Aetna Better Health of Texas
PROVIDER NOTIFICATION

Background

In accordance with the American Rescue Plan Act (ARPA) of 2021, CHIP MCO's must ensure COVID-19 related vaccines, treatments, and testing services are provided without cost-sharing, including copayments.

Key Details

For dates of service on and after December 21, 2022, it is required that MCOs reimburse CHIP providers without unauthorized cost-sharing. Copayments are not to be collected for COVID-19 related services, these services include vaccines, testing, treatment of COVID-19, preventative therapies for COVID-19, treatment of post-COVID conditions (long-haul COVID-19), and treatment of health conditions that, in conjunction with COVID-19, may seriously complicate the health of a member.

Action Needed of Providers

Before reimbursing providers for the uncollected copayment of COVID-19 related services, HHSC is requiring providers to attest that copayments were not collected from members. Please complete the attestation form which accommodates this letter and return to ABHTX by either email or facsimile. Email at abhtxcredentialing@aetna.com or facsimile (866) 510-3710.

As always, do not hesitate to contact your Aetna Better Health of Texas Provider Relations Representative with any questions or comments.

Sincerely,

Provider Relations, Aetna Better Health of Texas

CHIP

Bexar area: 1-866-818-0959 (TTY: 711)

Tarrant area: 1-800-245-5380 (TTY: 711)

STAR (Medicaid)

Bexar area: 1-800-248-7767 (TTY: 711)

Tarrant area: 1-800-306-8612 (TTY: 711)

STAR Kids

Dallas and Tarrant areas: 1-844-787-5437 (TTY: 711)

TEXAS
Health and Human Services

Form 5004
February 2021-E

Optional COVID-19 CHIP Provider Co-payment Attestation

I, _____ certify that the attached invoiced amounts represent office visit co-pays that my practice did not collect for dates of service on 12/21/2022 , through 3/31/2024 , for CHIP members, in accordance with direction from Texas Health and Human Services Commission*.

The above and the attached are true and correct to the best of my knowledge and belief. I know that I may be subject to penalties if I provide false or untrue information. All original documents will be retained and preserved, as required by law, and such documents will be submitted, or access to such documents permitted, as required by HHSC or any agency of the state or federal government or their representative(s).

_____ _____
Signature Date

_____ _____
Practice Name Tax ID

*__Note__: Dates should cover the dates of service of the claims being submitted to the managed care organization.