



2026 IHCP Works Annual Seminar:

Understanding Nursing Facility Services with UnitedHealthcare

UnitedHealthcare Community Plan - Indiana PathWays for Aging



United
Healthcare®
Community Plan

Session Overview

About Us

Indiana PathWays for Aging & Nursing Facilities

Eligibility

Patient Liability

Claims: Billing and Reimbursement

Claim Support: Reconsiderations, Appeals and Grievances

Doing Business with Us

Contracting

Resources





About Us

Mission and Vision

Our Mission

Delivering the most affordable coverage, simplest experience and highest quality supported care.

Our Vision

To be the premier health care delivery organization in the eyes of our state partners, providing health plans that meet the unique needs of our Medicaid members as well as our members in other government-sponsored health care programs, and to be effective partners with physicians, hospitals and other health care professionals in serving their patients.



UNITEDHEALTH GROUP®



Health care coverage and benefits

- Employer & Individual
- Medicare & Retirement
- Community & State
- Global



Health services and care delivery

- Optum Health
- Optum Insight
- Optum Rx

Optum Senior Community Care (SCC) is a business under Optum Health Complex Population Management specializing in:

- Network and clinical services for some of the most complex patient populations in the health care space, primarily patients in skilled nursing facilities.
- Contracting and provider service for UnitedHealthcare's free-standing skilled nursing facility (SNF) network.



Provider Engagement Representatives

Optum provider engagement representatives support providers for Long-Term Services and Supports (LTSS) services.

- Acting as a direct point of contact.
- Offering provider education and orientations.
- Facilitating resolution of escalated claim issues.



Direct Point of Contact



Assigned geographically



**Liaison between
organizations**



Education and Training

Optum Provider Engagement Representative Team

Region 1

Missy Bateman

Email: melissa_bateman@optum.com

Phone: 952-251-0179

DeKalb, Elkhart, Fulton, Jasper, Kosciusko, LaGrange, Lake, LaPorte, Marshall, Newton, Noble, Porter, Pulaski, St. Joseph, Starke, Stueben, Whitley

Region 2

Kelsie Buckley

Email: kelsie_buckley@optum.com

Phone: 763-361-1118

Allen, Adams, Benton, Blackford, Cass, Carroll, Clinton, Delaware, Fountain, Grant, Howard, Huntington, Jay, Madison, Miami, Montgomery, Randolph, Tippecanoe, Tipton, Wabash, Warren, Wells, White

Region 3

Missy Bateman

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Phone: 952-251-0179

Boone, Hamilton, Hendricks, Johnson, Marion, Morgan



Region 4

Amy Pritchett

Email: amy_pritchett@optum.com

Phone: 952-251-0770

Clay, Crawford, Daviess, Dubois, Gibson, Greene, Knox, Lawrence, Martin, Orange, Owen, Parke, Perry, Pike, Posey, Putnam, Spencer, Sullivan, Vanderburgh, Vermillion, Vigo, Warrick

Region 5

Amy Pritchett

Email: amy_pritchett@optum.com

Phone: 952-251-0770

Bartholomew, Brown, Clark, Dearborn, Decatur, Fayette, Floyd, Franklin, Hancock, Harrison, Henry, Jackson, Jefferson, Jennings, Monroe, Ohio, Ripley, Rush, Scott, Shelby, Switzerland, Union, Washington, Wayne

Director

Sandi Howard

Email: sandi.howard@optum.com

Phone: 952-202-3559





Indiana PathWays for Aging & Nursing Facilities

Nursing Facilities' Role in PathWays

The Indiana Health Coverage Programs (IHCP) cover long-term care (LTC) in nursing facilities for members who:

- Meet nursing facility level-of-care (NFLOC) criteria.
- Are enrolled in Traditional Medicaid (Fee - For - Service) or the PathWays managed care program.

As the primary residence of plan members, the nursing facility is involved in many aspects of the resident's life, including providing financial services and guidance on health plan decisions.



Nursing facilities are responsible for:

Verifying member eligibility and benefits before billing. Always check the IHCP Provider Healthcare Portal for Medicaid eligibility and NFLOC.

Timely filing for reimbursement (90 Calendar Days). Claims may be submitted as frequently as weekly, though most providers bill monthly or twice per month.

Updating the members' census in PathTracker (Ascend) upon admission to, and discharge from, their facility.





Eligibility

Who is Eligible

PathWays members are:

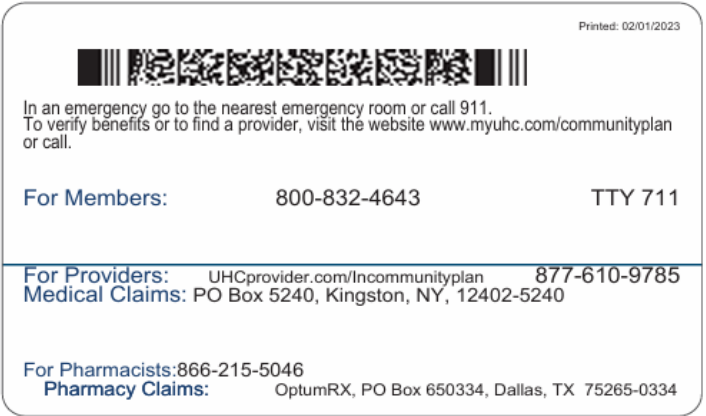
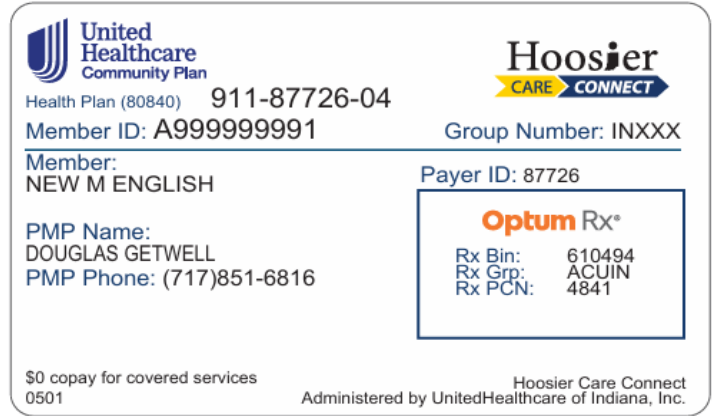
- 60 years of age and older
- Eligible for State Medicaid a full-coverage aged, blind or disabled category (with or without Medicare)

PathWays members can be:

- Receiving long-term support services including:
 - Individuals who reside in a nursing facility
- On the Behavioral and Primary Health Coordination program



Member ID Cards



UHC Community Plan of Indiana PathWays members receive an ID card with information to help you submit claims accurately and completely.

- Be sure to check the member's ID card at each visit and copy both sides for your files.
- Member ID cards can also be viewed online using the Eligibility & Benefits tool on uhcprovider.com

Sample member ID cards for illustration only; actual information varies depending on payer and other requirements



Verifying Member Eligibility and Benefits

Before providing services, always verify member eligibility and benefits.

Providers should review the member's Medicaid eligibility and facility NFLOC in the IHCP Provider Healthcare portal, as it is updated prior to the UHC Provider Portal.

Providers can check eligibility and benefits with UHC by:

- Visiting **UHCprovider.com**
Sign in > Eligibility and Benefits
- Calling Provider Services @ **877-610-9785**
Hours of operation are M-F 8am to 8pm ET





Patient Liability

Member Patient Liability

- Patient liability is the amount an IHCP resident is required to pay each month toward the cost of their care at the facility. It may also be referred to as client obligation, member liability, or personal resource contribution.
- The local county office of the Division of Family Resources calculates and assigns the patient liability amount. Member information, including patient liability reflected in the IHCP Provider Healthcare Portal, is updated daily from the information relayed by the Indiana Eligibility Determination and Services System (IEDSS) at the county offices.
- Patient liability is applied beginning with the first claim received for the month and continues to be deducted from subsequent claims until the full amount is satisfied.





Claims: Billing and Reimbursement

Claim Submission

Submit nursing facility claims using CMS Form *UB-04* in one of the following ways:



Electronic Claims Submission

- Use the Claims Submission Tool on **UHCprovider.com**
- Use **Payer ID 87726**
- For electronic submission, Payer ID may be located on the Member ID card. Learn more at UHCprovider.com/edi



Paper Claim Submission

UnitedHealthcare Community Plan of Indiana PathWays for Aging
P.O. Box 5270
Kingston, NY 12402



Nursing Facility Reimbursement: Skilled Care and Custodial Care

The per diem payment includes, but is not limited to, the following services:

- Laundry services
- Nutritional services
- Personal care services
- Personal care supplies
- Incontinence supplies
- Stock medical supplies
- Wound care supplies
- Analgesics
- Antacids
- Laxatives
- Vitamins



Nursing Facility Reimbursement: Leave of Absence

- The IHCP does not reimburse nursing facilities for bed-hold days unless the member is receiving hospice care.
- Members residing in a NF are directed to talk with their individual provider regarding any type of "bed-hold" or leave-day policy that may exist.
- Facilities must clearly communicate these policies and cannot charge members for services they did not request.
- Medicaid does not require facilities to hold beds, and any bed-hold during a member's absence is considered a noncovered service unless related to hospice.
- If a facility offers this option, it must be documented in its written policy and shared with the resident before any hospital transfer or therapeutic leave.



Nursing Facility Reimbursement: Special Care Unit & Ventilator Add-On Billing

- Qualifying nursing facilities are eligible to receive additional reimbursement for members who are in an **Alzheimer's and Dementia Care Special Care Unit** (SCU) and for members receiving **ventilator-dependent services**.
- Additional reimbursement per Medicaid resident day is in the form of an add-on.
- Revenue codes must be billed as an additional detail line, with the applicable room and board revenue code, for the claim dates of service.
 - Revenue code 0199 – Ventilator-dependent residents
 - Revenue code 0193 – Special Care Unit residents with Alzheimer's or dementia
- SCU and Vent approved provider listing can be viewed at: [Indiana Long-Term Care - Myers & Stauffer](#) Additional information can be found at: [Indiana Medicaid: Providers: IHCP Quick Hits](#).



Steps To Obtain Authorization For Special Care Unit & Ventilator Add-On

- To obtain Special Facility Qualification status to be reimbursed for the special add-on codes, NF providers will use the Nursing Facility Schedule of Special Facility Qualifications (Schedule Z). The Schedule Z form and instructions are available on the [Indiana Long-Term Care - Myers & Stauffer](#) section of the Myers and Stauffer website, under Nursing Facility > Forms > Schedule of Special Facility Qualifications (Schedule Z).
 - **SCU Requirements (Effective July 1, 2023):**
NF providers billing Medicaid for SCU reimbursement no longer need to include room numbers. However, they must complete and submit the *Special Care Unit Qualifications* section of Schedule Z by the deadline for Office of Medicaid Policy and Planning (OMPP) review.
 - **Ventilator Program:**
NF providers seeking ventilator program reimbursement must complete and submit the *Ventilator Program Qualifications* section of Schedule Z by the due date for OMPP determination.
 - **Certification Statement:**
An authorized representative (e.g., board member or owner) must sign and date the certification statement after reviewing Schedule Z. Handwritten signatures are required—PDFs or copies are acceptable, but electronic signatures are not.
 - **Program Changes:**
NF providers must promptly notify OMPP of any changes that affect their specialized service program qualifications.



Hospice in a Nursing Facility

- Hospice Providers are responsible for billing for room and board while the member is receiving hospice care within a nursing facility.
- Clean, electronically submitted hospice claims should be paid within 21 calendar days per the contract, enabling timely payment to the nursing facility, per their agreement with the hospice agency.
- When a member discharges from hospice care, the nursing facility should begin billing room and board effective the discharge date from hospice. Nursing facility should verify hospice LOC has been end dated within the state provider portal.
 - UHC will consider either the discharge notification receipt date or the discharge claim submission date, when determining overrides for potential NF timely filing issues.

Reminder: If the member resides in a Special Care Unit and the hospice provider is not informed, the hospice room and board claim may deny for timely filing when submitting an adjusted claim to include the SCU add-on code after initial submission.



Medicare Crossover Claims

- Medicare crossover claims billed with type of bill (TOB) 021x are only payable if the Medicaid rate is greater than the Medicare rate, at which time provider will be reimbursed for the difference.
 - Information entered from the Medicare EOB should always match the claim submitted to the Medicaid plan to avoid denials.
- **For aligned dual members** (members who have UHC Dual Eligible Special Needs Plan (D-SNP) and UnitedHealthcare PathWays):
 - Nursing facility will send one claim to UnitedHealthcare.
 - UnitedHealthcare will process the claim through the member's Medicare benefits first, then automatically submit it for processing under the member's Medicaid benefits.
- **For dual members, whose Medicare benefits are not UnitedHealthcare D-SNP:**
 - Nursing facility will need to submit the claim to Medicare or Medicare Advantage Plan.
 - Nursing facility will then submit the claim, with a copy of primary payor's, to UHC PathWays Medicaid.



UHC Provider Portal: Submitting a Facility/Institutional Claim

Boxes highlighted in blue and showing * indicate required fields

PROVIDER & BILL INFORMATION

- Some fields may prepopulate, but you can use the dropdown list to change the selection.
- If the address you are looking for does not appear in one of the dropdown results, you may do a ZIP code search.
- You can click the link to **View bill types**, if needed.



Facility claim form

Provider & bill information

Organization name *

Select organization name..

5. Federal tax ID number

56. NPI

Select NPI..

NPI not listed? Enter manually below.

NPI (manual entry)

Change provider

Billing address

1. Select billing address *

Select address..

Zip code search



Please select an organization before selecting an address

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

Service address

☒ Service address is the same as billing address

Billing information

3a. Patient account number *

6. Statement covers period

4. Type of bill *

From *

mm/dd/yyyy



mm/dd/yyyy

To *

mm/dd/yyyy



mm/dd/yyyy

[View bill types](#)

Submitting a Facility/Institutional Claim:

PATIENT INFORMATION

This section will be prepopulated from the member you selected.

Patient information

Patient name Bailey A Patient Change member	Patient ID 12345678	8. Patient relationship Self	9. Patient address 123 SAMPLE STREET CITY, VA 23456	10. Date of birth 05/09/1954	11. Gender FEMALE
Insured's name Bailey A Patient	Insured's ID 979656281	Insured's address 123 SAMPLE STREET CITY, VA 23456	Insured's date of birth 05/09/1954	Insured's gender FEMALE	

Insurance plan name or program name (optional)



Submitting a Facility/Institutional Claim:

ADMISSION INFORMATION

Boxes 12-17 **are required** when submitting a PathWays claim.

Admission information

12. Admission start date

mm/dd/yyyy

mm/dd/yyyy

13. Admission hour

--:--

14. Type of admission

15. Source/point of admission

16. Discharge hour

--:--

17. Patient discharge status *



Submitting a Facility/Institutional Claim:

CONDITION CODES & VALUE CODES

Condition codes and occurrence information

Condition codes

Maximum of 12 claim condition codes

18 - 28. Claim condition codes

Add claim condition code

Occurrence information

31 - 36. Occurrence or occurrence span codes

From

mm/dd/yyyy

Through

mm/dd/yyyy

Add occurrence

Value codes

39 - 41. Value codes

Code	Amount

Add value code

CONDITION CODES and VALUE CODES

- Maximum of 12 claim Condition Codes may be entered.
- Maximum of 6 Occurrence/Occurrence Span codes, with the corresponding date(s), may be entered.
- Maximum of 3 Value Codes may be entered.
- Providers should include the appropriate value codes on claims, as applicable.



Submitting a Facility/Institutional Claim:

SERVICE LINES

- When entering service line information, you can click **Look up code**, if needed.
- Click **Add another service line** to add a new blank line or click **Duplicate line** as needed to copy the service line and then make edits as needed.

Service lines

Line item number: 1

Duplicate lineDelete line

43. Revenue code * Description -- Look up code	44. HCPCS/modifiers / Description -- Look up code	HIPPS code 	45. Date from * mm/dd/yyyy mm/dd/yyyy Date to * mm/dd/yyyy mm/dd/yyyy	46. Service units * Units/days * Units	47. Charges * 	48. Non-covered charges
---	--	------------------------------------	--	--	---------------------------------------	---

Add any additional information for line 1 below

Provider information

Notes & attachments

NDC code

Service and facility tax amount

COB information

Molecular test identifier

Total charge
\$0.00

Add another service line



Submitting a Facility/Institutional Claim:

DIAGNOSIS CODES

- Principal diagnosis code is required.
- Use the icons on the right to add and remove codes.
- Click **Look up code** as needed.

Codes

Diagnosis codes

Diagnosis pointer	66. Principal diagnosis Code *	Diagnosis code description	Present on admission?	Remove or add code
Principal	Unsure what your principal diagnosis code is? Look up code			
Diagnosis pointer	Other diagnosis Code	Diagnosis code description	Present on admission?	Remove or add code
Other diagnosis code	Unsure what your code is? Look up code			
Diagnosis pointer	69. Admitting diagnosis Code	Diagnosis code description	Present on admission?	Remove or add code
Admitting	Unsure what your admitting diagnosis code is? Look up code			



Submitting a Facility/Institutional Claim:

ADDITIONAL CLAIM INFORMATION

Additional claim information

Release of info ⓘ *

Assignment of benefits ⓘ *

Yes ▾

Yes ▾

76. Attending provider

NPI *

First name *

Middle name (optional)

Last name *

77. Other provider

Add provider

Additional claim information type (optional)

Include additional documentation (optional)

☐ I want to add documents to this claim.

Claim level reference information (CLIA, prior auth, etc.) (optional)

Add item

Enter the required additional claim information and any other optional information that may support the claim.



Submitting a Facility/Institutional Claim:

ADD DOCUMENT(S) and SUBMIT

- You may add supporting documents before submitting.
- When complete, the Submit button will be enabled to continue.

Add document(s)

Add supporting documents for your request by uploading files from your computer.

The maximum file size for each file is 100MB. The following types are supported: .pdf, .txt, .png, .jpg, .jpeg, .bmp, .gif, .tiff, .doc, and .docx. For faster processing times, please attach only those documents that are required for review and combine attachments when available.



Drag and drop a document here

OR

Browse and upload document

Note: If any of the attachment fails to be uploaded, then the claim will still be submitted and if attachments are required they can be submitted later after the claim is processed in the ACT ON CLAIM section when viewing the status of the claim.

Cancel

Submit



Claim Processing and Payment

- **Claim Processing:**

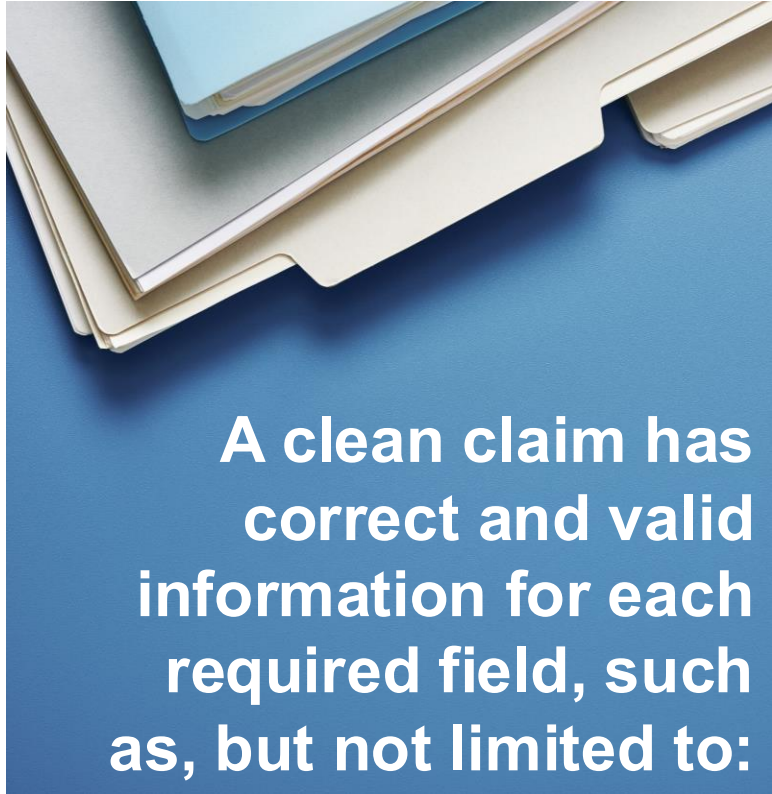
- We will pay or deny electronically filed clean claims within twenty-one (21) calendar days of receipt.
- We will pay or deny clean paper claims within thirty (30) calendar days of receipt.

- **Standard Timely Filing:**

- 90 days from the date of service for in-network and out-of-network providers.



Definition of a Clean Claim



- Provider name and address
- Type of bill
- Provider Tax ID
- Service from/through dates
- Patient name and date of birth
- Admission date, hour, type, and source
- Status code
- Discharge hour
- Condition, occurrence, and value codes
- Revenue Codes
- Rates
- Service units
- Total charges
- Provider NPI
- Third-party payer name
- Third-party prior payment amount
- Estimated amount due
- Member name
- Member ID
- Admitting diagnosis
- Attending physician NPI
- Attending physician name



Definition of a Clean Claim Continued

The following must also be true for a claim to be considered clean:

- The patient is Medicaid-eligible for the dates of service billed.
- The patient has an approved level of care for the provider and dates of service billed.
- The provider is eligible to render services for dates of service billed.
- The claim is not a duplicate of dates of service or charges already paid.

A claim is not considered clean if:

- The provider is under investigation for fraud or abuse.
- The claim is under medical necessity review.

Claims with errors originating in the state's claim processing system may still be considered clean if no additional provider input is needed.



Rate Cap

Rate Changes

- The Family and Social Services Administration (FSSA) contracts with Myers and Stauffer to complete periodic minimum data set (MDS) reviews for all residents of Medicaid-certified nursing facilities in Indiana, regardless of payer source.
- Every Medicaid-certified nursing facility in Indiana is reviewed a minimum of once every 3 years. (Year is defined as the State fiscal year – July 1 through June 30.)
- We will proactively reprocess any claims paid incorrectly due to delays in system updates or retroactive rate change by the state; providers do not need to submit claim reconsiderations or corrected claims for these scenarios.



Indiana PathWays for Aging – SNF Reimbursement Summary

Service Description	Revenue Code	Type of Bill	Payment Rate	Authorization Required
Nursing Facility Custodial Care	0110, 0120, 0130	065X	100% of Medicaid daily rate for both Participating (PAR) and Non-Participating (NON-PAR)	NFLOC required
Nursing Facility Skilled Care	0110, 0120, 0130	021X	100% of Medicaid daily rate for both Participating (PAR) and Non-Participating (NON-PAR)	No
Out of State	Non-Covered	N/A	N/A	N/A
Ventilator Unit Add-On - <i>state approved facilities only</i>	0199	065x	\$80 per diem	No
Alzheimer's and Dementia Care in Special Care Unit (SCU) -<i>state approved facilities only</i>	0193	065x	\$12 per diem	No
Bed Hold Days	0180, 0183, 0185	021x, 065x	Non-Covered	N/A
Medicare Crossover Part B Claims	042x, 043x, 044x	022x, 023x	Only payable if Medicaid rate is greater than the Medicare rate	N/A
Medicare Crossover Part A Claims	0110, 0119, 0120, 0129, 0130, 0139, 0022	021x	Only payable if Medicaid rate is greater than the Medicare rate	No





Claim Support: Reconsiderations, Appeals and Grievances

Claim Service Model

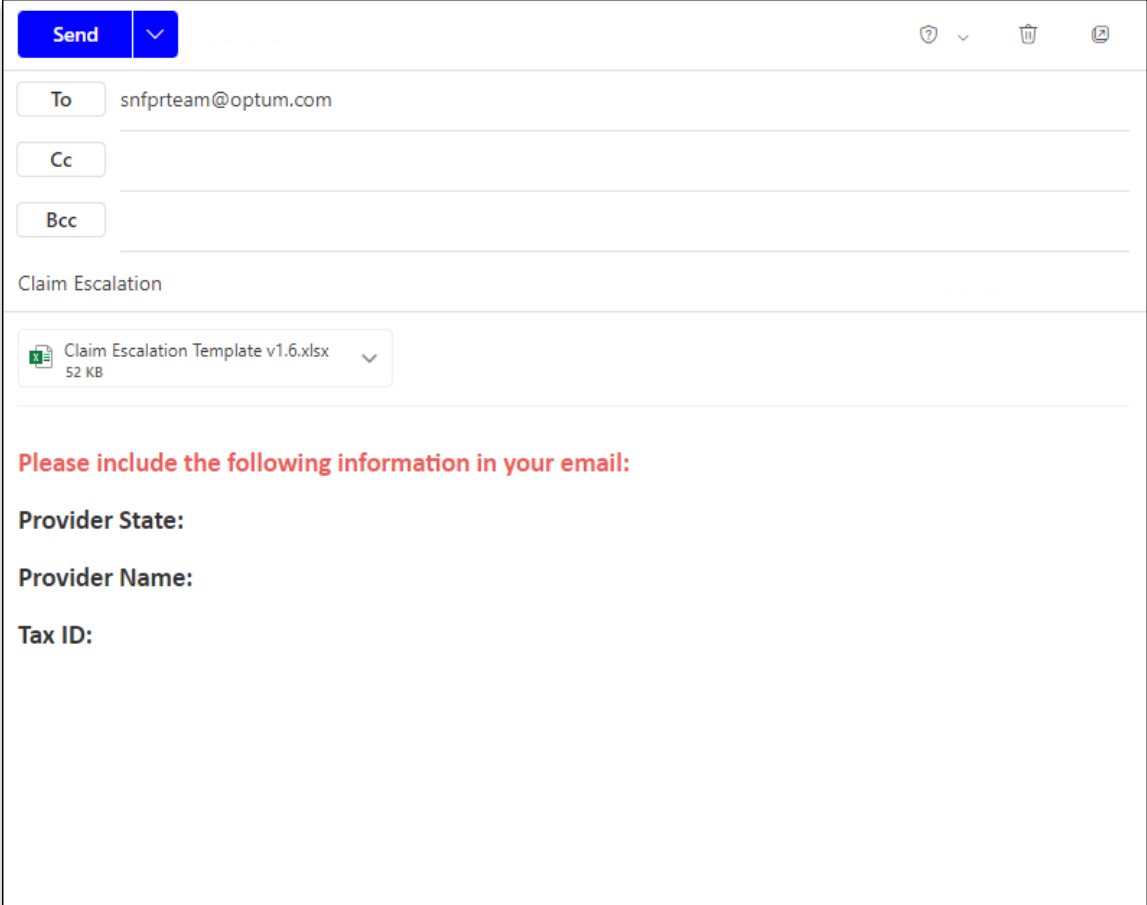
If you disagree with the processing of a claim, follow the 2-step claim service model for contracted skilled nursing facilities by completing the outlined steps in order below.

Step 1 – Request a claim reconsideration online

- Sign in to the UnitedHealthcare Provider Portal at UHCprovider.com > Sign In > Claims & Payments > **Act on Claim**
- Attach relevant documents to reconsideration request.

Step 2 – Request a claim escalation

- If you do not agree with our determination, you may email a [claim escalation](#) request to snfprteam@optum.com
 - Download the escalation template by clicking the download link at the top of the screen and complete the grey sections.
 - Include your Tax ID, Provider Name, and Provider State in the email.



The screenshot shows an email composition interface. At the top, there is a blue 'Send' button with a dropdown arrow. To the right of the button are icons for help, a dropdown, delete, and print. Below the button, the 'To' field is populated with 'snfprteam@optum.com'. The 'Cc' and 'Bcc' fields are empty. The subject line is 'Claim Escalation'. Below the subject line, there is a download link for 'Claim Escalation Template v1.6.xlsx' (52 KB). The body of the email contains the following text:

Please include the following information in your email:

Provider State:

Provider Name:

Tax ID:



Appeals Process

- An appeal is a formal request to review a claim that was denied or not fully paid.
- Providers must submit a claim reconsideration before filing an appeal.
- To start the dispute process, providers must submit a written objection:
 - Within 60 days of receiving the claim determination, or
 - Within 90 days of claim submission if no determination is made within 30 days.
- If the issue remains unresolved after 30 days, providers have an additional 60 days to submit a formal appeal.
- Refer to the [Reconsiderations and Appeals Interactive Guide](#) for additional information.



Provider Grievance/Appeals On Behalf of the Member

- Grievances are complaints expressing dissatisfaction with operations, activities, or behavior of a health plan or member.
- Grievances can be filed online, verbally or by mail:
 - Online: [UnitedHealthcare Community Plan Medicaid Appeals & Grievances tool](#)
 - Phone: Call Provider Services at 844-284-0146
 - Mail: UnitedHealthcare Community Plan
Attn: Appeals and Grievances Unit
P.O. Box 31364
Salt Lake City, UT 8413-0364
- Providers may only file a grievance on a member's behalf with the written consent of the member.





Doing Business with Us

UnitedHealthcare Provider Portal

- Provider Portal Chat
- Member Eligibility Information and Member ID Cards
- Inpatient Prior Authorization and Notification
- Claim Submissions
- Claim Status and Reconsideration Requests
- Digital reference number
- Keep Track of UnitedHealthcare Tasks with TrackIt
- Electronic Payments and Statements
- Policies and Procedures



Bookmark UnitedHealthcare Community Plan Homepage

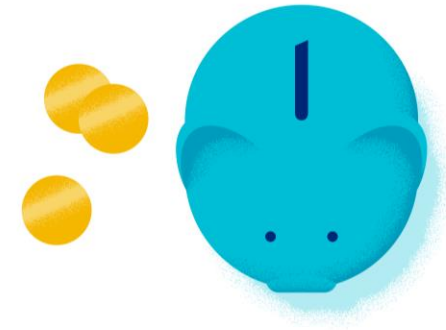


*Choose a state from dropdown>View Plans>
Select Community Plan*



Electronic Payments

- Optum Pay® lets you receive electronic funds transfer (EFT) for claim payments and receive Explanation of Benefits (EOBs) online.
- Fully integrated, full-service payment and remittance advice solution designed reduce administrative costs because mail time is eliminated.
- Funds are available as soon as they are posted to your bank account.
- To receive EFT and electronic EOBs through Optum Pay, visit Optum.com/enroll.
- Here's what you'll need:
 - Bank account information for direct deposit.
 - Either a voided check or a bank letter to verify bank account information.
 - A copy of your practice's W-9 form.



Fraud, Waste and Abuse

- When you report a situation that could be considered fraud, you're doing your part to help save money for the health care system and prevent personal loss for others.
- If you suspect another provider or member has committed fraud, waste or abuse, you have a responsibility and a right to report it.
- Taking action and making a report are important first steps.
- After your report is made, we will work to detect, correct and prevent fraud, waste and abuse in the health care system.
- To report health care fraud, waste, and abuse:
 - **Phone:** Health Care Fraud Tip Line at 844-359-7736 (24 hours per day).
 - **Online:** visit uhc.com/fraud





Contracting

Contracting

When a provider is planning to undergo a Change of Ownership (CHOW), please contact your UnitedHealthcare Provider Engagement Representative so they can coordinate with the Contracting Department. Before UnitedHealthcare can process any ownership-related changes, providers must first update their information with IHCP to ensure the changes are reflected in their enrollment record.

Types of contracts:

- CHOW divestiture (selling facility to another owner)
- Management change – When management changes but not the ownership
- Address change



Steps of contracting

1. Provider needs to notify the Network Director and/or the Provider Engagement Representative with UnitedHealthcare of upcoming CHOW or change. The Network Director and/or the Provider Engagement Representative will notify the contracting department with UnitedHealthcare.
2. The contracting department will reach back out to the provider and request that a contracting questionnaire be completed and a current dated and signed W-9 be sent back to them.
3. Provider needs to respond to all emails from Contracting department.
4. Provider will bill under new owner credentials to prevent timely filing issues once contract is complete.
5. Once the contract has been created, it will be sent to the facility or corporate office for approval. Please reply with your approval and include the name and email address of the person who will complete the Adobe Sign (electronic signature).
6. Once the contract is fully executed (signed by the provider and countersigned by a UnitedHealthcare representative), UnitedHealthcare will create a claims project for affected claims to reprocess according to your contract. However, the provider has the responsibility to perform due diligence in ensuring all applicable claims have been captured.





Resources

Provider Engagement Contact Information

Director of Network Strategy & Contracting

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amy_reeder@optum.com

Director of Medicaid Provider Engagement

Sandi Howard
sandi.howard@optum.com

Provider Engagement Representatives

Missy Bateman
melissa_bateman@optum.com

Kelsie Buckley
kelsie_buckley@optum.com

Amy Pritchett
amy_pritchett@optum.com



Support Contacts

Service	Contact Information
Provider Services	877-610-9785 24 hours a day
Optum Provider Engagement Rep	SNF Medicaid PER@optum.com
UnitedHealthcare Provider Portal Support	866-842-3278 Option 1 Monday-Friday 7 AM – 9 PM CST
Optum Pharmacy	800-613-3591 Monday-Friday 8 AM – 5PM PST
Transportation	800-832-4643 Monday-Friday 8 AM – 8 PM ET
Join Our Network	UHCprovider.com/join
Website for UHC Community Plan	UHCprovider.com/incommunityplan



UnitedHealthcare Online resources

- [UHCprovider.com](https://uhcprovider.com)
- [Provider Administrative Manual](#)
- [Network News](#)
- [UHC Provider Training](#)
- [Community Plan Reimbursement Policies](#)





Thank You.

PCA-1-24-02482-UHN-PRES_08072024

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