																																																																			

NUCC Instruction Manual available at: [www.nucc.org](http://www.nucc.org)

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER  
 PATIENT AND INSURED INFORMATION  
 PHYSICIAN OR SUPPLIER INFORMATION

**Aetna Better Health® of New Jersey**  
 3 Independence Way, Suite 104  
 Princeton, NJ 08540



**Paper UB-04 Guidance:**

1		2		3A FAC CPTL 4 B. MED FED. 4		4 TYPE OF BILL	
8 PATIENT NAME		9 PATIENT ADDRESS		5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM THROUGH	
10 BIRTHDATE		11 SEX		12 DATE		13 ADMISSION 13 ICD 14 TYPE 15 SPC 16 DHR	
17 STAT		18		19		20	
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ASC X12N • INSURANCE SUBCOMMITTEE 005010X222 • 837 • 2000A • PRV  
 TECHNICAL REPORT • TYPE 3 BILLING PROVIDER SPECIALTY INFORMATION

SEGMENT DETAIL

**PRV - BILLING PROVIDER SPECIALTY INFORMATION**

X12 Segment Name: Provider Information

X12 Purpose: To specify the identifying characteristics of a provider

X12 Syntax: 1. P0203  
 If either PRV02 or PRV03 is present, then the other is required.

Loop: 2000A — BILLING PROVIDER HIERARCHICAL LEVEL

Segment Repeat: 1

Usage: SITUATIONAL

Situational Rule: Required when the payer's adjudication is known to be impacted by the provider taxonomy code. If not required by this implementation guide, do not send.

TR3 Example: PRV\*BI\*PXC\*207Q0000X~

DIAGRAM

ASC X12N • INSURANCE SUBCOMMITTEE 005010X222 • 837 • 2310B • PRV  
 TECHNICAL REPORT • TYPE 3 RENDERING PROVIDER SPECIALTY INFORMATION

SEGMENT DETAIL

**PRV - RENDERING PROVIDER SPECIALTY INFORMATION**

X12 Segment Name: Provider Information

X12 Purpose: To specify the identifying characteristics of a provider

X12 Syntax: 1. P0203  
 If either PRV02 or PRV03 is present, then the other is required.

Loop: 2310B — RENDERING PROVIDER NAME

Segment Repeat: 1

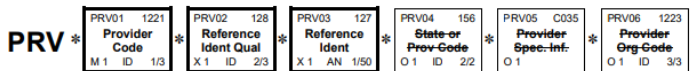
Usage: SITUATIONAL

Situational Rule: Required when adjudication is known to be impacted by the provider taxonomy code. If not required by this implementation guide, do not send.

TR3 Notes: 1. The PRV segment in Loop ID-2310 applies to the entire claim unless overridden on the service line level by the presence of a PRV segment with the same value in PRV01.

TR3 Example: PRV\*PE\*PXC\*1223G0001X~

DIAGRAM





**SEGMENT DETAIL**

**PRV - ATTENDING PROVIDER SPECIALTY INFORMATION**

**X12 Segment Name:** Provider Information  
**X12 Purpose:** To specify the identifying characteristics of a provider  
**X12 Syntax:** 1. P0203  
 If either PRV02 or PRV03 is present, then the other is required.  
**Loop:** 2310A — ATTENDING PROVIDER NAME  
**Segment Repeat:** 1  
**Usage:** SITUATIONAL  
**Situational Rule:** Required when adjudication of the destination payer, or any subsequent payer listed on this claim, is known to be impacted by the attending provider taxonomy code. If not required by this implementation guide, do not send.  
**TR3 Example:** PRV\*AT\*PXC\*208D0000X~

**DIAGRAM**

