



An Introduction for Providers to UHC's Home- and Community-Based Services (HCBS)

Partnering for Success with UnitedHealthcare Community Plan

Presented by

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Provider Relations Advocate

**United
Healthcare**

Acronyms

EVV - Electronic Visit Verification

NOA - Notice Of Action

TIN - Tax ID Number

LPI - Legacy Provider Identifier/Medicaid Provider ID

PCSP - Person-Centered Service Plan

ERA – Electronic Remittance Advice

RA – Remittance Advice

IHCP – Indiana Health Coverage Programs



Today's Agenda

1. Provider Resources and Portal Tools
2. Network Enrollment and Provider Maintenance
3. NOA and Care Planning
4. Waiver Liability
5. Claims Submission and Reimbursement
6. Electronic Visit Verification (EVV)
7. Provider Support Resources
8. Questions and Discussion



UnitedHealthcare Community Plan of Indiana
Homepage | UHCprovider.com

One Portal. Multiple Solutions.

Eligibility | Authorizations | Claims | Payments | Education

UHC Provider Website

<http://www.UHCprovider.com/incommunityplan>

-  Eligibility - Verify member coverage
-  NOA - View and download approvals
-  Claims and Payments-Submit claims and access ERAs
-  Training and Support - Provider education resources

UHCprovider.com | Your Central Resource for Eligibility, Authorizations, Claims, and Payments





Join the UnitedHealthcare Network **A Seamless Path to Partnership**

For new and prospective HCBS providers:

- ✓ Create a One Healthcare ID
- ✓ Complete enrollment through Onboard Pro
- ✓ Track application progress online
- ✓ Receive support from your Provider Advocate

**United
Healthcare**

Join Our Network

<https://identity.onehealthcareid.com/oneapp/index.html#/login>

Provider portal registration steps

1

Create a One Healthcare ID

Create your own One Healthcare ID to register your secure access

Create ID 

2

Sign in

Log in to complete tasks and manage your account

Sign in 

3

Connect your TIN

Connect organization TIN(s) and select your portal tools for access

Connect TIN 

4

Learn to use the portal

Easy-to-use portal self-paced educational tools

Learn to use 



Getting Started with Network Enrollment

One Healthcare ID →

Onboard Pro
Enrollment →

Application Review →

Status Tracking →

Network Participation

MembersNew User & User Access

Search

United Healthcare

Coverage and payments ▾Our network ▾Tools and resources ▾Sign In

Home > Provider portal registration

Provider portal registration

Welcome new users

The UnitedHealthcare Provider Portal is the secure place where we work together seamlessly 24/7/365 for accessing patient and practice-specific information including:

- Eligibility and benefits
- Claims
- Prior authorizations
- Referrals
- Forms, reports and more



What you'll need

- [Your own One Healthcare ID](#)
- Organization tax ID number (TIN)
- Clinicians and physicians: National Provider Identifier (NPI) number
- [Access and New User Registration Guide](#)



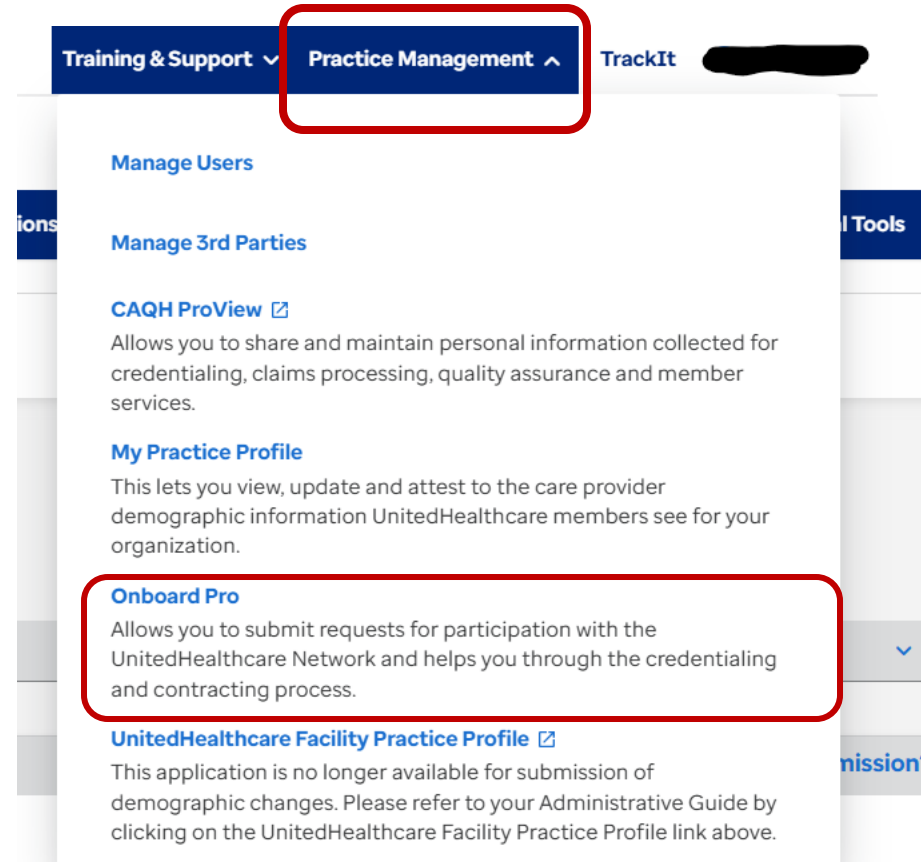
Maintaining Accurate Provider Information

- Provider Demographic Updates
 - ❖ Keep Your Information Current to Support Accurate Communication and Claims Processing
 - ❖ Update the Following Through Onboard Pro

-  Service Locations & Counties Served
-  Phone & Fax Numbers
-  Provider Contacts
-  Practice Information
-  Email Addresses & Communication Preferences

Why It Matters

- ✓ Accurate Provider Directory Listings
- ✓ Timely Claims Processing
- ✓ Reliable Provider Communications
- ✓ Reduced Administrative Delays



UHC Provider Portal Dashboard

The screenshot displays the UHC Provider Portal Dashboard. At the top, the United Healthcare logo is on the left, and navigation links for Training & Support, Practice Management, TrackIt, and a user profile (Lacey) are on the right. Below the logo is a search bar. A dark blue navigation bar contains tabs for Eligibility, Claims & Payments, Referrals, Prior Authorizations, Clinical & Pharmacy, Documents & Reporting, and Additional Tools. Below this bar, a row of status indicators shows 'Pending user requests', 'Expiring user requests', 'Pending 3rd party requests', and 'Expiring 3rd party requests', each with a green checkmark and a '0'. The main content area starts with a 'Welcome, Lacey!' message and a reminder to verify payer and provider information. A left sidebar lists menu items: Eligibility, Claims & Payments, Referrals, Prior Authorizations & Notifications, Documents & Reporting, and UnitedHealthcare Updates. The central section is titled 'Verify Eligibility & Benefits' and includes a search for a single member with options for Single Policy or Multiple Policies. It also features a search criteria dropdown, input fields for Member ID and Date of Birth, and a search range selector. On the right, there are links for Eligibility & Benefits Resources, Tool resources, Interactive training guide, Drug lists and pharmacy, and Indiana health plan. A 'Quick Links & Tools' section at the bottom right lists UMR and FlexWork.

Access TrackIt and see what tasks need attention

Get the latest training and technical resources

Manage user's demographics, paperless delivery and more

Make changes to your personal profile and settings

Use the payer and provider dropdown menus to switch the information used in your searches and tasks

Find shortcuts to resources, links, and tools



Accessing Service Authorizations

🔍 Search → 📄 Review → ✅ Verify → ⬇️ Download

 Payer 87726

Eligibility **Claims & Payments** **Referrals** **Prior Authorizations** **Clinical & Pharma**

Prior authorizations and advance notifications

[Create new/view existing](#) [Check requirements by code](#)

Create a new request or view existing request status

Currently selected provider [Edit](#)

What task would you like to do?

☐ Create a new request ☒ View an existing request status

What category applies to the services being performed?

Select a service category *

Standard medical (not listed below) ▼

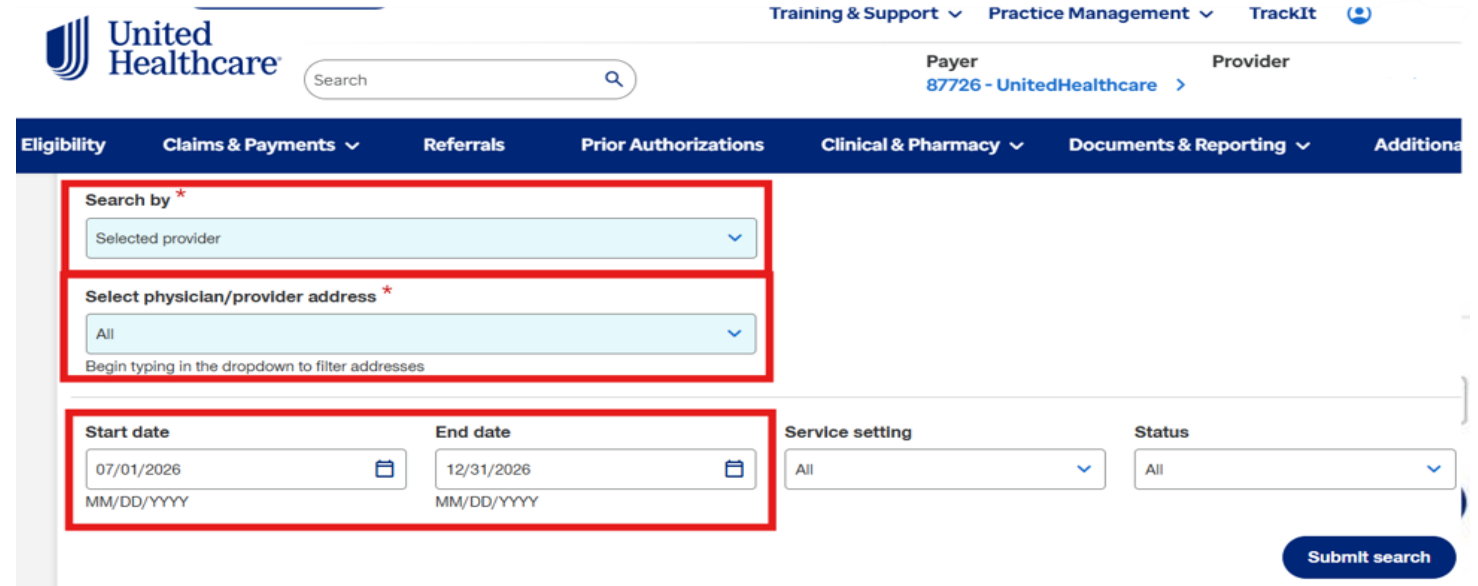


Reviewing Service Authorization Results

Confirm Approved Services and Billing Information

After Completing Your Search
Review Key Authorization Details

-  Member Information
-  Effective Dates
-  Authorization Status
-  Approved Units
-  Authorized Services



The screenshot displays the United Healthcare provider portal interface. At the top, there's a navigation bar with links for Training & Support, Practice Management, and TrackIt. Below this is a search bar and a header section showing Payer (87726 - UnitedHealthcare) and Provider information. The main content area features a search filter section with three red-bordered boxes highlighting the 'Search by' dropdown (set to 'Selected provider'), the 'Select physician/provider address' dropdown (set to 'All'), and the date range filters (Start date: 07/01/2026, End date: 12/31/2026). To the right of these are filters for 'Service setting' (set to 'All') and 'Status' (set to 'All'). A 'Submit search' button is located at the bottom right of the filter section.

Provider Best Practices

- Verify authorization details before delivering services
- Confirm units and service dates align with planned care
- Monitor authorizations for changes or updates
- Retain authorization records for billing support



Accessing Authorization Documents

- To access the document’s details, click the authorization number in Notification/prior authorization # column
- Service Authorizations can be downloaded and/or printed by clicking the blue arrow under document column.

Search by submitting provider [Change search criteria](#)

Results Per Page 5 < 1 of 1 >

Showing 1-5 of 5 Results

	Notification/prior authorization #	Member ID	Last name	First name	Service setting	Place of service	Service dates	Case status	Overall coverage status	Document
>	A				Outpatient	Home	07/01/2025-05/31/2026	Closed	Covered/Approved	↓
>	A				Outpatient	Home	06/19/2025-06/30/2025	Closed	Covered/Approved	↓
>	A				Outpatient	Home	04/01/2025-03/31/2026	Closed	Covered/Approved	↓
>	A				Outpatient	Home	04/01/2025-02/28/2026	Closed	Covered/Approved	↓
>	A				Outpatient	Home	03/24/2025-02/28/2026	Closed	Covered/Approved	↓

Showing 1-5 of 5 Results

< Previous 1 Next >





Understanding Service Plan Details

Service Plan Information

All members receiving HCBS will receive a service plan.

- A Person-Centered Service Plan (PCSP) is developed with the member in collaboration with the member's Interdisciplinary Care Team including the caregiver, providers, and Care and Service Coordinator.
- The PCSP includes the member's service plan and is inclusive of authorized HCBS services.
- Providers can log into the UHC provider portal to view the service plan authorizations that have been approved.
- Reassessment occurs annually or due to a trigger event ([Transitions between healthcare settings, a hospital discharge, decline in social status, change in the home setting or environment if the change impacts one or more areas of health or functional status, change in diagnosis that is not temporary/episodic and impacts one or more areas of health status or functioning, and as requested by the member or member's designee, caregiver, provider, ICT, or the State.](#)) to develop changes to the care/service plan and authorizations.



Service Plan Example

Service description	Service code	Modifier				Amount	From date	To date
Homemaker service, NOS; per 15 minutes	S5130	U7	UA			120 Units	08/22/25	08/31/25
Homemaker service, NOS; per 15 minutes	S5130	U7	UA			300 Units	09/01/25	09/30/25
Homemaker service, NOS; per 15 minutes	S5130	U7	UA			300 Units	10/01/25	10/31/25
Homemaker service, NOS; per 15 minutes	S5130	U7	UA			300 Units	11/01/25	11/30/25

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Care Coordinator Partnership

- Coordinators Can Assist With

- ✓ Service Plan Questions
- ✓ Benefit Clarification
- ✓ Care Transitions
- ✓ Service Coordination
- ✓ Barrier Resolution



NOTICE OF ACTION

January 23, 2026

Member Phone: .
RID:
SSN: XXX-XX-
DOB:
Authorization: A.

Dear Caregiver Staffing:

Attached is the approved NOTICE OF ACTION for who has selected you as a provider of the indicated Home and Community Based Services (HCBS) services under Indiana PathWays for Aging Program and approved by UHC.

If you have questions or concerns, please contact care coordinator at or or UnitedHealthcare Community Plan's Indiana PathWays for Aging Program Provider Services at 1-877-610-9785.

Important Provider Notice: the 21st Century Cures Act directs state Medicaid programs to require personal care service to use an electronic visit verification (EVV) system to document services rendered. The EVV requirement was effective January 1, 2021. For more information visit <https://www.in.gov/medicaid/providers/business-transactions/electronic-visit-verification/>.

Funding Source: Indiana PathWays for Aging Program									
Unskilled respite care, not hospice; per 15 minutes									
Caregiver Staffing - 201285620A									
Billing Code	Mod #1	Mod #2	Mod #3	Start Date	Stop Date	Unit Size	Unit Rate	# of Units	Current Cost
S5150	U7	UA	U9	05/01/2026	05/31/2026	0.25 Hour	\$9.23	800	\$7,384.00
S5150	U7	UA	U9	06/01/2026	06/30/2026	0.25 Hour	\$9.23	800	\$7,384.00
S5150	U7	UA	U9	07/01/2026	07/31/2026	0.25 Hour	\$9.23	800	\$7,384.00
S5150	U7	UA	U9	08/01/2026	08/31/2026	0.25 Hour	\$9.23	800	\$7,384.00



Waiver Liability

- Individuals who are approved for a HCBS waiver, but who have income more than the Medicaid threshold, may be enrolled with HCBS waiver liability provision.
- Similar to a deductible, IHCP reimbursement for HCBS waiver services begins after this liability obligation is met. Members with an HCBS waiver liability are responsible for payment of the expense.
- A waiver provider may bill a member for the amount listed under “PATIENT RESP AMT” on the remittance advice (RA).
- A member’s waiver liability due can be viewed under eligibility in the UHC portal or IHCP portal.



Where To Locate Waiver Liability

Waiver Liability Details	
These amounts are based on claims processed at the time of this eligibility verification. It is subject to change at any time following this eligibility verification as claims continue to process in the system. A provider may bill a member for the Waiver Liability amount deducted from the adjudicated claim; however, with the exception of point of sale (POS) pharmacy claims, the member is not required to pay the provider until the member receives the monthly Medicaid Waiver Liability Summary Notice listing the amount applied to Waiver Liability.	
Month	Waiver Liability Obligation
September 2025	\$1,259.00
Member has a Waiver Liability. Contact the Pathways MCE for Liability and Prior Authorization information.	

SUBSCRIBER ID:		SUBSCRIBER NAME:		PRO MPT PAY DISC:		\$0.00		CLAIM NUMBER:		PATIENT ACCO UNT:				
MEMBER ID:		INTEREST AMOUNT:		PCP NUMBER:				REMIT DETAIL:		Professional Claim				
CO B PRIMARY INS:		MEDICARE PART A & B		SERVICING PROV NM:		COVERAGE DATE:		07/01/12		PCP NAME:				
		POLICY NUMBER:								BILLING NPI:				
										CARRIER ID:				
DATE(S) OF SERVICE	DESCRIPTION OF SERVICE SUBMITTED/ADJUDICATED	UNITS	BILLED AMT	DISALLOW AMT	ALLOWED AMT	DEDUCT AMT	COPAY/CO INS AMT	CO B PMT AMT	WITHHOLD AMT	PAID TO PROVIDER AMT	PATIENT RESP AMT	AUTH#	RMK CD	GRP CD/ RSN CD
07/01/25 - 07/31/25	T2031-U7, U1 POS/ Bill Type 13	1	\$3,028.81		\$3,028.81		\$1,259.00	\$0.00	\$0.00	\$1,769.81	\$1,259.00	274167798		PR142
CLAIM NUMBER:			\$3,028.81		\$3,028.81		\$1,259.00	\$0.00	\$0.00	\$1,769.81	\$1,259.00			
SUBTOTAL:														



How To View Waiver Liability In The Portal

Training & Support

Practice Management

TrackIt

Search

Payer

87726 - UnitedHealthcare

Provider

Eligibility

Claims & Payments

Referrals

Prior Authorizations

Clinical & Pharmacy

Documents & Reporting

Additional Tools

Admin

Home

Eligibility & Benefits

View Recent Search Results

Print / Generate a Reference Number

Subscriber

Date of Birth:

Gender:

Member ID Selected:

New Search

Policy Selected: In Mtss Acute Hcbs

Active (01/01/2025 - 12/31/2025)

Service Dates Requested: 10/02/2025 - 10/02/2025

Modify Search

Patient Demographics

Policies

Coordination of Benefits

Care Provider

Deductibles, Maximums, & Liabilities

Coverage

Detailed Benefits

Waiver liability

Please note that liability information for future months is not available.

Current month

October 1, 2025 - October 31 2025	\$0.00 of \$1,259.00 Met \$0 Remaining: \$1,259.00 \$1,259.00
September 1, 2025 - September 30 2025	\$0.00 of \$1,259.00 Met \$0 Remaining: \$1,259.00 \$1,259.00
August 1, 2025 - August 31 2025	\$1,259.00 of \$1,259.00 Met \$0 Remaining: \$0.00 \$1,259.00
July 1, 2025 - July 31 2025	\$1,259.00 of \$1,259.00 Met





Claims & Reimbursement Overview

Ways to Bill

[Claims and Payments | UnitedHealthcare Community Plan of Indiana | UHCprovider.com](#)

Portal

Securely log-in then select “Claims and Payments”

Electronic

Payer ID: 87726

Ensure your clearinghouse can transmit claims to Optum (UHC’s clearinghouse)

Paper

UnitedHealthcare Community Plan of Indiana
P.O. Box 5270
Kingston, NY 12402-5270



Portal Claim Submission



Training & Support ▾ Practice Management ▾ TRACKIT 

Search 

Payer

87726 - UnitedHealthcare ▾

 Provider



Eligibility

Claims & Payments ▴

Referrals

Prior Authorizations

Clinical & Pharmacy ▾

Documents & Reporting ▾

Additional Tools

Claims Tasks

[Look up a Claim](#)

[Search PRA](#)

Search, view, and/or print Provider Remittance Advice (PRA) documents. Depending on payer and/or the line of business, results may return: Explanation of Benefits (EOB), Provider Remittance Advice (PRA), Electronic Remittance Advice (ERA), or Explanation of Payment (EOP).

[Submit a Claim](#)

Use Claim Submission to enter claims electronically using the same information as the CMS-1500 paper form. This tool is ideal for small practices that don't work with an electronic data interchange (EDI) clearinghouse.

Payment Tools

[Direct Connect](#) 

Direct Connect is a web-based platform that helps providers and UnitedHealthcare communicate effectively, automate workflows and drive overpayment resolutions.

[Fee Schedule Lookup](#)

Allows participating providers to look up contracted rates of Commercial plans for CPT and HCPC codes, for a specific physician/healthcare professional name and product.

[HBMA Find a Medical Biller](#) 

This helps identify medical billing companies by specialty and certification.

[InstaMed Payments](#) 

[Office Ally](#) 

Our programs allow patients, providers and IPAs/Health Plans to interact in real time, providing immediate communication between all parties.

[Optum Pay](#) 

This transforms the payment process by moving the claims and electronic remittance data with the electronic payment.

[Claim Estimator](#)

Allows you to predetermine patient benefits, allowable service bundling, and claim financials. (Not available for all policies.)



Claim Submission - Required Authorizations

Fields 12 & 13

General claim information

12. Patient's authorized signature/release of information *

I authorize the release of 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.

Yes

13. Insured authorized signature/benefits assigned *

I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

Yes

15. Description (optional)

Date (optional)

mm/dd/yyyy

mm/dd/yyyy

16. Dates patient unable to work

From (optional)

mm/dd/yyyy

mm/dd/yyyy

To (optional)

mm/dd/yyyy

mm/dd/yyyy

18. Hospital dates related to current service

From (optional)

mm/dd/yyyy

mm/dd/yyyy

To (optional)

mm/dd/yyyy

mm/dd/yyyy



Claim Submission - Additional Information

Field 19 & Place of Service

19. Additional claim information type (optional)

The additional information entered here applies ONLY to the entire claim. If info is specific to a service line, then enter in field 24K.

ADDITIONAL INFORMATION × ✓

Caregiver full name *

Caregiver relationship *

Include additional documentation (optional)

☐

I want to add documents to this claim.

Place of service *

12 - Home ✓



Claim Submission - Service Lines

- Required Fields:
 - Date From - Date To
 - Current Procedural Terminology/Healthcare Common Procedure Code CPT/HCPCS
 - Modifiers: The proper corresponding modifiers are required for appropriate payment of service.
 - Diagnosis Pointer(s)
 - Charges: This should correspond with services and units billed.
 - Number of Units

[Patient & insured information](#) | [General claim information](#) | [Diagnosis, authorizations & miscellaneous claim search](#) | [Service lines](#) | [Provider information](#)

Service lines

Line item number: 1

[Duplicate line](#)

[Delete line](#)

Date from *

06/09/2026



Date to *

06/09/2026



Place of service (optional)

Select...



EMG (optional)



CPT/HCPC code *

T2022



Modifiers ~~(optional)~~

U7

U1

Diagnosis pointers *

1

Charges *

\$156.31

Family plan (optional)



Number of days or units *

11

Units



EPSTD (optional)



Claim submission Example

Provider information

25. Provider tax ID number

TIN type

26. Patient account number *

27. Accept assignment *

31. Provider's signature on file *

32. Service facility location

Select service facility address *

Search by zip code (optional)

Change provider

If the address you're looking for does not appear in the results, please do a zip code search.

33. Billing provider

Select billing provider address *

Search by zip code (optional)

If the address you're looking for does not appear in the results, please do a zip code search.

Do you have a national provider identifier (NPI)?

☐ Yes
☒ No

33A. Billing provider secondary ID *

33B. Taxonomy code (optional)

34. Servicing provider info

Do you have a national provider identifier (NPI)?

☐ Yes
☒ No

34A. Servicing provider secondary ID *

34B. Taxonomy code (optional)

NOTE: For Medicaid, certain states require a taxonomy code. Enter a valid taxonomy code only for the billing provider if NPI/secondary ID is the same for both billing and servicing providers.



Timely Filing Requirement

- The timely filing limit for managed care is 90 calendar days.
- The timely filing limit for a corrected claim is 60 calendar days from the date of eligibility of benefits from original claim.
- Electronic clean claims will be paid within 7 business days.
- Please be sure to check eligibility on the IHCP Provider Healthcare Portal prior to providing services or billing claims for members. A member must have the PathWays Waiver coverage for waiver claims to be paid.

Benefit Details 			
Coverage	Description	Effective Date	End Date
Aged and Disabled HCBS Pathways	Aged and Disabled HCBS Pathways	02/01/2025	02/28/2025
Full Medicaid	Full Medicaid for individuals who are 65 years old, blind, or disabled (FFS or Managed Care)	02/01/2025	02/28/2025





EVV Program Requirements

EVV Compliance & Common Denials

- UHC connects to Sandata.
- Providers can use an alternate EVV aggregator as long as it connects to Sandata.
- Services requiring EVV data include Skilled Home Health & Non-Skilled Home Health, Home and Community Assistance, Attendant Care, and Respite services.
- [Indiana Medicaid: Providers: Electronic Visit Verification](#)
- [Indiana Medicaid: Providers: Electronic Visit Verification Training](#)
- Common denials due to EVV for UHC:
 - OK5 - No visit found in Sandata aggregator
 - OH1 - Units do not match



Resolving OH1 EVV Denials

- If a provider receives an OH1 denial, this means only part of the units were matched for the date billed.
 - **Resolution – The provider should review the units billed and submit a corrected claim or correct the record in Sandata appropriately.**



Resolving OK5 EVV Denials

- If a waiver claim only sends the application programming interface (API) call to Sandata one time and the claim was billed too quickly before units could be validated or processed:
 - **Resolution would be to submit a corrected claim if you are able to validate data in Sandata.**
- The provider sent the caregiver data to the wrong managed care organization(MCO)/State, IE: FSSA, Anthem, Humana:
 - **Provider should send data to UHC Provider ID. Provider should make correction and submit a corrected claim.**

Visit Details

Visit Start Date: 09/30/2025

CLIENT NAME

CLIENT ID #

MEDICAID ID #

EMPLOYEE NAME

EMPLOYEE ID #

GENERAL

CLIENT

EMPLOYEE

CALL LOG

TASKS

EXCEPTIONS

GPS

MEMO

CLAIMS

HISTORY

REASON CODE	ITEM	DATE	CHANGED BY
	Visit Received	9/30/2025 6:09:03 PM	

Showing 1 to 1 of 1 entries

<<

<

1

>

>>



Additional OK5 Denial Scenarios

- Provider used the wrong ID for the patient IE: Used UHC internal ID or transposed numbers for Medicaid MID and its not loaded correctly in Sandata:
 - **Provider can update the patient's ID to the correct Medicaid MID and resend data to UHC. Provider can submit corrected claim.**
- Time was missing from caregiver when the claim was billed, and the Provider had to adjust hours:
 - **Resolution would be to submit a corrected claim if you are able to validate data in Sandata.**
- Late adjustments or duplicate loads to Sandata can cause denials:
 - **Resolution – The provider should review the units billed and submit a corrected claim or correct the time in Sandata appropriately.**



Sandata Overview

Visit Details

Visit Start Date: 09/30/2025

X

CLIENT NAME	CLIENT ID #	MEDICAID ID #	
EMPLOYEE NAME	EMPLOYEE ID #		

GENERAL

CLIENT

EMPLOYEE

CALL LOG

TASKS

EXCEPTIONS

GPS

MEMO

CLAIMS

HISTORY

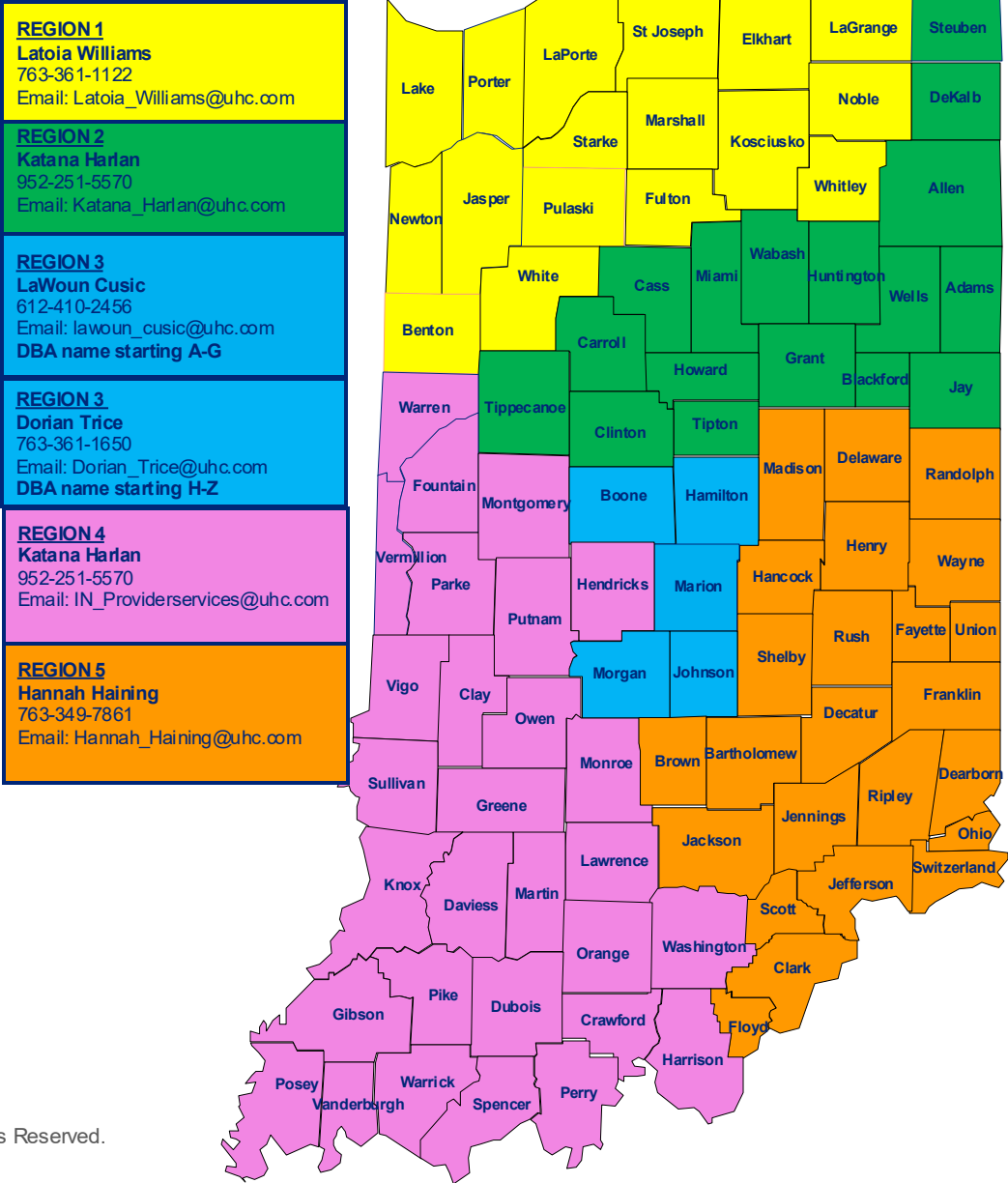
SCHEDULED START TIME	SCHEDULED END TIME		
09/30/2025 03:00 PM	09/30/2025 05:30 PM		
FROM DATE	TO DATE	VISIT TIME ZONE	VISIT STATUS
09/30/2025	09/30/2025	US/Eastern	Verified
CALL IN	CALL OUT	CALL HOURS	UNITS
03:04 PM	05:28 PM	02:24	10
ADJUSTED IN DATE	ADJUSTED OUT DATE		
09/30/2025	09/30/2025		
ADJUSTED IN TIME	ADJUSTED OUT TIME	BILL HOURS	
03:04 PM	05:28 PM	02:24	
AGENCY ID	AGENCY NAME		
PAYER	PROGRAM	SERVICE	GROUP VISIT CODE
INUHC	UHC	UHC - ATTC Agency (A&D/TBI)	None
CLIENT VERIFIED TIME	CLIENT VERIFIED SERVICE	CLIENT SIGNATURE	
Yes	Yes	Yes	
VISIT SOURCE	SCHEDULE ID	EXTERNAL ID	☐ DO NOT BILL
WellSky	None		





HCBS Provider Advocates

UnitedHealthcare Indiana
Provider Advocate Territory Map





Thank you

Questions?

United
Healthcare

