2018 Administrative Guide

Physician, Health Care Professional, Facility and Ancillary

KanCare Program

Chapter 15: Claims

PCA-1-013294-12122018_01142019

UnitedHealthcare® Community Plan

Welcome

Welcome to the UnitedHealthcare Community Plan provider manual. This up-to-date reference PDF manual allows you and your staff to find important information such as how to process a claim and submit prior authorization requests. This manual also includes important phone numbers and websites on the How to Contact Us page. Find operational policy changes and other electronic tools on our website at UHCprovider.com.

Click the following links to access different manuals:

- UnitedHealthcare Administrative Guide or Commercial and Medicare Advantage member information. Some states may also have Medicare Advantage information in their Community Plan manual.
- A different Community Plan manual: go to UHCprovider.com, Click Menu on top left, select Administrative Guides and Manuals, then Community Plan Care Provider Manuals, select state.

Easily find information in this manual using the following steps:

1. Press CTRL+F.
2. Type in the keyword.
3. Press Enter.

If available, use the binoculars icon on the top right hand side of the PDF to search for information and topics.

We greatly appreciate your participation in our program and the care you offer our members. If you have questions about the information or material in this manual, or about our policies, please call Provider Services.

Important Information about the use of this manual.

If there is a conflict between your Agreement and this care provider manual, use this manual unless your Agreement states you should use it, instead. If there is a conflict between your Agreement, this manual and applicable federal and state statutes and regulations and/ or state contracts, applicable federal and state statutes and regulations and/or state contracts will control. UnitedHealthcare Community Plan reserves the right to supplement this manual to help ensure its terms and conditions remain in compliance with relevant federal and state statutes and regulations.

This manual will be amended as policies change.

Participation agreement.

In this manual, we refer to your Participation Agreement as “Agreement”.

Effective January 1, 2019, all care providers (participating and non-participating) are required to be enrolled with the State of Kansas (and obtain a KMAP ID) in order to receive payment from UnitedHealthcare Community Plan. Additionally, for non-participating care providers, a non-participating care provider reimbursement agreement will be required for each claim.

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Chapter 15: Claims

15.1 Claims Billing Procedures

Electronic claims reduce errors and shorten payment cycles. For electronic claims submission requirements, please see our companion documents located at **UHCProvider.com**. This documentation should be shared with your software vendor.

To obtain more information regarding electronic claims, please refer to the EDI section of this manual or the care provider section of the website at **UHCProvider.com**, or you may call our EDI Customer Service at 800-210-8315 from 9 a.m. to 3 p.m. Central Time (CT) Monday through Friday, excluding holidays.

Non-Participating Care Provider Claim Submission

Claims submitted by non-participating care providers on or after 1/1/19 must be submitted with a signed Non-Participation Reimbursement Agreement attached to each claim. We will not accept or consider the claim for payment without it. We will deny any non-participating care provider claims without this form.

The Non-Participation Reimbursement Agreement is on **www.UHCprovider.com**.

15.2 Claims Format

All claims for medical or hospital services must be submitted using the standard CMS-1500, UB04 (also known as CMS1450), 5010 format or respective electronic format. We recommend the use of black ink when completing a CMS-1500. Black ink on a red CMS-1500 form will allow for optimal scanning into the claims processing system. No matter which format you use to submit the claim, help ensure that all appropriate secondary diagnosis codes are captured and indicated for line items. This allows for proper reporting on encounter data.

15.3 Claims Processing Time

Please allow 30 days before inquiring about claims status. The standard turnaround time for clean claims is 30 business days, measured from date of receipt.

15.4 Corrected Claims

Care providers have 365 days from the date of service to file a corrected claim. Our standard timely filing requirement is 180 days from the date of service (for new day claims only). Please refer to your UnitedHealthcare Community Plan Participation Agreement for your specific requirement.

How to correct a claim electronically: Electronic claim clearinghouse:

UB Claims:

- You may submit a corrected claim electronically through their claim clearinghouse
  - Update the 3rd digit in the bill type to a:
    - "7" for a replacement request
    - "8" for a void request
  - The change in bill type will flag the claim as a corrected claim.

1500 Claims:

- You may submit an adjustment or void claim request electronically through their claim clearinghouse.
- Using resubmission codes in box 22 on the CMS 1500 claim titled Resubmission Code.
  - Resubmission code "7" for replacement request
  - Resubmission code "8" for void request
  - Include Original Claim Number in the Original Reference Number box

How to correct a claim via paper:

UB Claims:
Corrected claim should be mailed to:

UnitedHealthcare
P.O. Box 5270
Kingston, NY 12402

Write "CORRECTED" on the claim.
Update the third digit of the bill type to a 7.
The change in bill type will flag the claim as a corrected claim.

1500 Claims:
Corrected claim should be mailed to:

UnitedHealthcare
P.O. Box 5270
Kingston, NY 12402

Write "CORRECTED" on the claim.
Add the original claim number in Box 22 of the 1500 form.

15.5 Paper Claim Submissions

Mail Paper Claims Directly to UnitedHealthcare Community Plan for our KanCare Members

Please send all paper claims for UnitedHealthcare Community Plan KanCare members directly to one of the following addresses as appropriate. Please do not send claims to the Kansas Medical Assistance Program (KMAP).

If KMAP receives paper claims for our KanCare members, they will return the claims to you.

Mail paper claims for KanCare members	
For this service:	**To this address:**
Behavioral health and substance use disorders	UnitedHealthcare P.O. Box 5270 Kingston, NY 12402
Dental services	Scion P.O. Box 1158 Milwaukee, WI 53201
Pharmacy orders	Optum Rx P.O. Box 29044 Hot Springs, AR 71903

Mail paper claims for KanCare members	
For this service:	**To this address:**
Non-emergent medical transportation	LogistiCare Claims Dept. 2552 West Erie Driver, Suite 101 Tempe, AZ 85282
Vision services	MARCH® Vision Care 6701 Center Drive West Suite 790 Los Angeles, CA 90045
All other health care services such as hospital and home- and community-based	UnitedHealthcare P.O. Box 5270 Kingston, NY 12402

15.6 Tax Identification Numbers/Care Provider IDs

Please submit standard transactions using your tax identification number and your NPI. To help ensure proper claims adjudication, please use the ID that best represents the Health Care Professional that performed the service. If you have any questions about IDs, please contact your local office or EDI Customer Service at 800-210-8315 from 9 a.m. to 3 p.m. CT, Monday through Friday, excluding holidays.

15.7 Subrogation and Coordination of Benefits

Our benefits contracts are subject to subrogation and coordination of benefits (COB) rules.

Subrogation - We reserve the legal right to recover benefits paid for a member's health care service when those services are related to an accident or workman's comp.

COB - Coordination of benefits is administered according to the member's benefit contract and in accordance with applicable statutes and regulations. Please update your office records with the patient's other insurance carrier information, at each visit. When billing claims, ensure COB information is provided on each claim form for accurate coordination of benefits and processing of payment.

Note: UnitedHealthcare Community Plan follows KMAP TPL policy. All KMAP TPL billing requirements still apply. Please refer to KMAP General TPL Payment provider manual. Clarification to this provider manual will be added at a later date.

15.8 Medicare Crossover Claims

You are required to enter Medicare information at both the claim level, in addition to the line level. When entering Medicare information at the claim level, please ensure the amount entered is the sum of the amounts entered at the line level.

15.9 Electronic Claims Submission and Billing

All documents, frequently asked questions and other information regarding electronic claims submission can be found at **UHCProvider.com** under EDI Services.
Please share this information with your software vendor. Your software vendor can help in establishing electronic connectivity.
Please note the following:

- Clearinghouse connectivity is **OptumInsight** for our Payer ID 96385.
- All claims are set up as "commercial" through the clearinghouse.
- Our Payer ID is 96385.
- Clearinghouse Acknowledgment Reports and Payer Specific Acknowledgment Reports identify claims failing to successfully transmit electronically.
- We follow CMS National Uniform Claim Committee (NUCC) Manual guidelines for placement of data for both CMS-1500 & UB04.
- **Link to CMS NUCC CMS-1500 Manual**

Address questions to EDI Customer Service at 800-210-8315 from 9 a.m. to 3 p.m. CT, Monday through Friday, excluding holidays.

Importance and Usage of EDI Acknowledgment/Status Reports

Software vendor reports only show the claim left your office and either was accepted or rejected by the vendor. Your software vendor report does not confirm claims have been received or accepted at clearinghouse or by the Health Plan. Acknowledgment reports show you the status of your electronic claims after each transmission. Analyzing these reports, you will know if your claims have reached the Health Plan for payment or if claim(s) have been rejected for an error or additional information.

You **MUST** review your **reports, clearinghouse acknowledgment reports** and the Health Plan's status reports to eliminate processing delays and timely filing penalties for claims that have not reached the Health Plan.

How do I get these reports?

Your software vendor is responsible for establishing your connectivity to our clearinghouse **OptumInsight**, and will instruct you in how your office will receive Clearinghouse Acknowledgment Reports.

How do I correct errors?

If you have a claim that rejects, you can correct the error and retransmit the claim electronically the same day, causing no delay in processing. It is very important that clearinghouse reports are reviewed and worked after each transmission. These reports should be kept if you need documentation for timely filing later.

IMPORTANT: **If a claim is rejected and corrections are not received by the Health Plan within 180 days from date of service or EOB from primary carrier, the** CLAIM WILL BE CONSIDERED LATE BILLED and denied as not allowed for timely filing.

EDI Companion Documents
The Health Plan's Companion Guides are intended to convey information that is within the framework of the ASC X12N Implementation Guides (IG) adopted by Health Insurance Portability and Accountability Act. The companion guides identify the data content being requested when data is electronically transmitted. The Companion Documents are located on our website at **UHCProvider.com**.

The Health Plan utilizes the Companion Guides to:

- Clarify data content that meets the needs of the Health Plan's business purposes when the IG allows multiple choices.
- Outline which situational elements the Health Plan requires.
- Provide values that the Health Plan will return in outbound transactions.

Section 1 provides general information.
Section 2 provides specific details pertinent to each transaction.
Share these documents with your software vendor for any programming and field requirements.
As the Health Plan makes information available on various transactions, we will identify our requirements for those transactions in Section 2 of the Companion Guide.

e-Business Support

- ERA – To enroll for 835 Electronic Remittance Advice (ERA), go to **OptumInsight** and click on Physicians, then ERA Manager. The ERA will be returned through your clearinghouse.
- EFT – EF T enrollment forms are located at **UHCProvider.com**.

e-Business support is available for the following issues:

EDI Claims Issues
800-210-8315
ac_edi_ops@uhc.com
9 a.m. to 3 p.m. CT,
Monday through Friday excluding holidays

Website Issues
866-842-3278
UHCprovider.com/edi
7 a.m. to 9 p.m. CT, Monday through Friday

Consider contacting your software vendor and/or clearinghouse prior to calling us.

Note: Electronic claim submission through the Kansas Medical Assistance Plan is also still available.

15.10 Span Dates

Exact dates of service are required when the claim spans a period of time. Please indicate the specific dates of service in Box 24 of the CMS-1500, Box 45 of the UB04, or the Remarks field This will eliminate the need for an itemized bill and allow electronic submission.

15.11 Effective Date/Termination Date

Coverage will be effective on the date the member is effective with the Health Plan, as assigned by the State of Kansas. Coverage will terminate on the date the member's benefit plan terminates with the Health Plan.

If a portion of the services or confinement take place prior to the effective date, or after the termination date, an itemized split bill will be required. For KanCare, if a member is covered by us upon the date of admission, termination does not occur until discharge.

Please be aware that Health Plan eligibility may change when individuals re-apply for KanCare. You should verify eligibility at each visit, to help ensure coverage for services.

15.12 Overpayments

If an overpayment has been made, please include reference to the claim number or member ID number and date of service. The best way to handle a potential overpayment is to call a Provider Services Representative.

If we find an overpayment, we will issue a recovery letter prior to deducting that overpayment from the remittance advice.

If you identify an overpayment, please contact Provider Services at 877-542-9235, Monday through Friday from 8 a.m. to 5 p.m. CT or you may send a check to:

UnitedHealthcare
PO Box 5230
Kingston, New York 12401

Item should include the following:

- Patient name
- Patient Medicaid ID #
- Date of service
- Amount originally paid by UnitedHealthcare
- Amount overpaid
- Reason account is considered overpaid
- Claim number (if available)
- UID from recovery letter (if available)
- Copy of UnitedHealthcare remit (if available)
- Name and phone number of person submitting refund in case questions arise

This information can also be accessed through **UHCProvider.com** under Refunding Care Provider Overpayments.

15.13 Subrogation

The Health Plan may override timely filing denials based on decisions received from third-party carriers on subrogation or workers' compensation claims. At the time of service, please submit all claims to the Health Plan for processing.

Through recovery efforts, we will work to recoup dollars related to subrogation and workers' compensation.

In addition, if your office receives a third-party payment on a previously paid UnitedHealthcare Community Plan claim, notify Provider Services at 877-542-9235, Monday through Friday, 8 a.m. to 5 p.m. CT and the overpayment will be recouped.

15.14 Timely Filing and Late Bill Criteria

Our standard timely filing requirement is 180 days from the date of service, however this can vary by contract. Please refer to your UnitedHealthcare Participation Agreement for your specific requirement. Care providers have 365 days from the date of the service to file a corrected claim.

For claims with coordination of benefits, timely filing starts from the date on the explanation of benefits provided by the primary insurance company. If submitting a claim for retroactive eligibility on a member, timely filing limits start on the day the member is determined to be eligible by Kansas Department of Health and Environment (KDHE) and not the back-dated eligibility start date.

15.15 Reconsideration Requests

A claim reconsideration request is typically the quickest way to address any concerns you have with how we processed your claim. With a claim reconsideration request, we review whether a claim was paid correctly. This includes if your provider information and/or contract are set up incorrectly in our system. This could result in the original claim being denied or reduced.

You are allowed to file:

1. Original claim submissions within 180 days of the date of service.
2. Reconsideration requests within 120 calendar days from the remittance date, plus three calendar days are allowed for mailing time.

Reconsideration is an optional process available to providers prior to submitting an appeal. Reconsideration requests can be submitted in the following ways:

Electronically:
Using the claimLINK Self-Service Tool at **UHCProvider.com**

By phone:
Provider Services 877-542-9235

By mail:
Complete the Claim Reconsideration Form found at **UHCProvider.com** and mail to:
UnitedHealthcare Community Plan
P.O. Box 5270
Kingston NY 12401

You should submit a fully completed claims reconsideration request form and all supporting documentation. Please do not send a claim or claim copy with your reconsideration request. If you send a claim or claim copy with the reconsideration, the reconsiderations team cannot accept it and will return it to you.

If you disagree with a claim adjustment or our decision not to make a claim adjustment, you can file a formal claim dispute/appeal (see the following Provider Formal Appeals section).

15.16 Provider Grievances

Grievance – An oral or written expression of dissatisfaction by a provider about any matter other than an action received at UnitedHealthcare Community Plan. Providers have 180 calendar days to file a grievance with us.

We track and resolve your grievances within 30 calendar days of receipt. We respond fully and completely to your grievance in writing. A grievance can be submitted in the following ways:

Electronically:
UHCprovider.com > **Menu > Health Plans By State > KS > Medicaid > Provider Forms**

By phone:
877-542-9235
Monday through Friday, 8 a.m. – 5 p.m. CT

In writing:
UnitedHealthcare Community Plan - Kansas
Attention: Appeals and Grievances
P.O. Box 31364
Salt Lake City, UT 84131-0364

Or, In Person:
10895 Grandview Drive, Suite 200
Overland Park, KS 66210
(During regular business hours 8 a.m. – 5 p.m. CT)

15.17 Provider Formal Appeals

An appeal is a request to review an action. An action is the denial, in whole or part, of payment for a service to a care provider.

Note: A provider must complete the UnitedHealthcare Community Plan appeal process before submitting a State Fair Hearing.

All formal appeals must be filed within 60 calendar days (plus three calendar days are allowed for mailing time) from the date of the care provider remittance or notice of action. You forfeit your right to a State Fair Hearing if appeal requests are submitted untimely. Formal appeal requests can be submitted in the following ways:

By mail:
UnitedHealthcare Community Plan Kansas
Attention: Formal Grievances and Appeals
P.O. Box 31364
Salt Lake City, UT 84131-0364.

Electronically:
For non-claims related appeals —
UHCProvider.com > Menu > Health Plans By State > KS > Medicaid > Provider Forms

For claims related appeals —
Using the claimLINK Self-Service Tool at UHCProvider.com

In person:
UnitedHealthcare Community Plan
10895 Grandview Drive, Suite 200
Overland Park, KS 66210
During regular business hours (8 a.m. – 5 p.m. CT)

The cover letter should state you are filing a formal appeal. Several claims with the same reasons for appeal may be combined in a single appeal letter, with an attached list of claims. State the specific reason for denial as stated on the remittance and/or notice of action. Please enclose all relevant documentation including, but not limited to, contract rate sheets, fee schedule, medical records, prior authorization, and/or retro-eligibility information with your appeal request.

If you are appealing a claim that was denied because filing was not timely, for:

- Electronic claims: include confirmation that we, or one of our affiliates, received and accepted your claim.
- Paper claims: include a copy of a screen print from your accounting software to show the date you submitted the claim.

Appeal Filing Timeframes			
Calendar days allowed for care providers to file an appeal from the date on the Notice of Action and/or Provider Remittance Advice	**Calendar days allowed for UnitedHealthcare Community Plan to send care provider appeal acknowledgment letter**	**Calendar days allowed for UnitedHealthcare Community Plan to respond to an appeal request**	**Calendar days allowed for care provider to file a State Fair Hearing from the date on the appeal resolution letter**
60 (+three for mailing)	10	30	120 (+three for mailing)

Prior Authorization Denial Appeal Request

You may request an appeal for a pre-service denial on behalf of members, with a signed authorization form. Authorized representatives acting on behalf of members can access the authorization form at UHCProvider.com. A copy of the authorization form can also be found in the last page of this administrative guide.

15.18 Provider State Fair Hearings

If you disagree with the outcome of an appeal reviewed by UnitedHealthcare Community Plan, you can file a State Fair Hearing. A State Fair Hearing is a formal proceeding before an impartial Hearing Officer, also known as a Presiding Officer, who will listen to the facts of the case, and then issue a decision based upon the facts and the law.

You must complete the UnitedHealthcare Community Plan appeal process before submitting a State Fair Hearing.

A request for a State Fair Hearing must be submitted within 120 calendar days (plus three calendar days are allowed for mailing) from the date of the appeal resolution notice. Requests for a State Fair Hearing can be submitted in the following ways:

In writing:
Office of Administrative Hearings
1020 S. Kansas Avenue
Topeka, KS 66612

By telephone (toll-free):
877-542-9235
(during business hours 8 a.m. – 5 p.m. CT)

Electronically via Office of Administrative Hearings
fax: **785-296-4848**

In person:
10895 Grandview Drive, Suite 200
Overland Park, KS 66210
During regular business hours (8 a.m. – 5 p.m. CT)

The Office of Administrative Hearings will generally inform the parties that a written decision will be issued within 30 days from the date of the hearing.

15.19 Excluded Care Providers

As part of ongoing efforts to help ensure compliance with federal and state requirements, we perform monthly screenings of the Office of Inspector General (OIG) (**oig.hhs.gov/fraud/exclusions.asp**), the Excluded Parties List System (EPLS), and other databases for individuals or entities who have been "excluded" or "debarred" from federal programs. Individuals or entities identified as excluded or debarred as a result of these screenings will be terminated from participation in the KanCare plan, immediately, upon discovery. Payments made to "excluded" or "debarred" care providers will be recovered retroactive to the date of exclusion.

15.20 The Correct Coding Initiative

The Health Plan performs coding edit procedures, based primarily on the CCI (Correct Coding Initiative) and other nationally recognized and validated sources.

The edits fall into one of two categories:

1. Comprehensive and Component Codes.

Comprehensive and component code combination edits apply when the code pair(s) in question appears to be inclusive of each other in some way. This category of edits can be further broken down into subcategories that explain the bundling rationale in more detail. Some of the most common causes for denials in this category include:

- Separate procedures. Codes that are, by CPT definition, separate procedures should only be reported when they are performed independently and not when they are an integral part of a more comprehensive procedure.
- Most extensive procedures. Some procedures can be performed at different levels of complexity. Only the most extensive service performed should be reported.
- With/without services. It is contradictory to report code combinations where one code includes and the other excludes certain other services.
- Standards of medical practice. Services and/or procedures that are integral to the successful accomplishment of a more comprehensive procedure are bundled into the comprehensive procedure, and not reported separately.
- Laboratory panels. Individual components of panels or multichannel tests should not be reported separately.
- Sequential procedures. When procedures are often performed in sequence, or when an initial approach is followed by a more invasive procedure during the same session, only the procedure that achieves the expected result should be reported.

2. Mutually Exclusive Codes.

These edits apply to procedures that are unlikely or impossible to perform at the same time, on the same patient, by the same physician. There is a significant difference in the processing of these edits versus the comprehensive and component code edits.

CCI guidelines are available in paper form, on CD ROM, and in software packages that will edit your claims prior to submission. Your CPT and ICD-10 vendor probably offers a version of the CCI manual, and many specialty organizations have comprised their own publications geared to address specific CCI issues within the specialty. CMS publishes information on CCI and can be found by clicking **here**.

15.21 Immunizations Billing

Vaccines for Children Program (ages 0-18)

The Health Plan must provide for administration of all mandated childhood immunizations according to the recommended schedule of the Advisory Committee on Immunization Practices (ACIP) standards, a current copy of which is included on UHCCommunityPlan.com.

All vaccines for members ages 0-18 will be provided through the State of Kansas Vaccines for Children Program, which will distribute vaccines to care providers who are willing to participate in the vaccine program.

The vaccines should be billed with the appropriate CPT Codes and $0.01 as a billed charge for the vaccine. No payment will be made for vaccines covered under the Vaccine for Children Program. Vaccines for Children care providers will be reimbursed for the appropriate vaccine administration code. The only cost associated with immunizations to be reimbursed under the Policy shall be the cost to administer the vaccine. Vaccines may be administered by network care providers, including school-based nurses, by a non-participating care provider to whom UnitedHealthcare Community Plan has referred the member, or by the State of

Kansas. Care providers administering State of Kansas vaccines must agree to participate in the state's Immunization Registry. UnitedHealthcare Community Plan must reimburse these care providers on a fee-for-service basis for the cost of administering any immunizations they provide to members. Other non-routine immunizations, such as influenza vaccine or tetanus boosters provided pursuant to an injury, shall be covered as any other covered service. UnitedHealthcare Community Plan shall submit a monthly report containing a list of care providers, their contact information, claimant information and corresponding vaccine administrations to the state of Kansas.

Adult Immunization (19 years and older)

You will bill the appropriate vaccine immunization and administration code. Services will be processed in accordance with state benefits and paid per state fee schedule.

15.22 Sterilization Procedure Billing

The surgeon performing the sterilization procedure is responsible for obtaining a complete and accurate Sterilization Consent Form. However, it is recommended other care providers billing services related to sterilizations, including hospitals, obtain a copy of the Sterilization Consent Form from the surgeon PRIOR to the service being performed to validate the form is completed and correct.

If a hospital (other than the surgeon performing the sterilization) files a claim prior to the surgeon, we will not have a valid sterilization consent form on file. As a result, the hospital or other care provider claim will deny and you will be responsible for submitting a corrected claim once they have validated the surgeon's claim is on file with valid sterilization consent form. If you obtained a copy of the complete and accurate Sterilization Consent Form from the surgeon, you may submit the form with your claim to facilitate payment.

If the surgeon does not complete the sterilization consent form correctly, making it invalid per federal regulation, we cannot accept it for the surgeon, you, or any other care provider. All sterilization-related services will be denied. If the surgeon performs a sterilization procedure without obtaining the necessary sterilization consent form, no care provider will be paid for any services related to the sterilization. As a result, it is recommended that all care providers of services related to sterilization obtain a copy of a correct and complete Sterilization Consent Form from the surgeon PRIOR to the sterilization procedure to avoid claim issues. Effective immediately, please complete and submit a "Federal Sterilization Consent form", which is available at **kmap-state-ks.us**, with your initial claim for any sterilization procedures for KanCare members — even if KanCare is not the primary payer.

If you have questions, please call Provider Services at 877-542-9235, Monday through Friday from 8 a.m. to 5 p.m. CT or your Provider Advocate.

Hysterectomy Procedure Billing

A copy of the Hysterectomy Necessity Form must be attached to the surgeon's claim at the time of submission. The form is located at **kmap-state-ks.us/Public/forms.asp**. It may be photocopied for your use. A copy of the Hysterectomy Necessity Form does not have to be attached to related claims (anesthesia, assistant surgeon, hospital, or rural health clinic) at the time of submission. However, a related claim will not be paid until the Hysterectomy Necessity Form with the surgeon's claim has been reviewed and determined to be correct, unless the related claim has the correct Hysterectomy Necessity Form attached.

A total hysterectomy and the removal of tubes/ovaries cannot be billed as separate procedures when performed by the same care provider.

15.23 Member Identification Cards


UnitedHealthcare Community Plan

Health Plan (80840) 911-96385-07

Member ID: 99999993122

Group Number: KSKCMD

Member:
REISSUE ENGLISH

Payer ID: 96385

DOB: 02/04/1947

PCP Name:
DOUGLAS GETWELL

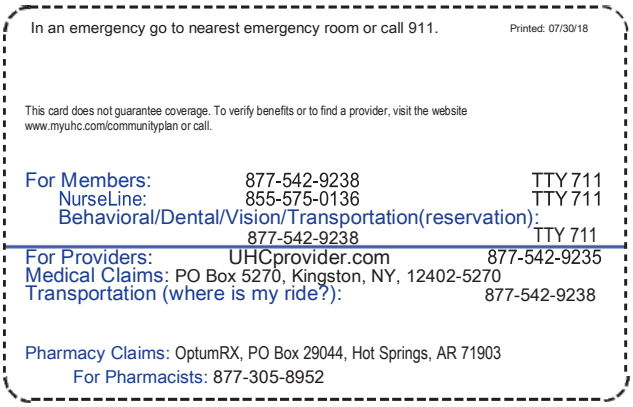
PCP Phone: (620)852-3550

Effective Date:
06/16/2013

Copays: $0

0501

Administered by UnitedHealthcare of the Midwest, Inc.


In an emergency go to nearest emergency room or call 911.

Printed: 07/30/18

This card does not guarantee coverage. To verify benefits or to find a provider, visit the website www.myuhc.com/communityplan or call.

For Members: 877-542-9238 TTY 711

NurseLine: 855-575-0136 TTY 711

Behavioral/Dental/Vision/Transportation(reservation): 877-542-9238 TTY 711

For Providers: UHCprovider.com 877-542-9235

Medical Claims: PO Box 5270, Kingston, NY, 12402-5270

Transportation (where is my ride?): 877-542-9238

Pharmacy Claims: OptumRX, PO Box 29044, Hot Springs, AR 71903

For Pharmacists: 877-305-8952