



UnitedHealthcare Community Plan of Indiana

Hoosier Care Connect Health Plan

Claims 101

Presented by Jodie Hattery, Vice President, Provider Market Operations

United
Healthcare®

Agenda

- Medical/Behavioral Health
 - How to file a claim
 - How to dispute a claim
 - How to file a reconsideration
 - a) Via UnitedHealthcare Provider Portal
 - b) Via paper form
 - How to dispute the reconsideration decision
 - How to appeal the dispute decision
 - When to escalate to the Provider Advocate Team
- Vision
 - How to file a claim
 - How to dispute a claim
- Dental
 - How to file a claim
 - How to dispute a claim



Our Service Lines

❖ UnitedHealthcare



❖ Optum Behavioral Health



❖ March Vision



❖ UnitedHealthcare Dental





UnitedHealthcare Medical & Optum Behavioral Health Claims

MEDICAL & BEHAVIORAL

- Submit CMS 1500 Claim Form or UB-04 form, whichever is appropriate.
- Standard Timely Filing for Par Providers - 90 days from the date of service (DOS).
- Non-Contracted Providers Timely Filing – 180 days from DOS.
- Newborn Claims Timely Filing – 180 days from DOS.
- Secondary Claims Timely Filing – 90 days from date of Primary EOB for INN Providers & 180 for OON providers from the Primary EOB date.



- For electronic submission:

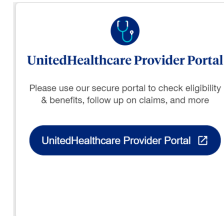
Payer ID 87726

- Claims Mailing Address:



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

- Claim Submission Tool for Medical Professional claims (CMS 1500) on our **UnitedHealthcare Provider Portal (formerly Link)**



- Behavioral Health Professional claims (CMS 1500) on our **Provider Express-Indiana Portal**

- Click claim entry

MEDICAL

Claims and Eligibility

- Check claim status.
- Check member eligibility status.
- Start a claim reconsideration or appeal once claim has been located.
- 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](#)



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When Should You Submit a Claims Reconsideration?



You should submit a claims reconsideration request through the Claims tool when you believe a claim was paid incorrectly. Situations for reprocessing include, but are not limited to:

- Amount is different than what provider expected
- Claim was filed in a timely manner, but denied for timely filing
- Claim was denied for no authorization, when provider has an authorization number
- Difference in Coordination of Benefits (COB) information

A screenshot of the UnitedHealthcare Provider Portal dashboard. The top navigation bar includes links for "Return to Link Dashboard", "Training & Support", "Alerts", "Practice Management", "TrackIt", and a user profile icon. Below this, there are tabs for "Eligibility", "Claims & Payments", "Referrals", "Prior Authorizations", "Clinical & Pharmacy", "Documents & Reporting", and "Additional Tools". The main content area starts with a welcome message "Hello, JODIE" and a prompt to "Make this my Primary View". Below this, there are two main sections: "Verify Eligibility & Benefits" and "Look Up a Claim or Ticket". The "Verify Eligibility & Benefits" section has a search criteria dropdown and input fields for "Member ID*" and "Date of Birth*". The "Look Up a Claim or Ticket" section has a search criteria dropdown, a "Search By:" dropdown with "TIN" selected, and input fields for "Member ID*" and "Date of Birth*".

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How do I Submit a Claims Reconsideration within the Claims Tool?



Click **Create Claim Reconsideration** to start your reconsideration request or submit a corrected claim.

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



How To Request a Claim Reconsideration

Providers in states other than Maryland and California may submit processed claims for reconsideration, or appeal a decision online. The system will display available options based on the claim. [Click the tabs to learn more.](#)


 **Act on Claim** 

Corrected Claim

This is not available for this 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

Please provide requested documentation to complete the adjudication of this claim.

This is not available for this claim, at this time.

Add Attachments

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>

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- 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
Taylor

Last Name
Demo

Phone Number
(555) 955-4555

Email Address
email@sample.com

Street Address
123 Demo St

City
Great City

State
VA

ZIP Code
23456

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BEHAVIORAL

How do I Submit a Claims Reconsideration?

Securely login to Provider Express

- Claim Inquiry
- Search for claim
- Click “Enter” under claim adjustment

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



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 (default is 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 Anytown 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:
\$60.00	\$60.00	\$0.00	\$0.00	\$0.00	\$60.00	Finalized	<div>Enter</div>

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 explaining why a reconsideration is being requested.
- 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
Reason dropdown menu with options: Claim Overpaid, Claim Underpaid, CCB Adjustment, Claim Paid to Incorrect Provider, Change in Patient Eligibility, Incorrect Member Liability. A red circle highlights the "Review" button.

Comments:
255 characters left

Review **Cancel**

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?

➤ Per the Administration Guide, Par Providers must adhere to the following filing limits from the date of the **original** processing/denial date to dispute a claim:

- 1) Reconsideration – 90 Days from original denial
 - 1.5) Send to Advocate or SNF Claims Teams
- 2) Formal Dispute – 60 Days from reconsideration
- 3) Formal Provider Grievance – 120 Days from the failed Dispute (must include additional or new information)



MEDICAL & BEHAVIORAL

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

MEDICAL ADVOCATE TEAM

- If you are a health system or provider with a dedicated Claims/Internal Advocate, please email to that dedicated Advocate.
- If you do not have a dedicated Claims/Internal Advocate, utilize the claims template and email to: centralprteam@uhc.com.
- If you need the claims template and instructions, you can request those from the Central PR Team via email at centralprteam@uhc.com.

SKILLED NURSING FACILITY CLAIMS TEAM

- Send unresolved SNF claims to: snfprteam@optum.com.



MEDICAL & BEHAVIORAL

What is the next step in the Dispute Process?

- If you still 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 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 the Claims Tool on our 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.
- Formal Provider Grievance must be submitted within 120 days from the failed Formal 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 on our UnitedHealthcare Provider Portal for medical claims or Provider Express Indiana for BH claims



MEDICAL

Administrative Provider Resources



UnitedHealthcare Provider Portal

Please use our secure portal to check eligibility & benefits, follow up on claims, and more

UnitedHealthcare Provider Portal 

- Education resources for submitting claims is 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 **professional** claims with United Healthcare UHCprovider.com/claims





March Vision Claims

VISION

How to file March Vision Care claims

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

- Online provider portal: eyeSynergy.com

eyeSynergy®

- For electronic submission:
Payer ID 52461

- Claims Mailing Address:



MARCH® Vision Care
6601 Center Drive West, Suite 200
Los Angeles, CA 90045



VISION

How do I Submit a Claim Reconsideration?

Providers have 60 days from the original EOB date to submit a Claim Reconsideration.



Provider Dispute Resolution Process

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

Please submit your request by mail to:

MARCH® Vision Care
Attention: Claims Appeals
6601 Center Drive West, Suite 200
Los Angeles, CA 90045

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

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





UnitedHealthcare Dental Claims

DENTAL

How to file Dental claims

- Timely filing
 - All claims, including secondary claims, should be submitted within 90 days from the date of service for participating providers or within 180 days from the date of service for non-contracted (Out of Network) 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 secure as the information being transmitted is encrypted.
- Call **1--877-897-4941** for more information regarding electronic claims submission.



DENTAL

How to file Dental claims

➤ 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.



DENTAL

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 days of receipt.
- 100% of all clean electronic claims will be paid or denied within 21 calendar days of receipt.

➤ Paper claims

➤ UnitedHealthcare Dental Claims

PO Box 781

Milwaukee, WI 53201

- Paper claims must be submitted on an American Dental Association (ADA) Dental Claim Form (2012 version or later).
- Claims filed on incorrect forms will be returned.
- Claims must be legible.
 - Computer-generated forms are recommended.
 - Additional documentation and radiographs should be attached, when applicable. (Such attachments are required for pre-treatment estimates and for the submission of claims for complex clinical procedures).



DENTAL

How to file Dental Corrected Claims

- **Corrected claim process**
 - Providers who receive a claim denial and need to submit a corrected claim should submit a corrected claim and appropriate documentation, if necessary, to:
 - **Corrected Claims**
P.O. Box 481
Milwaukee, WI 53201
 - The determination of a corrected claim request will be provided via a remittance statement within 30 days of receipt.



DENTAL

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

Informal Objections and Formal Appeals
PO Box 1391
Milwaukee, WI 53201

- **Appealing a denied claim payment**
- Providers have the right to appeal a claim payment that is fully or partially denied. UnitedHealthcare will follow state and Federal guidelines in the management of the appeals process, including 405 Indiana Administrative Code (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 at the address below. The Informal Objection 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 to the same address below. The Formal Appeal will be reviewed and resolved within 30 days.



DENTAL

Tips for successful Dental claim resolution

- Do not let claim issues grow or go unresolved.
- Call Provider Services if you can't 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 you must exceed the maximum daily frequency for a procedure, submit the medical records justifying medical necessity. If you have questions, call Dental Provider Services.



DENTAL

Tips for successful Dental claim resolution – Con't

- UnitedHealthcare Community Plan is the payer of last resort. This means you 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, even 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.





Meet Your Advocate Teams

Your Medical Network Provider Advocate Team

Cindy Fabian
Manager,
Provider Advocacy

312-803-5623
cynthia_fabian@uhc.com

Lori Reeder
Sr Provider Advocate

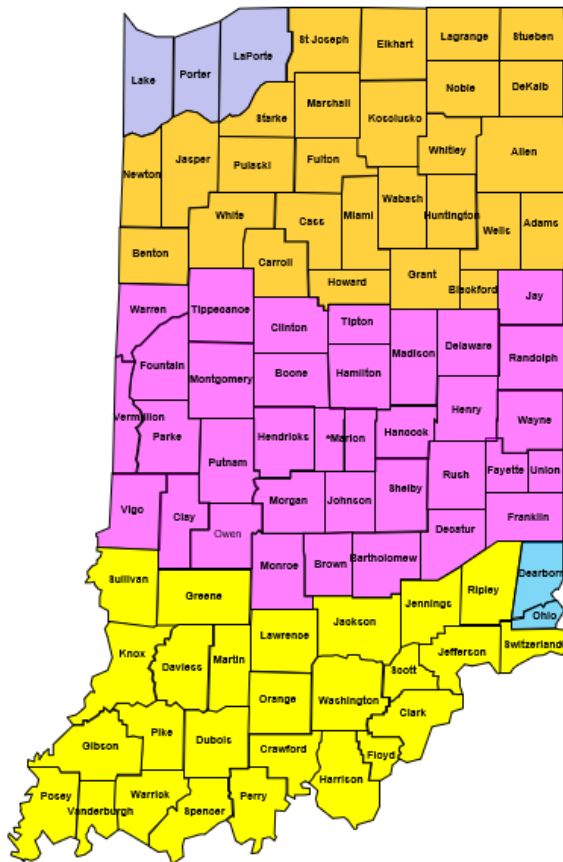
763-321-3822
lreeder@uhc.com

Zakiya Cooper
Provider Advocate

612-383-4914
zakiya_cooper@uhc.com

Kim Berry
Sr Provider Advocate

612-395-8106
kim_berry@uhc.com



Jodie Hattery

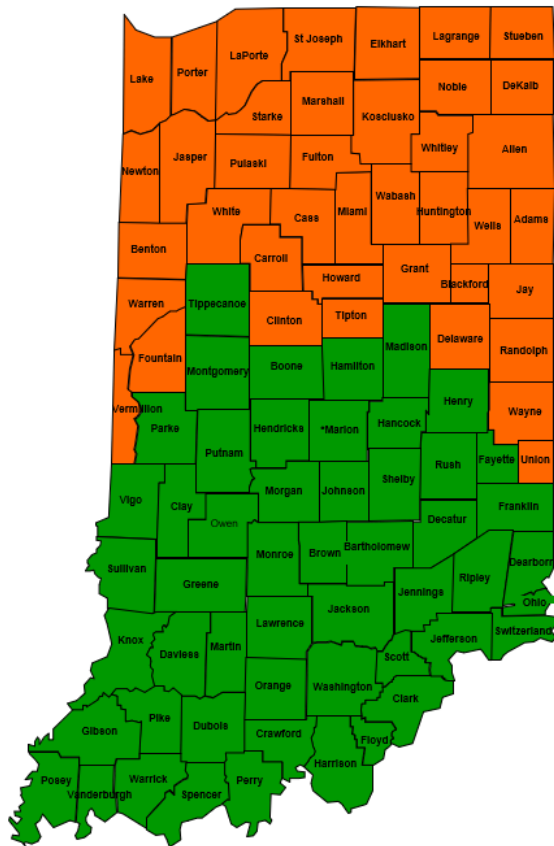
VP, Provider Market Ops
952-406-6449
jodie_hattery@uhc.com



Your Skilled Nursing Provider Engagement Team

Stephen Price
Provider Engagement Rep
612-474-7315
Stephen.a.price@optum.com

Tiffany Cashion
Sr Provider Engagement Rep
317-352-6578
Tiffany.Cashion@optum.com



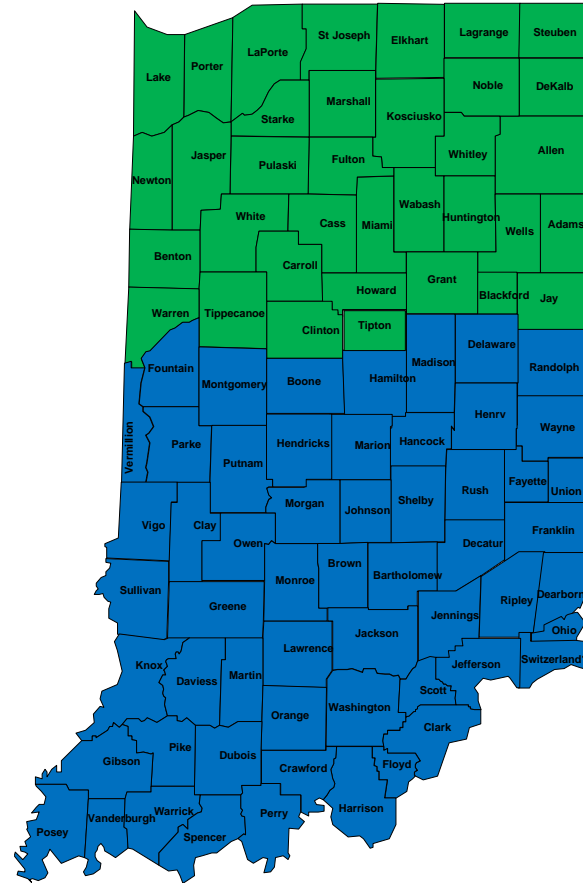
Lynette Gatewood
Manager,
Provider Engagement
952-246-4983
Lynette.Gatewood@optum.com



Your Optum Behavioral Health Advocate Team

Belen Stewart
Provider Advocate
Behavioral Health
612-632-5962
Belen.Stewart@optum.com

David Hoover
Senior Provider Advocate
Behavioral Health
763-330-7588
David_Hoover@optum.com



Your Optum Behavioral Health ABA Advocate

Nacole Thompson
Provider Advocate
ABA Therapy- all counties
952-406-6449
Nacole.Thompson@optum.com



Your March Vision Advocate

Cassandra Pattison
Sr. Provider Relations Advocate
210-474-5592
Cassandra_Pattison@uhc.com

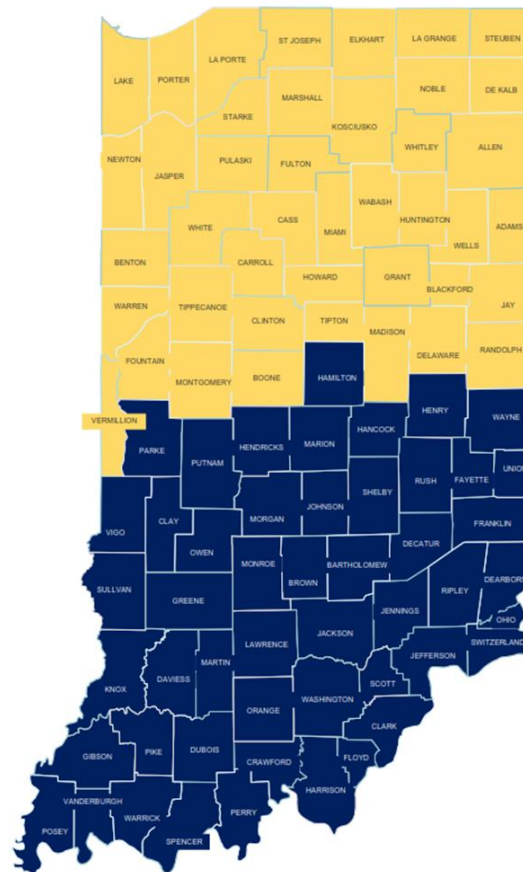
(Cassandra covers all Indiana counties)



Your Dental Advocate Team

Catrice Campbell
Provider Advocate
763-283-4522
catrice_campbell@uhc.com

Paul Curry III
Provider Advocate
952-202-2072
paul_curry@uhc.com





Questions & Answers



Thank you