



UnitedHealthcare Community & State

Hoosier Care Connect Health Plan

Tips for billing and correcting *CMS-1500* and *UB-04* Claims

Presented by Jen Smith, Manager of Provider Advocacy & Account Management

United
Healthcare®

Agenda

- Our Service Lines
- Claim Submission
- General Billing Reminders
- How to Submit Corrected Claims
- When to Escalate a Claim
- Questions and Answers



Acronyms

- CMS – Centers for Medicare and Medicaid Services
- DOS – Date of Service
- EDI – Electronic Data Interchange
- EOB – Explanation of Benefits
- FDA – Food and Drug Administration
- HCFA – Health Care Finance Administration
- INN – In-Network
- NDC – National Drug Code
- OON – Out-of-Network
- PAR – Participating
- RFP – Request for Participation
- UHC – UnitedHealthcare



Our Service Lines

- ❖ UnitedHealthcare
- ❖ Optum Behavioral Health
- ❖ March Vision
- ❖ UnitedHealthcare Dental





Claim Submission

How to file Medical/Behavioral CMS-1500 claims

- Submit claims using the *CMS-1500* Claim Form (v 02/12).
- Standard Timely Filing for Par Providers – 90 calendar days from the date of service (DOS).
- Non-Contracted Providers Timely Filing – 180 calendar days from DOS.
- Newborn Claims Timely Filing – 180 calendar days from DOS.
- Secondary Claims Timely Filing – 90 calendar days from date of Primary EOB for INN Providers and 180 for OON providers from the Primary EOB date.

- For electronic submission: utilize Payer ID 87726
- Claims Mailing Address:



UnitedHealthcare Community Plan
P.O. BOX 5240
Kingston, NY 12402

- Claim Submission Tool for Medical Professional claims (*CMS-1500*) on our UnitedHealthcare Provider Portal
- Behavioral Health Professional claims (*CMS-1500*) on our Provider Express Portal



How to file Dental claims

- HIPAA-Compliant 837D file

HIPAA-Compliant 837D file

- The 837D is a HIPAA-compliant EDI transaction format for the submission of dental claims.
- This transaction set can be used to submit health care claim billing information, encounter information or both, from providers of health care services to payers via established claims clearinghouses.



How to file Dental claims

Paper Claims

- Refer to the [Quick Reference Guide](#) for addresses and phone number information.
- 100% of all clean paper claims will be paid or denied within 30 calendar days of receipt.
- 100% of all clean electronic claims will be paid or denied within 21 calendar days of receipt.

Claims Submission Tips

To receive payment for services, practices must submit claims via paper or electronic submission.

Dentists must submit an American Dental (ADA) Dental Claim Form (2012 version or later).

Computer-generated forms are recommended.

Attach documentation and radiographs if applicable.

Attachments are required for pre-treatment estimates and for the submission of claims for complex clinical procedures.

Refer to the Coverage, Limits and Billing for Specific dental Services section in the [Dental Services](#) module to find the recommendations for dental services.



How to file Dental claims

- Timely filing
 - All claims, including secondary claims, should be submitted within 90 calendar days from the date of service for participating providers or within 180 calendar days from the date of service for non-participating providers.

Electronic Claims

- Electronic claims processing requires access to a computer and usually the use of practice management software.
- Electronically generated claims can be submitted through a clearinghouse or directly to our claims processing system via the internet.
- UnitedHealthcare Community Plan partners with electronic clearinghouses to support electronic claims submissions.
- If you wish to submit claims electronically, contact your clearinghouse to initiate this process.
- While the Payer ID may vary for some plans, the Payer ID for **Community Plan members is GP133**.
- Please refer to the Important Addresses and Phone Numbers section for additional information as needed.
- Electronic submission is private as the information being encrypted.
- Call **1-877-897-4941** for more information regarding electronic claims submission.



Tips for successful Dental claim resolution

- Do not let claim issues grow or go unresolved.
- Call Provider Services at 1-844-402-9118 if you cannot verify a claim is on file.
- Do not resubmit validated claims on file unless submitting a corrected claim with the required indicators.
- File adjustment requests and claims disputes within contractual time requirements.

- If a provider must exceed the maximum daily frequency for a procedure, submit the medical records justifying medical necessity. If you have questions, call Dental Provider Services.
- UnitedHealthcare Community Plan is the payer of last resort. This means Providers must bill and get an EOB from other insurance or source of health care coverage before billing UnitedHealthcare Community Plan.
- Secondary claims must be received within 365 days from the date of service if the primary carrier has not made payment.
- When submitting appeal or reconsiderations requests, provide the same information required for a clean claim. Explain the discrepancy, what should have been paid and why.



How to file MARCH® Vision Care claims

- Use our convenient online provider portal: [eyeSynergy.com](https://eyesynergy.com).
- Submit claims electronically or via paper claim using the *CMS-1500* Claim Form.
- Standard Timely Filing for Participating Providers - 90 calendar days from the date of service (DOS).
- Non-Contracted Providers Timely Filing 180 calendar days from DOS.

- Online provider portal: [eyeSynergy.com](https://eyesynergy.com)

The logo for eyeSynergy, with "eye" in orange and "Synergy" in blue.

- For electronic submission:
Payer ID 52461

- **Claims Mailing Address:**



MARCH® Vision Care
Attn: Medicaid Vision Claims
PO Box 30989
Salt Lake City, UT 84130





Reconsiderations

MEDICAL

When Should You Submit a Claims Reconsideration?

- Claim reconsideration requests should be submitted through the Claims tool when a claim was processed incorrectly. Situations for reprocessing include, but are not limited to:
 - Paid amount is different than what provider expected.
 - Claim was filed in a timely manner, when provider has proof.
 - Claim was denied for no authorization, when provider has an authorization number.
 - Difference in Coordination of Benefits (COB) information .



How Do I Submit a Medical Claims Reconsideration Within the Tool?

- Click **Create Claim Reconsideration** to start your reconsideration request or submit a corrected claim.
- Providers have 90 calendar days from the original EOB date to submit a Claim Reconsideration.
- Need a paper form because you are unable to submit your reconsideration online? Use our Single Paper Claim Reconsideration Request Form found at the link below and mail to the claims mailing address:

<https://www.uhcprovider.com/content/dam/provider/docs/public/claims/UHC-Single-Paper-Claim-Reconsideration-Form.pdf>



Claims Tool

- With the Claims tool, you can:

- View claims information for multiple UnitedHealthcare plans.

- Access letters, remittance advice documents and reimbursement policies.

- Submit additional information requested on pended claims.

- Flag claims for future viewing.

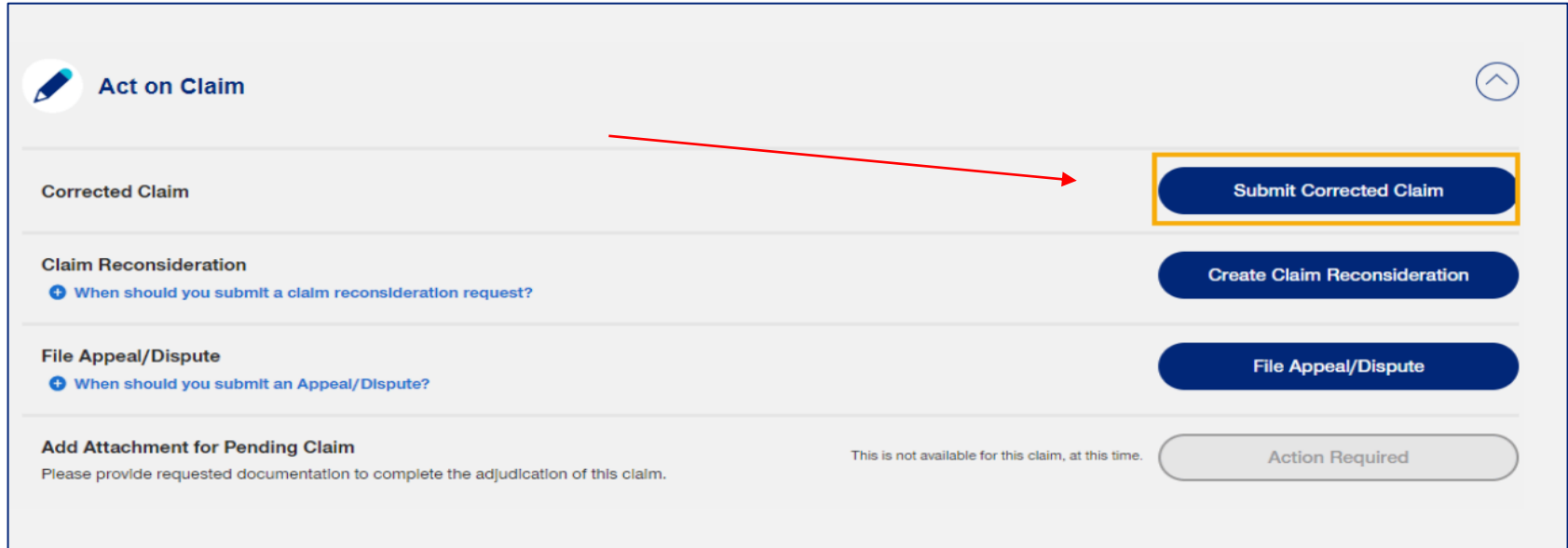
- Submit corrected claims or claim reconsideration request.

- Receive instant printable confirmation for your submissions.

The screenshot displays the UnitedHealthcare Claims Tool interface. At the top, there is a search bar and navigation tabs for 'Eligibility', 'Claims & Payments', 'Referrals', 'Prior Authorizations', 'Clinical & Pharmacy', 'Documents & Reporting', and 'Additional Tools'. The 'Claims & Payments' tab is active, showing a 'Trackit: Action Required' status and a 'Completed' status. The main content area is titled 'Welcome, Taylor!' and includes a 'Verify Eligibility & Benefits' section. This section has a 'Select Your Eligibility Search Criteria*' dropdown, a 'Member ID*' input field, a 'Date of Birth*' input field, and a 'Verify Eligibility' button. A right sidebar contains 'Eligibility & Benefits Resources' and 'Quick Links & Tools'. A red arrow points to the 'Claims & Payments' menu item, and an orange box highlights the 'Verify Eligibility & Benefits' section.



Example of How to Submit Corrected Claim



Act on Claim ⌆

Corrected Claim ➔ **Submit Corrected Claim**



Claim Reconsideration
+ When should you submit a claim reconsideration request? **Create Claim Reconsideration**

File Appeal/Dispute
+ When should you submit an Appeal/Dispute? **File Appeal/Dispute**

Add Attachment for Pending Claim This is not available for this claim, at this time. **Action Required**
Please provide requested documentation to complete the adjudication of this claim.



Corrected Claims

 **Request Information and Comments** 

Request Information

All Fields are Required

Amount Requested

 I don't know

Request Reason

Request Comments

Please include what you are expecting from UnitedHealthcare to close this in your practice management system in the amount requested field, and include any additional comments you would like in the comment field.

New Comment

Comments are required

- In **Amount Requested**, enter the total amount you expect for the claim, including any previous payments.
- Select Resubmission of a Corrected Claim as the Request Reason from the pulldown menu.
- Help us understand the situation by adding a New Comment.



Example of How to Create a Reconsideration



The screenshot displays the 'Act on Claim' interface with the following elements:

- Act on Claim** (Header with a pencil icon and an upward arrow icon)
- Corrected Claim** (Section with a disabled button: **Submit Corrected Claim**, and text: *This is not available for this claim.*)
- Claim Reconsideration** (Section with a link: [When should you submit a claim reconsideration request?](#) and a highlighted button: **Create Claim Reconsideration**)
- File Appeal/Dispute** (Section with a link: [When should you submit an Appeal/Dispute?](#) and a button: **File Appeal/Dispute**)
- Add Attachment for Pending Claim** (Section with text: *Please provide requested documentation to complete the adjudication of this claim.* and a disabled button: **Add Attachments**, and text: *This is not available for this claim, at this time.*)



MEDICAL

- Scroll down to review the details.
- Enter your contact information in the Submitter's Contact Information section.
- Once Submitted, document the ticket number received.

Current Claim Status: ▲ Denied • First Date of Service: 08/08/2020 • Total Billed: \$1,234.56

[Contact Information](#) | [Request Information & Comments](#) | [Attachments](#) [View Patients Eligibility & Benefits](#)

Create a Reconsideration

This form is to be completed by physicians, hospitals or other health care professionals to request a claim reconsideration for members enrolled in benefit plans administered by UnitedHealthcare. **A separate request must be filled out for each claim reconsideration. Don't use this form for appeals or disputes. Continue to use your standard appeals process for formal appeals and disputes.**

Contact Information ⤴

Provider Information

Billing Provider Medical Center	Tax ID Number 123456789
Servicing Provider Jamie Doctor	

Submitter's Contact Information

All Fields are Required

First Name <input type="text" value="Taylor"/>	Last Name <input type="text" value="Demo"/>	
Phone Number <input type="text" value="(555) 955-4555"/>	Email Address <input type="text" value="email@sample.com"/>	
<small>(###) ###-####</small>		
Street Address <input type="text" value="123 Demo St"/>		
City <input type="text" value="Great City"/>	State <input type="text" value="VA"/>	ZIP Code <input type="text" value="23456"/>



BEHAVIORAL

How do I Submit a Claims Reconsideration?

Securely log in to [Provider Express](#).

- **Claim Inquiry.**
- Search for claim.
- Click **Enter** under claim adjustment.

Providers have 90 calendar days from the original EOB date to submit a Claim Reconsideration.

Home Eligibility & Benefits Auth Request Auth Inquiry Claim Inquiry **Claim Inquiry** EPR ALERT Provider Reports My Provider Express My Practice Info Message Center Contact Us

Claim Inquiry* - indicates required field(s)

[Click here to register for or view Electronic Payments and Statements](#) [Can't find claim status online?](#)

My Patients | Member ID Search | Name/DOB Search

Please complete the form below and click "Search"
* - indicates a required field

Member ID -

Group #

First Name -

Optional - Dates of Service (defaults to 180 days before today's date)

Month and Year
 Date Range (180 day limit)
 Previous 12 Months
 Previous 24 Months

Provider Express recommends using the minimum search criteria of Member ID and First Name only. Do not enter a group number unless the system prompts you via a specific message.

Search

Claim Detail

Date(s) of Service:	11/11/2015	Date Paid:	11/14/2015				
Clinician Name:	Provider, John Q.	Check #:	0				
Authorization #:							
Payee Name:	John Q Provider	Claim #:	X0987654321				
Address:	123 Main Street Anywhere USA 55555	Place Of Service:	OFFICE				
		Service Code:	90834HJ				
Claimed Amount:	Contract Rate:	Deductible Amount:	PT Responsibility:	Disallowed Amount:	Paid Amount:	Claim Status:	Claim Adjustment:
\$80.00	\$80.00	\$0.00	\$0.00	\$0.00	\$60.00	Finalized	Enter

Explanation:

Optum follows the prompt payment regulations applicable to each state and payments on finalized claims will be paid within these timeframes. Please be aware that some customers have asked to have payments made in batches, releasing payment for a number of clinician claims at specified intervals rather than as each claim is received and processed. The claim status detail will be updated with Paid Date, Check Number and other claim details once a payment has been released. If you have additional questions about this claim, please contact Optum at the toll-free number located on the member's ID card.

Previous Page Summary Page New Inquiry



BEHAVIORAL

- Select a reason from the dropdown.
- Select **Review**.
- Review details and add necessary comments on next screen.
- Select **Submit**.
- Once submitted, document the Confirmation Number and Issue ID.

Claim Adjustment - Entry

After a claim has been processed, you may make a Claim Adjustment request. If you believe that a claim was processed incorrectly, please select a Reason from the list below. In addition, please include any information that should be evaluated in the claim adjudication process.

Member Name MEMBER NAME Member Id XXXXX0000-00

Clinician Name Provider, John Q

Date(s) of Service	Date Paid	Claimed Amount	Copay Amount	Disallowed Amount	Paid Amount
11/11/2015	11/14/2015	\$60.00	\$60.00		\$0.00

Reason
Claim Overpaid
Claim Underpaid
COB Adjustment
Claim Paid to Incorrect Provider
Change in Patient Eligibility
Incorrect Member Liability

Comment
which was met on 10/31/2015. Please reprocess

255 characters left



Member Name MEMBER NAME Member Id XXXXX0000-00

Clinician Name Provider, John Q

Date(s) of Service	Date Paid	Claimed Amount	Copay Amount
11/11/2015	11/14/2015	\$60.00	\$60.00

Confirmation Number: 500000005

Issue Id: C21911807314774

Reason: Incorrect Member Liability

Comments:

Claim processed against member deductible, which was met on 10/31/2015. Please reprocess and pay.



MEDICAL & BEHAVIORAL

What if I don't agree
with the outcome of
my Claim
Reconsideration?

- If you disagree with the outcome of your Claim Reconsideration, please escalate the issue to your Indiana Medical or Behavioral Advocate Team.

Medical

Regions 1 and 2 – Lori Reeder – lreeder@uhc.com

Regions 3 and 4 – Karen Cockerham –
karen.Cockerham@uhc.com

Region 5 – Kelly Carpenter – kelly_carpenter@uhc.com

Behavioral Health

Northern IN – Belen Stewart – belen.stewart@optum.com

Central and Southern IN – Paulette Means –
paulette.means@optum.com



MEDICAL & BEHAVIORAL

What is the next step in the Reconsideration Process?

- If you continue to disagree with the outcome of your claim after the Advocate team has escalated, your next step is to file a Formal Dispute.
- Must be submitted within 60 calendar days from the failed reconsideration.
 - Mail to:

UnitedHealthcare Community Plan of Indiana
Attn: Appeals and Grievances Unit
PO Box 31364
Salt Lake City, UT 84131-0364
 - Submit within Claims on the UnitedHealthcare Provider Portal.



MEDICAL & BEHAVIORAL

What if I still
disagree?

- If you still disagree with the outcome of your formal Dispute, you may file a Formal Provider Grievance.
- Must be submitted within 120 calendar days from the failed Dispute (must include additional or new information).
- Mail to:

UnitedHealthcare Community Plan of Indiana
Attn: Appeals and Grievances Unit
PO Box 31364
Salt Lake City, UT 84131-0364
- Submit within Claims tool on our UnitedHealthcare Provider Portal.



MARCH® Vision Care

How do I Submit an Informal Dispute?



Providers can also use our online form to submit electronically from the following link:

<https://forms.marchvisioncare.com/Forms/PDR>

Provider dispute resolution process

- Providers have 60 calendar days to file an informal dispute. Disputes must be in writing (paper, portal, email, etc.), not taken over the phone.
- We have 30 calendar days to respond or request additional information .
- If the Dispute is not resolved to your satisfaction, you will have 60 calendar days after the end of the 30-calendar day period to submit a formal appeal. The appeal must be in writing.
- The appeal review is conducted by a panel of 1 or more individuals selected by the Managed Care Organization.
- The panel's written determination must be issued within 45 calendar days. Failure to respond within 45 calendar days shall have the effect of an approval.

Please submit your request by mail to:
UnitedHealthcare | March Vision Care
Attn: Medicaid Vision Appeals
PO Box 30988
Salt Lake City, UT 84130



How to file Dental Corrected Claims

- Providers who receive a claim denial and need to submit a corrected claim should submit a corrected claim and appropriate documentation, if necessary, to:

UHC Dental

PO Box 481

Milwaukee, WI 53201

- Providers can submit a request for an additional claim review, if a claim was denied due to missing information, missing tooth number/ surface on the original submission or you have additional information you feel may change the claim payment decision.
- The determination of a corrected claim request will be provided on a remittance statement within 30 days of receipt.



How do I dispute how a dental claim was processed or denied?

- UnitedHealthcare will follow state and Federal guidelines in the management of the appeals process, including 405 IAC 1-1.6.
- Providers may submit an Informal Objection within 60 days of the adverse claim determination ("claim denial"). This Informal Objection must be submitted in writing and will be reviewed and resolved within 30 days.
- If providers are not satisfied with the resolution to the Informal Objection, providers may submit a Formal Appeal in writing within 60 days of the Informal Objection which will be reviewed and resolved within 30 days.





UnitedHealthcare Community & State

Hoosier Care Connect Health Plan UB-04 Claims

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Claim Submission

How to file Medical/Behavioral UB-04 Claims

- Submit claims using claim submission tool on UHCprovider.com.
- Standard Timely Filing for Par Providers 90 days from the date of service (DOS).
- Non-Contracted Providers Timely Filing – 180 calendar days from DOS.
- Newborn Claims Timely Filing – 180 calendar days from DOS.
- Secondary Claims Timely Filing – 90 calendar days from date of Primary EOB for INN Providers & 180 for OON providers from the Primary EOB date.

- **For electronic submission:**

Payer ID 87726



- **Claims Mailing Address:**

**UnitedHealthcare Community Plan
PO BOX 5240
Kingston, NY 12402**



Electronic Secondary Claims

- **Primary Payer Paid Amount:** Submit the primary paid amount for each service line reported on the 835-payment advice or EOB. The paid amount on institutional claims can be submitted at the claim level.
- **Adjustment Group Code:** Submit other payer claim adjustment group code as found on the 835-payment advice or identified on the EOB. Deductible, co-insurance, copayment, contractual obligations and/or non-covered services are common reasons why the other payer paid less than billed.
- **Adjustment Reason Code:** Submit other payer claim adjustment reason code as found on the 835-payment advice or identified on the EOB. Deductible, co-insurance, copayment, contractual obligations and/or non-covered services are common reasons why the other payer paid less than billed.
- **Adjustment Amount:** Submit other payer adjustment monetary amount.
- **Preference:** Submit professional claims at the line level and institutional claims at either the line or claim level. The service level and claim level should be balanced. UnitedHealthcare follows 837P/837I guidelines.



COB Electronic Specifications

- For secondary or institutional claims to be paid electronically, the COB information must be submitted in the applicable loops and segments.
- Loops IDs include:
 - 2320 Other Subscriber Information
 - 2330A Other Subscriber Name
 - 2330B Other Payer Name
 - 2330C Other Payer Referring Provider
 - 2330D Other Payer Rendering Provider
 - 2330E Other Payer Service Facility Location
 - 2330F Other Payer Supervising Provider
 - 2430 Line Adjudication Information
- To learn more about submitting secondary/COB claims electronically to UnitedHealthcare, please consult your vendor, 837P/837I Implementation Guide, or our Companion Guides page for eCOB specifications.





General Billing Reminders

Tips for Claim Submission

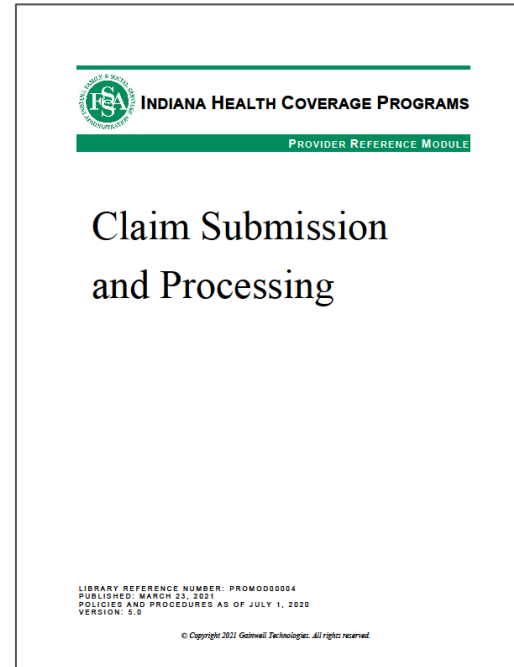
- An occurrence code is required for all types of bill except for an outpatient type of bill. UnitedHealthcare follows the guidance found on the IHCP Claims Submission and Processing, the link is provided on the next slide.
- Rejected Claims are not visible in our claims system – Claim rejections that appear on clearinghouse reports have not been accepted by UnitedHealthcare and should be corrected and resubmitted electronically to avoid timely filing denials.
- Secondary Claims – When another insurance plan is primary and UnitedHealthcare is secondary, the secondary claim can be submitted electronically. Information from the primary payer's EOB/COB should be included in the electronic claim.



General Billing Reminders – IHCP Modules

UnitedHealthcare Community Plan of Indiana follows the [Indiana Medicaid Claims Submission and Processing Module](#)

A facility's enrolled service location address should always be billed in box 1 of the UB-04. This includes the ZIP + 4.



General Billing Reminders - NDC

Unique Identifier Assigned to Medication under Section 510 of United States Federal Food Drug and Cosmetic Act

First five digits identify the manufacturer of drug and are assigned by the FDA

The remaining six digits are assigned by the manufacturer and identify the specific product and package size.

If eleven digits not included on the label, add a leading zero to create a 5-4-2 NDC

If package NDC is 66733-948-23 the billing will be 66733-0948-23

Place the valid NDC on claim without hyphens or spaces

If the NDC number on internal container and external package do not match – list only the NDC number from internal package

Detailed info can be located in the [Injections, Vaccines and Other Physician-Administered Drugs](#) Module



General Billing Reminders – NDC Units

- The actual decimal quantity administered, and the units of measurement are required on the claim. If reporting a partial unit, use a decimal point. (i.e., if three 0.5 ml vials are dispensed, report mL1.5).
 - GR0.045
 - ML1.5
 - UN2.0
- The number of digits for the quantity is limited to eight digits before the decimal and three digits after the decimal. If entering a whole number, do not use a decimal. Do not use commas. Do not zero fill, leave remaining positions blank. Please refer to the following examples:
 - 1234.56
 - 2
 - 12345678.123
- Requiring the NDC information will differentiate drugs that share the same HCPCS, CPT, or Revenue Codes for drug preferences and enhance reimbursement processes.
- The NDC requirement will not apply to child and adult immunization drug codes.



General Billing Reminders on Reimbursement Policies

- If you are experiencing claim denials for a specific code or service, check the Reimbursement Policies page as the denial may be related to a Reimbursement Policy.
- Reimbursement Policies can be found:

<https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-policies/reimbursement-community-state-policies-indiana>

Note: All UnitedHealthcare Community Plan of Indiana Reimbursement Policies have been approved by the state.



General Billing Reminders - Smart Edits

- Smart Edits is a claims optimization tool that identifies billing errors within a claim and allows care providers the opportunity to review and repair problematic claims. Smart Edits are sent within 24 hours of a claim submission, so you can review identified claims in a matter of hours instead of potential claims denials days later.
- When claims are submitted accurately and in compliance with the latest policies and regulations, it results in less re-work, quicker approvals and faster payments.
- Link to documentation on portal:
[Smart Edits | UHCprovider.com](https://www.uhcprovider.com)



UnitedHealthcare Smart Edits

If the Smart Edit description refers to a reimbursement policy, coverage summary, or policy guideline please visit [UHCprovider.com/policies](https://www.uhcprovider.com/policies) and select the appropriate line of business as it pertains to the edit. The effective date of the Smart Edits is the original effective date. The Edit Type may change as Smart Edits evolve.

[Click here for Professional Edits](#)
[Click here for Facility Edits](#)

What's New with Smart Edits?

Edit Type	Smart Edit	Smart Edits Message	Description	Effective Date	Market	Claim Type
Documentation Edit	uATCCT5T	Medical records may be required for EM code +1+ and can be updated in the claim. Link tool at healthid.uhplm.com . For more information on this edit, go to uhprovider.com/smartedit .	EM Code with COVID Test Message: Medical Records Claims submitted for COVID testing reimbursement that have a Level 3 Evaluation and Management code without supporting diagnosis codes may require medical records for payment. Please see the Emergency Department (ED) Facility Evaluation and Management (EEM) Coding Policy - Reimbursement Policy for UnitedHealthcare Commercial Plans for more information.	7/22/2021	Commercial	Facility
Documentation Edit	uATCCT5T	Medical records may be required for EM code +1+ and can be updated in the claim. Link tool at healthid.uhplm.com . For more information on this edit, go to uhprovider.com/smartedit .	EM Code with COVID Test Message: Medical Records Claims submitted for COVID testing reimbursement that have a Level 3, 4, or 5 Evaluation and Management code without supporting diagnosis codes may require medical records for payment. Please see the Commercial Evaluation and Management Policy for more information.	7/22/2021	Commercial	Professional
Reject Edit	u0055F	REJECT - Add-on HCPCS code U0005 reported without a high-throughput COVID-19 test code on the same claim. Please report and resubmit. This claim is rejected and will not be processed.	U0005 Add-On Without Test Code U0005 is an add-on code that must be submitted with another high-throughput COVID test code, which at this time is U0003 and/or U0004. UnitedHealthcare is requiring that all of the changes be submitted on the same claim.	7/22/2021	Medicaid	Facility

PCA-1-20-02998-PHWEB-1006/2020





Corrected Claims

Corrected Claims – UB-04

- Electronic Corrected Claims.
 - Corrected UB-04 claims can be sent electronically.
 - Using the appropriate Bill Type to indicate that it's a replacement of a previous claim.
 - If you cannot submit corrected claims using EDI, submit a claim reconsideration request via the Claims Tool via the UnitedHealthcare Provider Portal in the same manner as you would for a HCFA or *CMS-1500* claim form.



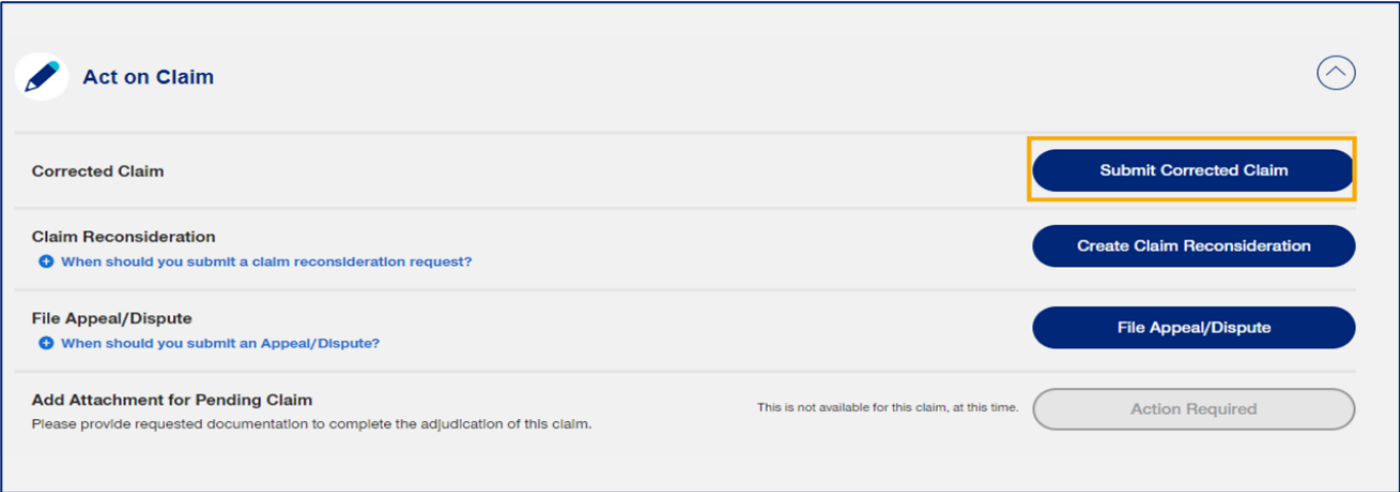
Claims Tool

- With the Claims tool, you can:
 - View claims information for multiple UnitedHealthcare plans.
 - Access letters, remittance advice documents and reimbursement policies.
 - Submit additional information requested on pended claims.
 - Flag claims for future viewing.
 - Submit corrected claims or claim reconsideration request.
- Receive instant printable confirmation for your submissions.

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Submit Corrected Claim



The screenshot shows a user interface titled "Act on Claim" with a pencil icon and an upward arrow icon. It features four main sections, each with a title, a question, and a corresponding button:

- Corrected Claim**: A dark blue button labeled "Submit Corrected Claim" is highlighted with a yellow border.
- Claim Reconsideration**: A dark blue button labeled "Create Claim Reconsideration".
- File Appeal/Dispute**: A dark blue button labeled "File Appeal/Dispute".
- Add Attachment for Pending Claim**: A light gray button labeled "Action Required". Below the title, it says "Please provide requested documentation to complete the adjudication of this claim." and "This is not available for this claim, at this time."

- Proceed to the “Submit Corrected Claim” tab to submit your claim correction.





When to Escalate a Claim

When Should I Escalate a Medical Claim to a Provider Advocate?



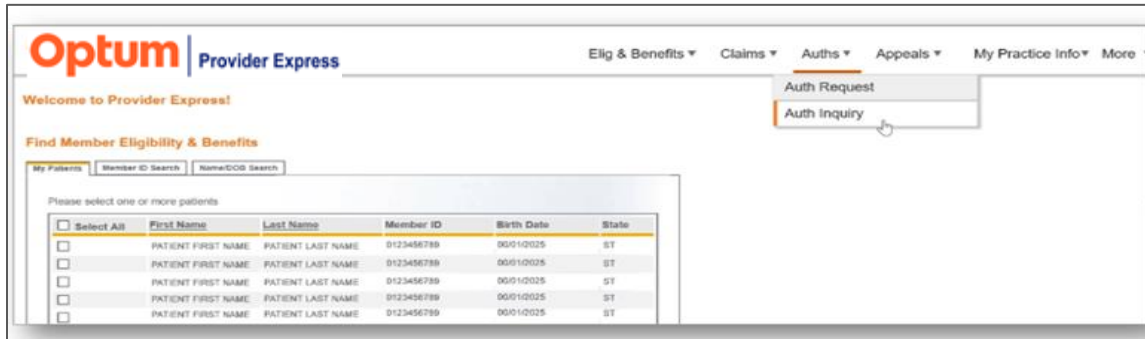
- 1st Level Dispute (Reconsideration)
- 2nd Level Appeal



When Should I Escalate a Behavioral Health Claim?

Lack of response after submitting an Authorization request:

1. Check the Provider Express portal.
2. Call the number on the back of the member's ID card.
3. If 1 and 2 do not provide a response, please reach out to your Provider Relations Advocate.



Behavioral Health Advocates

Northern IN:

Belen Stewart

belen.stewart@optum.com

Central & Southern IN:

Paulette Means

paulette.means@optum.com





Resources

Additional Claims Trainings on UHCprovider.com

[Claims Research Project](#)

[Document Library Interactive User Guide](#)

[CommunityCare Provider Portal User Guide \(chameleoncloud.io\)](#)



Administrative Provider Resources – Medical and Vision Claims

- Education resources for submitting claims are available on our provider website.
- Claim system configuration follows Federal and Indiana Medicaid claims billing guidelines.
- Accept paper or electronic claim submissions.
 - Link to file medical claims with United Healthcare UHCprovider.com/claims



Medical Claims and Eligibility

- Check claim status.
- Check member eligibility status.
- Start a claim reconsideration or appeal once claim ID is pulled up.
- Obtain electronic image of a member's Hoosier Care Connect Insurance Card.

Hello, Taylor

Before you get started, make sure your [payer information](#) and [provider information](#) in the top right corner of the page are correct. Try out our shortcuts to eligibility and claims information below for quick links to common tasks.

Verify Eligibility & Benefits

[View Recent Search Results](#)

Select Your Eligibility Search Criteria* *Required Fields

Member ID & Date of Birth ▼

Member ID* Date of Birth*

[Search for Multiple Members](#)

Leaving the dates blank will default to using today's date and will return current, past and future policies. You may also enter a date range up to 6 years in the past and 12 months in the future.

First Service Date - Last Service Date

Verify Eligibility

Look Up a Claim or Ticket

[View Flagged Claims in Trackit](#)

Select Your Claim or Ticket Search Criteria* *Required Fields

Member ID & Date of Birth ▼

Search By: TIN **123456789** [Edit](#) Provider [Infusion Services](#) [Edit](#)

Member ID* Date of Birth*

Select Range: Custom Date Predefined Date

You may search for claims up to 18 months in the past.

First Service Date* - Last Service Date*

Submit Search

[Feedback](#)



Provider Reference Appendix



Provider Service Line Website Links

- United Health Community Plan (Medical): www.uhcprovider.com/INcommunityplan
- UHC Dental: www.uhcdentalproviders.com
- MarchVision: www.marchvisioncare.com
- Optum Behavioral Health: [Provider Express - Indiana Medicaid](#)





Provider Advocate Teams

Your Medical Network Provider Advocate Team

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Territory & all FQHC/RHC's

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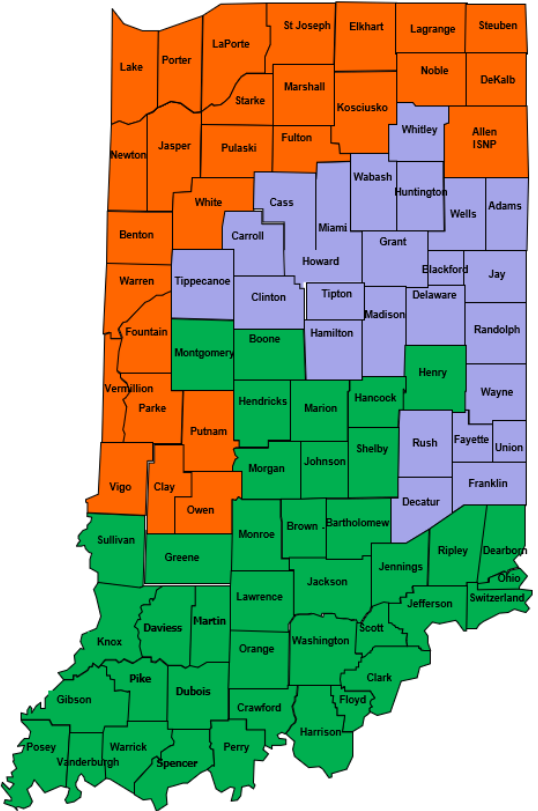
Your Skilled Nursing Provider Engagement Team

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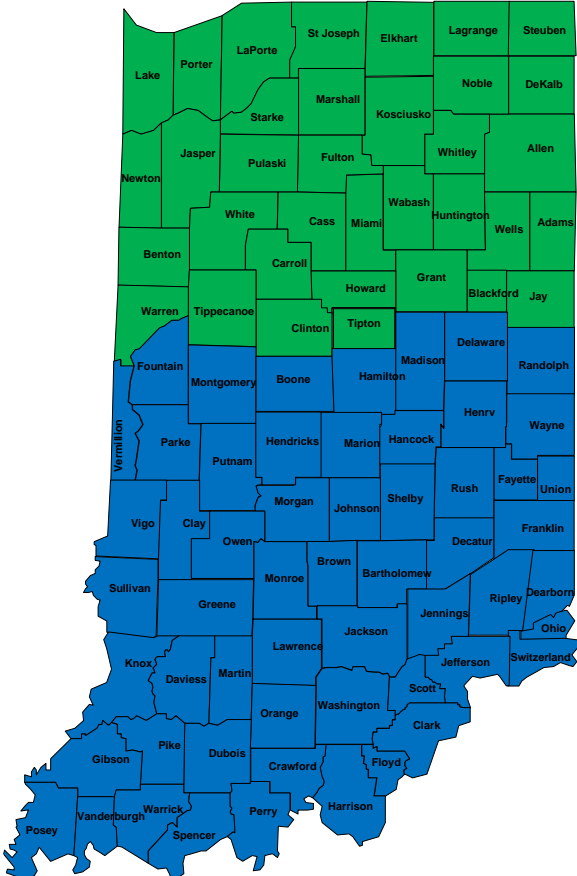


Your Optum Behavioral Health Advocate Team

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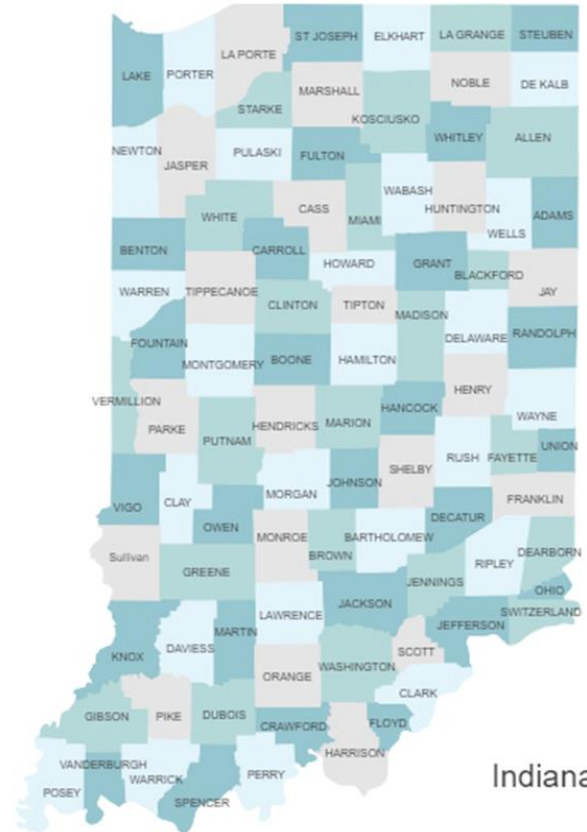
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Your March Vision Advocate

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Questions and Answers

Thank You for Attending Today's Session

