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Aetna Better Health® of California

Aetna Better Health of California **Enhanced Care Management (ECM) / Community Support Invoice**		Send this invoice using secure email to ABHCAECMCSInvoicing@aetna.com
Invoice Date (MM/DD/YYYY)	Invoice Number	Optional: Control Number
☐ Enhanced Care Management ☐ Community Support		Member Client Identification Number (CIN)
Member Name (Last Name, First Name, Middle Initial)	Member Date of Birth (MM/DD/YYYY)	Member Homelessness Indicator
Optional: Medical Record Number (MRN)	Member Residential Address (Street, State, City, Zip)	
Primary Payer Identifier	Payer Name	
Billing Provider Name (Last Name, First Name)	Billing Provider National Provider Identifier (NPI)	Billing Provider Tax Identification Number (TIN)
Billing Provider Phone Number	Billing Provider Address (Street, State, City, Zip)	
Member Diagnosis Code(s)	Optional: Authorization Number	

Service Start Date		Service End Date		Place of Service (POS)		
Procedure Code(s)	Procedure Code Modifier(s)	Optional: Service Name(s)	Service Unit Count(s) (#units of service)	Unit (Monthly, Hourly, 15-Min, By Report)	Service Unit Cost(s)	Service Charge Amount(s)
					Invoice Amount	

Rendering Provider Name (Last Name, First Name)	Rendering Provider National Provider Identifier (NPI)	Rendering Provider Tax Identification Number (TIN)	Rendering Provider Phone Number
Rendering Provider Address (Street, State, City, Zip)			

Invoicing Guidance

Provider Information			
Data Element	Required for ECM	Required for CS	Guidance
Billing Provider National Provider Identifier (NPI)	Yes	Yes	10-digit numeric
Billing Provider Tax Identification Number (TIN)	Yes	Yes	9-digit numeric (no dashes)
Billing Provider Name	Yes	Yes	Provider organization name; may be the name of the solo practitioner, if applicable
Billing Provider First Name	Optional	Optional	Provider name, if applicable; may be left blank
Billing Provider Last Name	Optional	Optional	Provider name, if applicable; may be left blank
Billing Provider Phone Number	Yes	Yes	Numbers only; no dashes; character limit of ten
Billing Provider Address	Yes	Yes	USPS formatted address
Billing Provider City	Yes	Yes	
Billing Provider State	Yes	Yes	2-character state abbreviation
Billing Provider Zip	Yes	Yes	Zip+4
Rendering Provider National Provider Identifier (NPI)	Optional	Optional	10-digit numeric

Rendering Provider Tax Identification Number (TIN)	Yes	Yes	9-digit numeric (no dashes)
Rendering Provider Name	Yes	Yes	Provider organization name; may be the name of the solo practitioner, if applicable
Rendering Provider First Name	Optional	Optional	Provider name, if applicable; may be left blank
Rendering Provider Last Name	Optional	Optional	Provider name, if applicable; may be left blank
Rendering Provider Phone Number	Yes	Yes	Numbers only; no dashes; character limit of ten
Rendering Provider Address	Yes	Yes	USPS formatted address
Rendering Provider City	Yes	Yes	
Rendering Provider State	Yes	Yes	2-character state abbreviation
Rendering Provider Zip	Yes	Yes	Zip+4
Member Information			
Data Element	Required for ECM	Required for CS	Guidance
Member Client Identification Number (CIN)	Yes	Yes	
Medical Record Number (MRN)	Optional	Optional	
Member First Name	Yes	Yes	
Member Last Name	Yes	Yes	
Member Homelessness Indicator	Yes	Yes	Identifier for if the Member does not have an address and is experiencing homelessness. If homeless, enter “1”, if not or unknown leave blank.
Member Residential Address	Yes	Yes	USPS formatted address ECM/Community Supports Providers may complete data element as “HOMELESS” if the Member is identified as homeless by the “Member Homelessness Indicator.”

Member Residential City	Yes	Yes	2-character state abbreviation
Member Residential Zip	Yes	Yes	Zip+4
Member Date of Birth	Yes	Yes	MM/DD/YYYY
Section 3: Service and Billing Information			
Data Element	Required for ECM	Required for CS	Guidance
Primary Payer Identifier	Yes	Yes	As provided by the MCP
Payer Name	Yes	Yes	
Procedure Code(s)	Yes	Yes	Reference your contract for specific procedure code reimbursements and billing frequency.
Procedure Code Modifier(s)	Yes	Yes	
Service Start Date	Yes	Yes	MM/DD/YYYY
Service End Date	Yes	Yes	MM/DD/YYYY
Service Name(s)	Optional	Optional	
Service Unit Count(s)	Yes	Yes	
Place of Service (POS)	Yes	Yes	

Member Diagnosis Code(s)	Yes	Yes	Multiple diagnoses (up to ten ICD-10 codes) may be submitted; codes may include Z-codes that identify social needs. Claims/encounters must have at least one recorded diagnosis code to be compliant when submitted by MCPs to DHCS.
Service Unit Cost(s)	Yes	Yes	The service unit cost(s) may not be reflective of the amount paid for the service, if the services are covered under a capitated or per member per month payment arrangement.

Service Charge Amount(s)	Yes	Yes	Service charge amount(s) are the total service-line costs (i.e., Service Unit Count(s) multiplied by the respective Service Unit Cost(s)). The service charge amount may not be reflective of the amount paid for the service, if the services are covered under a capitated or per member per month payment arrangement.
Invoice Amount	Yes	Yes	
Section 4: Administrative Information			
Data Element	Required for ECM	Required for CS	Guidance
Invoice Date	Yes	Yes	MM/DD/YYYY
Invoice Number	Yes	Yes	ECM/Community Supports Provider-generated ten digit, numeric code that identifies the invoice being submitted.
Control Number	Optional	Optional	
Authorization Number	Optional	Optional	