2025 Care Provider Manual

Physician, Care Provider, Facility and Ancillary

Pennsylvania

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United Healthcare® Community Plan

Welcome

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

Click to access different care provider manuals

- **Administrative guide** – **UHCprovider.com/guides**
  - Under UnitedHealthcare Care Provider Administrative Guide for Commercial, Medicare Advantage (including Dual Complete Special Needs Plans), click on View Guide. Some states may also have Medicare Advantage information in their Community Plan manual.
- **A different Community Plan care provider manual** – **UHCprovider.com/guides**
  - Under Community Plan Care Provider Manuals for Medicaid Plans by State, click on **Your State**

View the **Medicaid glossary** for definitions of terms commonly used throughout the care providers manuals.

If you have questions about the information or material in this manual, or about our policies, please call **Provider Services** at **1-800-600-9007**.

Important information about the use of this care provider 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.

Terms and definitions as used in this manual:

- "Member" or "customer" refers to a person eligible and enrolled to receive coverage from a payer for covered services as defined or referenced in your Agreement.
- "You," "your" or "care provider" refers to any health care professional subject to this manual, including physicians, clinicians, facilities and ancillary providers; except when indicated and all items are applicable to all types of care providers subject to this manual.
- "Community Plan" refers to UnitedHealthcare's Medicaid plan
- "Your Agreement," "Provider Agreement" or "Agreement" refers to your Participation Agreement with us
- "Us," "we" or "our" refers to UnitedHealthcare Community Plan on behalf of itself and its other affiliates for those products and services subject to this guide
- Any reference to "ID card" includes both a physical or digital card
- Health Care Services – Any covered treatment, admission, procedure, medical supplies and equipment or other services prescribed or otherwise provided or proposed to be provided by a Health Care Provider to a Member for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease under the terms of this Agreement

Pennsylvania Medical Assistance Manual

Along with this manual, you need to be aware of the information in the Pennsylvania Medical Assistance Manual. This is found on the Commonwealth's website at: pacode.com. The DHS website, dhs.pa.gov, is also a good resource for state-specific information.

Table of contents

Chapter 1: Introduction

Key contacts

Topic	Link	Phone number
Provider Services	**UHCprovider.com** Live chat available at **UHCprovider.com/contactus**	**1-800-600-9007**
Training	**UHCprovider.com/training**	**1-800-600-9007**
UnitedHealthcare Provider Portal	**UHCprovider.com**, then Sign In using your One Healthcare ID or go to **UHCprovider.com/portal** New users: **UHCprovider.com/access**	**1-800-600-9007**
CommunityCare provider portal training	**UnitedHealthcare Provider Portal Digital Guide Overview course**	
One Healthcare ID support	Chat, with a live advocate, is available 7 a.m.–7 p.m. CT at **UHCprovider.com/chat.**	**1-855-819-5909**
Resource library	**UHCprovider.com/resourcelibrary**	

UnitedHealthcare Community Plan of Pennsylvania currently offers the following programs:

- UnitedHealthcare Community Plan Medicaid is offered through the product name UnitedHealthcare Community Plan for Families under HealthChoices program of the Pennsylvania Department of Human Services
- UnitedHealthcare Community Plan Children's Health Insurance Program (CHIP) is offered through the product UnitedHealthcare Community Plan for Kids under CHIP administered by the Pennsylvania Department of Human Services

If you have questions about the information in this manual or about our policies, go to **UHCprovider.com** or call **Provider Services** at **1-800-600-9007**.

How to join our network

Learn how to join the UnitedHealthcare Community Plan care provider network at **UHCprovider.com/join**. There you will find guidance on our credentialing process, how to sign up for self-service and other helpful information.

Already in network and need to make a change?

To change an address or phone number, add or remove physicians from your TIN, or make other changes, go to My Practice Profile at **UHCprovider.com/attestation**.

Our approach to health care

Care Model

The Care Model program seeks to empower UnitedHealthcare Community Plan members enrolled in Medicaid, working with care providers and our community to help people lead healthier lives. We work with members with chronic complex medical conditions

and may also be challenged by social determinants of health that impede access to care. The Care Model team is comprised of RN case managers, community health workers, and behavioral health advocates to provide a full range of support services.

The program provides interventions to members with complex medical, behavioral, social, pharmacy and specialty needs, resulting in better quality of life, improved access to health care and reduced expenses. Care Model provides a care management/coordination team that helps increase member engagement, offers resources to fill gaps in care and develops personalized health goals using evidence-based clinical guidelines. This approach is essential to improving the health and well-being of the individuals, families and communities UnitedHealthcare Community Plan serves. Care Model provides:

- Market-specific care management encompassing medical, behavioral and social care
- An extended care team including primary care provider (PCP), pharmacist, medical and behavioral director, and peer specialist
- Options that engage members, connecting them to needed resources, care and services
- Individualized and multidisciplinary care plans
- Assistance with appointments with PCP and coordinating appointments. The Clinical Health Advocate (CHA) refers members to an RN, Behavioral Health Advocate (BHA) or other specialists as required for complex needs
- Education and support with complex conditions
- Tools for helping members engage with providers, such as appointment reminders and help with transportation
- Foundation to build trust and relationships with hard-to-engage members

The Care Model program goals are to:

- Lower avoidable admissions and unnecessary emergency room (ER) visits, measured outcomes by inpatient (IP) admission and ER rates
- Improve access to PCP and other needed services, measured by number of PCP visit rates within identified time frames
- Identify and discuss behavioral health (BH) needs, measured by number of BH care professional visits within identified time frames
- Improve access to pharmacy
- Identify and remove social and environmental barriers to care
- Improve health outcomes, measured by improved Healthcare Effectiveness Data and Information Set (HEDIS®) and Centers for Medicare & Medicaid Services (CMS) Star Ratings metrics
- Empower the member to manage their complex/chronic illness or problem and care transitions
- Improve coordination of care through dedicated staff resources and to meet unique needs
- Engage community care and provider networks to help ensure access to affordable care and the appropriate use of services

To refer your patient who is a UnitedHealthcare Community Plan member to the Care Model program, call Member Services at **1-800-414-9025,** TTY **711**. You may also call **Provider Services** at **1-800-600-9007**.

Compliance

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandates National Provider Identifier (NPI) usage in all standard transactions (claims, eligibility, remittance advice, claims status request/response, and authorization request/response) for all care providers who handle business electronically.

Cultural resources

To help you meet membership needs, UnitedHealthcare Community Plan has developed a Cultural Competency Program. The goal of the program is to break down linguistic and cultural barriers to build trust and improve health outcomes. You must support our Cultural Competency Program. For more information, go to **UHCprovider.com/resourcelibrary** > Health Equity Resources > **Cultural Competency**.

- **Cultural competency training and education**

  Free continuing medical education (CME) and non-CME courses are available on our **Cultural Competency page** as well as other important resources.
- Cultural competency information is stored within your provider profile and displayed within the directory. Showcase your cultural competencies by keeping your data current through our **data attestation process**.
- **Translation/interpretation/auxiliary aide services**

  You must provide language services and auxiliary aides, including, but not limited to, sign language interpreters to members as required, to provide members with an equal opportunity to access and participate in all health care services.

  If the member requests translation/interpretation/auxiliary aide services, you must promptly arrange

these services at no cost to the member.

Members have the right to a certified medical interpreter or sign language interpreter to accurately translate health information. Friends and family of members with limited English proficiency, or members who are deaf or hard of hearing, may arrange interpretation services only after you have explained our standard methods offered, and the member refuses. Document the refusal of professional interpretation services in the member's medical record.

Any materials you have a member sign, and any alternative check-in procedures (like a kiosk), must be accessible to an individual with a disability.

If you provide Virtual Visits, these services must be accessible to individuals with disabilities. Post your Virtual Visits procedures for members who are deaf or hard of hearing, so they receive them prior to the Virtual Visit.

- **Translation services**

  Get a quote for Accredited Language Services (ALS) International professional translation services in more than 200 languages at accreditedlanguage.com or call 1-800-322-0284

- **Care for members who are deaf or hard of hearing**

  You must provide a sign language interpreter if a member requests one. You must also have written office procedures for taking phone calls or providing Virtual Visits to members who are deaf or hard of hearing.

UnitedHealthcare Community Plan provides the following:

- **Language interpretation line**
  - We provide oral interpreter services Monday–Friday from 8 a.m.–8 p.m. ET
  - To arrange for interpreter services, please call **1-877-842-3210** TTY **711**
  - **To conference in the limited English-speaking patient:** Request the language your caller speaks through our simple interactive voice response system. When the interpreter is connected, explain the situation. Conference in your patient.
  - **To make a call to a limited English-speaking patient:** Request the language your client speaks through our simple interactive voice response system. When the interpreter is connected, call your patient or the interpreter can place the call for you.
  - **If you are face-to-face with a limited English-speaking patient:** Request the language your client speaks through our simple interactive voice response system. When the interpreter is connected, use the LanguageLine Solutions phone or your speakerphone, or pass your handset back and forth.

- **Sign language interpretation**

  Preview Languages Unlimited, LLC services for American Sign Language, telephonic and on-site interpretation at languagesunlimited.com or call 1-800-864-0372.

- **711 relay**

  Dial **711** to use Hamilton Relay in Pennsylvania at hamiltonrelay.com/state_711_relay or call TTY: 1-800-654-5984
  - **Voice:** 1-800-654-5988
  - **Speech-to-Speech:** 1-844-308-9292
  - **Spanish:** 1-844-308-9291

- **I Speak language assistance card**

  This resource allows individuals to identify their preferred language and provides directions to arrange interpretation services for UnitedHealthcare members.

- **Materials for limited English-speaking members**

  We provide simplified materials for members with limited English proficiency and who speak languages other than English or Spanish. We also provide materials for visually impaired members.

For more information, go to **uhc.com** > **Language Assistance**.

Evidence-based clinical review criteria and guidelines

UnitedHealthcare Community Plan uses InterQual® for medical care determinations.

Online resources

Going digital means less paper and more automation, faster workflow between applications and a quicker claims submission process to help you get paid faster.

Learn the differences by viewing the **digital solutions comparison guide**. Care providers in the UnitedHealthcare network will conduct business with us electronically.

This means using electronic means, where allowed by law, to submit claims and receive payment, and to submit and accept other documents. This includes appeals prior authorization requests and decisions. Using electronic transactions is fast and efficient

– and supports a paperless work environment. Use Application Programming Interface (API), electronic data interchange (EDI) or the **UnitedHealthcare Provider Portal** for maximum efficiency in conducting business electronically.

Application Programming Interface

Application Programming Interface (API) is a free digital solution that allows health care professionals to automate administrative transactions. API is designed to help your organization improve efficiency, reduce costs and increase cash flow. Automatic data feeds are created to share information between your organization and UnitedHealthcare on a timetable you set, and transfer the data to your practice management system, proprietary software, portal, spreadsheets or any application you prefer.

This can help you create a smoother workflow with fewer interruptions. We have API functionality for many of your day-to-day transactions. For more information, visit **UHCprovider.com/api**.

Electronic Data Interchange

Electronic Data Interchange (EDI) is an online resource using your internal practice management or hospital information system to exchange transactions with us through a clearinghouse.

The benefit of using EDI is it permits care providers to send batch transactions for multiple members and multiple payers in lieu of logging into different payer websites to manually request information. This is why EDI is usually care providers' and UnitedHealthcare Community Plan's first choice for electronic transactions.

- Send and receive information faster
- Identify submission errors immediately and avoid processing delays
- Exchange information with multiple payers
- Reduce paper, postal costs and mail time
- Cut administrative expenses
- EDI transactions available to care providers are:
  - Claims (837),
  - Eligibility and benefits (270/271),
  - Claims status (276/277),
  - Referrals and authorizations (278),
  - Hospital admission notifications (278N), and
  - Electronic remittance advice (ERA/835).

Visit **UHCprovider.com/edi** for more information. Learn how to optimize your use of EDI at **UHCprovider.com/optimizeedi.**

Getting Started

- If you have a practice management or hospital information system, contact your software vendor for instructions on how to use EDI in your system
- Contact clearinghouses to review which electronic transactions can interact with your software system

Read our **Clearinghouse Options** page for more information.

Point of Care Assist

When made available by UnitedHealthcare Community Plan, you will do business with us electronically. Point of Care Assist® integrates members' UnitedHealthcare health data within the Electronic Medical Record (EMR) to provide real-time insights of their care needs, aligned to their specific member benefits and costs. This makes it easier for you to see potential gaps in care, select labs, estimate care costs and check prior authorization requirements, including benefit eligibility and coverage details. This helps you to better serve your patients and achieve better results for your practice. For more information, go to **UHCprovider.com/poca**.

UHCprovider.com

This **public website** is available 24/7 and does not require registration to access. You'll find valuable resources, including administrative and plan-specific policies, protocols and guides, health plans by state, regulatory and practice updates, and quality programs.

UnitedHealthcare Provider Portal

Access patient- and practice-specific information 24/7 within the **UnitedHealthcare Provider Portal.** You can complete tasks online, get updates on claims, reconsiderations, appeals and payment detail, submit prior authorization requests, check eligibility and update your practice demographic information – all at no cost without calling.

See **UnitedHealthcare Provider Portal** for access and to create ID or sign in using a One Healthcare ID.

- If you already have a One Healthcare ID, simply go to

the **UnitedHealthcare Provider Portal** to access

- If you need to set up an account on the portal, follow **these steps** to register

Here are the most frequently used tools on the **UnitedHealthcare Provider Portal**:

- **Eligibility and benefits**

  View patient eligibility and benefits information for most benefit plans. For more information, go to **UHCprovider.com/eligibility**.

- **Claims**

  Get claims information for many UnitedHealthcare plans, including access letters, remittance advice documents and reimbursement policies. For more information, go to **UHCprovider.com/claims**.

- **Prior authorization and notification**

  Submit notification and prior authorization requests. For more information, go to **UHCprovider.com/priorauth**.

- **Specialty pharmacy transactions**

  Submit notification and prior authorization requests for certain medical injectable specialty drugs. Go to **UHCprovider.com/pharmacy** for more information.

- **My Practice Profile**

  View and update the provider demographic data that UnitedHealthcare members see for your practice. For more information, go to **UHCprovider.com/mypracticeprofile**.

- **Document Library**

  Access reports and claim letters for viewing, printing, or download. The Document Library Roster provides member contact information in a PDF, which can only be pulled at the individual practitioner level. For more information, go to **UHCprovider.com/documentlibrary**.

  See **UnitedHealthcare Provider Portal** to learn more about the available self-paced user guides for various tools/tasks.

Direct Connect

Direct Connect is a free online portal that lets you securely communicate with payers to address errant claims. This portal can replace previous methods of letters, faxes, phone calls and spreadsheets. It also helps:

- Manage overpayments in a controlled process
- Create a transparent view between care provider and payer
- Avoid duplicate recoupment and returned checks
- Decrease resolution timeframes
- Real-time reporting to track statuses of inventories in resolution process
- Provide control over financial resolution methods

All users will access Direct Connect using the **UnitedHealthcare Provider Portal**. On-site and online training are available.

Email **directconnectsupport@optum.com** to get started with Direct Connect.

Privileges

To help our members access appropriate care and minimize out-of-pocket costs, you must have privileges at applicable in-network facilities or arrangements with an in-network provider to admit and provide facility services. This includes full admitting hospital privileges, ambulatory surgery center privileges and/or dialysis center privileges.

Provider Services

Provider Services is the primary contact for care providers who need help. It is staffed with representatives trained specifically for UnitedHealthcare Community Plan.

They can answer your questions about Medicaid benefits, eligibility, claim decision, forms required to report specific services, billing questions and more. Provider Services works closely with all departments in UnitedHealthcare Community Plan.

How to contact us

**We no longer use fax numbers.*

Topic	Contact	Information
Behavioral health	Optum® **providerexpress.com** **1-877-614-0484**	Ask about eligibility, claims, benefits, authorization, and appeals.
Benefits	**UHCprovider.com/benefits** **1-800-600-9007**	Confirm a member's benefits and/or prior authorization.
Cardiology prior authorization	**UHCprovider.com/cardiology**.> Sign In **1-866-889-8054**	Review or request prior authorization, see basic requirements, guidelines, CPT code list, and more information.
Care model (care management/disease management)	For further details, contact Enhanced Member Support Unit (formerly the Special Needs Unit) **1-877-844-8844**.	Refer high-risk members (e.g., asthma, diabetes, obesity) and members who need private-duty nursing.
ChildLine	compass.state.pa.us/cwis 1-800-932-0313	Report suspected child abuse or neglect.
Chiropractor care	**myoptumhealthphysicalhealth.com** **1-800-873-4575**	This benefit does not need prior authorization.
Claims	**UHCprovider.com/claims** **1-800-600-9007** For FedEx (use for large packages/more than 500 pages): **UnitedHealthcare Community Plan** 709 Grant Avenue, North Lobby Lake Katrine, NY 12249	Verify a claim status, ask about proper completion or submission of claims.
Claim overpayments	Sign in to **UHCprovider.com/claims** to access the **UnitedHealthcare Provider Portal** Mailing address: **UnitedHealthcare Community Plan** ATTN: Recovery Services P.O. Box 740804 Atlanta, GA 30374-0800	Ask about claim overpayments. See the **Overpayment** section for requirements before sending your request.

Topic	Contact	Information
Client support center	**1-800-249-3114**	Ask about electronic claims submissions (not through Optum Insight).
Dental services (UnitedHealthcare specialty dental benefits)	**1-800-508-4876**	
Electronic Data Intake (EDI) issues	**EDI Transaction Support Form** **UHCprovider.com/edi** **ac_edi_ops@uhc.com** **1-800-210-8315**	Contact EDI Support for issues or questions.
Eligibility	**UHCprovider.com/eligibility** **1-800-600-9007**	Confirm member eligibility.
Enterprise Voice Portal	Connect with us through chat 24/7 in the **UnitedHealthcare Provider Portal**	The Enterprise Voice Portal provides self-service functionality or call steering prior to speaking with a contact center agent.
Fraud, waste and abuse (payment integrity)	Payment integrity information: **UHCprovider.com/PAcommunityplan** > Integrity of Claims, Reports, and Representations to the Government Reporting: **uhc.com/fraud** **1-877-401-9430** (UnitedHealthcare) 1-844-347-8477 (Pennsylvania DHS)	Learn about our payment integrity policies. Report suspected FWA by a care provider or member by phone or online.
Healthy First Steps/ obstetrics (OB) referral	Healthy First Steps® Pregnancy Notification Form at **UHCprovider.com**, then Sign In for the **UnitedHealthcare Provider Portal** **1-800-599-5985** **uhchealthyfirststeps.com**	For pregnant members, contact Healthy First Steps by calling or filling out the online Pregnancy Notification Form. Refer members to **uhchealthyfirststeps.com** to sign up for Healthy First Steps Rewards.
Interactive voice response (IVR) Line	**1-800-600-9007**	Available 24 hours a day, 7 days a week to check member eligibility.
Laboratory services	**UHCprovider.com/findprovider** > **Preferred Lab Network**	Use a preferred lab provider in our network, such as Labcorp or Quest Diagnostics.
Medicaid (Department of Social Services)	1-877-267-2323	Contact Medicaid directly.

Topic	Contact	Information
Medical claim, reconsideration and appeal	**UHCprovider.com/claims** **1-800-600-9007** Most care providers in your state must submit reconsideration requests electronically. For further information on reconsiderations, see the **Reconsiderations and Appeals interactive guide.** For those care providers exempted from this requirement, requests may be submitted at one of the following addresses: Reconsiderations mailing address: **UnitedHealthcare Community Plan** P.O. Box 5240 Kingston, NY 12402-5240 Appeals mailing address: **UnitedHealthcare Community Plan Grievances and Appeals** P.O. Box 31364 Salt Lake City, UT 84131-0364	Claim issues include overpayment, underpayment, payment denial, or an original or corrected claim determination you don't agree with.
Member Services	**myuhc.com®** Member handbook: **UHCCommunityPlan.com/pa/medicaid/community-plan-for-families** > Member Information > Member Handbook in English and Spanish **1-800-414-9025** / TTY **711** for help accessing member account	Assist members with issues or concerns. Available Monday–Friday from 8 a.m. - 5 p.m. ET, and on Wednesdays until 8 p.m. 24 hours, 7 days a week, service is available to assist members with urgent or emergent issues/concerns.

Topic	Contact	Information
Mental health & substance abuse (CHIP members: Optum Behavioral Health; Medicaid members: Behavioral Health Managed Care Organization by county)	**Community Behavioral Health** Philadelphia: 1-888-545-2600 **Community Care Behavioral Health Member Services** Delaware County: 1-833-577-2682 **Community Care Behavioral Health Organization** Chester: 1-866-622-4228 **Magellan Behavioral Health of Pennsylvania** Bucks: 1-877-769-9784 Montgomery: 1-877-769-9782 Optum: **1-866-261-7692**	**UnitedHealthcare Community Plan – Medicaid** Behavioral health services are carved out of the agreement between UnitedHealthcare Community Plan and the Department of Human Services (DHS). Members contact the following organizations at the numbers listed based on the counties they reside in for behavioral health services. **UnitedHealthcare Community Plan for Kids-CHIP** UnitedHealthcare Community Plan contracts with Optum Behavioral Health to provide benefits to UnitedHealthcare Community Plan – CHIP members. Outpatient therapy with a participating care provider does not require prior authorization. Care providers seeking authorization of services can call **1-866-261-7692**.
Multilingual/ Telecommunication Device for the Deaf (TDD) Services	TDD **711**	Available 8 a.m. – 5 p.m. ET, Monday–Friday, except state-designated holidays.
National Plan and Provider Enumeration System (NPPES)	nppes.cms.hhs.gov 1-800-465-3203 Correspondence: NPI Enumerator P.O. Box 6059 Fargo, ND 58108-6059	Apply for a National Provider Identifier (NPI).
Network Management	**Network Management** PO Box 9472 Minneapolis, MN 55440-9472 Phone: **1-800-414-5349** Email: **UHC-Network-WPA@UHC.com**	Ask about Participation Agreement and Network related questions.
Network Management support	Chat with a live advocate, available 7 a.m.-7 p.m. CT at **UHCprovider.com/chat**.	Self-service functionality to update or check credentialing information.

Topic	Contact	Information
NurseLine	**1-844-222-7341 (**HealthChoices**)** **1-877-440-0253 (**CHIP**)** **1-877-440-9407 (**D-SNP**)** **1-866-351-6827**	Available 24 hours a day, 7 days a week.
Oncology prior authorization	**UHCprovider.com/oncology** > Sign In **1-888-397-8129** Monday–Friday, 7 a.m.–7 p.m. CT	View current list of CPT codes that require prior authorization for oncology.
One Healthcare ID support center	Chat with a live advocate, is available 7 a.m.-7 p.m. CT at **UHCprovider.com/chat.** **1-855-819-5909**	Contact if you have issues with your ID. Available 7 a.m. – 9 p.m. CT, Monday-Friday; 6 a.m. – 6 p.m. CT, Saturday; and 9 a.m. – 6 p.m. CT, Sunday.
Pharmacy services	**professionals.optumrx.com** **1-877-305-8952** Pharmacy Help Desk for Pharmacists: **1-888-306-3243**	Optum Rx® oversees and manages our network pharmacies.
Prior authorization/ notification for pharmacy	**UHCprovider.com/pharmacy** **1-800-310-6826**	Request authorization for medications as required. Use the **UnitedHealthcare Provider Portal** l to access the **PreCheck MyScript®** tool. Request prior authorization and receive results, and see which prescriptions require prior authorization or are not covered or preferred. Check coverage and price, including lower-cost alternatives.
Prior authorization requests/advance and admission notification	To notify us or request a medical prior authorization: • EDI: Transactions 278 and 278N • **UHCprovider.com/priorauth** • Call Care Coordination at the number on the member's ID card (self-service available after hours) and select "Care Notifications."	Use the Prior Authorization and Notification Tool online to: • Determine if notification or prior authorization is required. • Complete the notification or prior authorization process. • Upload medical notes or attachments. • Check request status Information and advance notification/ prior authorization lists: **UHCprovider.com/ PAcommunityplan** > **Prior Authorization and Notification.**
Provider Services	**1-800-600-9007**	Available 8 a.m. – 5 p.m. ET, Monday-Friday.

Topic	Contact	Information
Radiology prior authorization	**UHCprovider.com/radiology** > Sign In **1-866-889-8054**	Review or request prior authorization, see basic requirements, guidelines, CPT code list, and more information.
Referrals	**UHCprovider.com/referrals** Provider Services **1-800-600-9007**	Submit new referral requests and check the status of referral submissions.
Reimbursement policy	**UHCprovider.com/PAcommunityplan** > **Policies and Protocols**	Reimbursement policies that apply to UnitedHealthcare Community Plan members. Visit this site often to view reimbursement policy updates.
Enhanced Member Support Unit (EMSU) formerly the Special needs unit	**1-877-844-8844**	Available to assist members and care providers with various special needs issues.
Technical support	For chat options and contact information, visit **UHCprovider.com/contactus** **1-866-209-9320** for Optum support	Contact if you have issues logging in the **UnitedHealthcare Provider Portal**, you cannot submit a form, etc.
Tobacco Free Quit Line	1-800-784-8669	Ask about services for quitting tobacco/ smoking. This toll-free number connects you directly to your state quitline, where trained coaches provide information and help with quitting tobacco.
Transportation (Medicaid only)	Medical Assistance Transportation Program (MATP) for non-emergency transports: Refer to the appendix for phone numbers based on county.	To arrange non-emergent transportation, please contact MATP at least 3 business days in advance.
UnitedHealthcare of Pennsylvania Hearing Impaired Access	Languages Unlimited: 1-800-864-0372 ALS International: 1-800-322-0284	
Utilization management	Provider Services **1-800-310-6826**	UM helps avoid overuse and under-use of medical services by making clinical coverage decisions based on available evidence-based guidelines. For UM policies and protocols, go to **UHCprovider.com/protocols.** Request a copy of our UM guidelines or information about the program.

Topic	Contact	Information
Vaccines for Children (VFC) Program (Medicaid Only)	health.pa.gov 1-888-646-6864 kids.phila.gov (Philadelphia County only) 1-215-685-6728 (Philadelphia County only)	Vaccines are provided free of charge to care providers for Medicaid members 0–18 years old.
Vision services	marchvisioncare.com	Prior authorization is required for all routine eye exams and hardware.
Website for Pennsylvania Community Plan	**UHCprovider.com/pacommunityplan**	Access your state-specific Community Plan information on this website.

Chapter 2: Care provider standards and policies

Key contacts

Topic	Link	Phone number
Provider Services	**UHCprovider.com**	**1-800-600-9007**
General care provider assistance	Connect with us through chat 24/7 in the **UnitedHealthcare Provider Portal**	
Eligibility	**UHCprovider.com/eligibility**	**1-800-600-9007**
Referrals	**UHCprovider.com/referrals**	**1-800-600-9007**
Provider Directory	**UHCprovider.com/findprovider**	**1-800-600-9007**

General care provider responsibilities

Non-discrimination

You can't refuse an enrollment/assignment or disenroll a member or discriminate against them based on:

- Age
- Sex
- Race
- Physical
- Mental handicap
- National origin
- Religion
- Type of illness or condition

You may only direct the member to another care provider type if that illness or condition may be better treated by someone else.

Communication between care providers and members

The UnitedHealthcare Community Plan Agreement is not intended to interfere with your relationship with members as patients or with UnitedHealthcare Community Plan's ability to administer its quality improvement, utilization management (UM) or credentialing programs. Instead, we require communication between PCPs and other participating care providers. This helps ensure UnitedHealthcare Community Plan members receive both quality and cost-effective health services.

UnitedHealthcare Community Plan members and/or their representatives may take part in the planning and implementation of their care. To help ensure members and/or their representatives have this chance, UnitedHealthcare Community Plan requires you:

1. Educate members, and/or their representatives about their health needs.
2. Share findings of history and physical exams.
3. Discuss options (without regard to plan coverage), treatment side effects and symptoms management. This includes any self-administered alternative or information that may help them make care decisions.
4. Recognize members (and/or their representatives) have the right to choose the final course of action among treatment options.
5. Collaborate with the plan care manager in developing a specific care plan for members enrolled in high-risk care management.

Provide official notice

Write to us within 10 calendar days if any of the following events happen:

1. Bankruptcy or insolvency.
2. Indictment, arrest, felony conviction or any criminal charge related to your practice or profession.
3. Suspension, exclusion, debarment or other sanction from a state or federally funded health care program.

4. Loss or suspension of your license to practice.
5. Departure from your practice for any reason.
6. Closure of practice.

Visit **UHCprovider.com/attestation** to view ways to update and verify your provider demographic data.

Transition member care following termination of your participation

If your network participation ends, you must transition your UnitedHealthcare Community Plan members to timely and useful care. This may include providing services for a reasonable time at our in-network rate. **Provider Services** at **1-800-600-9007** is available to help you and our members with the transition.

Arrange substitute coverage

If you cannot provide care and must find a substitute, arrange for care from other UnitedHealthcare Community Plan care providers. For the most current list of network professionals, review our Provider Directory at **UHCprovider.com/findprovider**.

Administrative terminations for inactivity

Up-to-date directories are a critical part of providing our members with the information they need to take care of their health. To accurately list care providers who treat UnitedHealthcare Community Plan members, we:

1. End Agreements with care providers who have not submitted claims for UnitedHealthcare Community Plan members for 1 year and have voluntarily stopped participation in our network.
2. Inactivate any tax identification numbers (TINs) with no claims submitted for 1 year. This is not a termination of the Provider Agreement. Call UnitedHealthcare Community Plan to reactivate a TIN.

Changing an existing TIN or adding a care provider

Visit **UHCprovider.com/attestation** to view ways to update and verify your provider demographic data.

Updating your practice or facility information

You can update your practice information through the **UnitedHealthcare Provider Portal** or access through **UHCprovider.com**. Go to **UHCprovider.com**, then Sign In > My Practice Profile. Or submit your change by:

- Visiting **UHCprovider.com/attestation** to view ways to update and verify your provider demographic data electronically
- Connect with us through chat 24/7 in the **UnitedHealthcare Provider Portal**

After-hours care

Life-threatening situations require the immediate services of an emergency department. Urgent care can provide quick after-hours treatment and is appropriate for infections, fever, and symptoms of cold or flu.

If a member calls you after hours and you can't fit them in your schedule, refer them to the appropriate level of care.

Participate in quality initiatives

You must help our quality assessment and improvement activities. You must also follow our clinical guidelines, member safety (risk reduction) efforts and data confidentiality procedures.

UnitedHealthcare Community Plan clinical quality initiatives are based on optimal delivery of health care for diseases and conditions. This is determined by United States government agencies and professional specialty societies. See **Chapter 10** for more details on the initiatives.

Provide access to your records

You must provide access to any medical, financial or administrative records related to services you provide to UnitedHealthcare Community Plan members within 14 calendar days of our request. We may request you respond sooner for cases involving alleged fraud and abuse, a member grievance/appeal, or a regulatory or accreditation agency requirement. Maintain these records for 6 years or longer if required by applicable statutes or regulations.

Performance data

You must allow the plan to use care provider performance data.

Comply with protocols

You must comply with the UnitedHealthcare Community Plan and payer's protocols, including those contained in this care provider manual.

You may view protocols at **UHCprovider.com/protocols.**

Office hours

You must provide the same office hours of operation to UnitedHealthcare Community Plan members as those offered to commercial members.

Protect confidentiality of member data

UnitedHealthcare Community Plan members have a right to privacy and confidentiality of all health care data. We only give confidential information to business associates and affiliates who need that information to improve our members' health care experience. We require our associates to protect privacy and abide by privacy law. If a member requests specific medical record information, we will refer the member to you. You agree to comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and associated regulations. In addition, you will comply with applicable state laws and regulations.

UnitedHealthcare Community Plan uses member information for treatment, operations and payment. UnitedHealthcare Community Plan has safeguards to stop unintentional disclosure of protected health information (PHI). This includes passwords, screen savers, firewalls and other computer protection. It also includes shredding information with PHI and all confidential conversations. All staff is trained on HIPAA and confidentiality requirements.

Follow medical record standards

Please reference **Chapter 9** for **medical record standards**.

Inform members of advance directives

The federal Patient Self-Determination Act (PSDA) gives patients the legal right to make choices about their medical care before incapacitating illness or injury through an advance directive. Under the federal act, you must provide written information to members on state laws about advance treatment directives, members' right to accept or refuse treatment, and your own policies regarding advance directives. To comply with this requirement, we inform members of state laws on advance directives through Member Handbooks and other communications.

Your Agreement

If you have a concern about your Agreement with us, send a letter with the details to the address in your contract. A representative will look into your complaint. If you disagree with the outcome, you may file for arbitration. If your concern relates to certain UnitedHealthcare Community Plan procedures, such as the credentialing or care management process, follow the dispute procedures in your Agreement. After following those procedures, if one of us remains dissatisfied, you may file for arbitration.

If we have a concern about your Agreement, we'll send you a letter containing the details. If we can't resolve the complaint through informal discussions, you may file an arbitration proceeding as described in your Agreement. Your Agreement describes where arbitration proceedings are held.

If a member asks to appeal a clinical or coverage determination on their behalf, follow the appeal process in the member's benefit contract or handbook. You may locate the Member Handbook at **UHCCommunityPlan.com**.

Also reference **Chapter 12** for information on care provider claim reconsiderations, appeals and grievances.

Reportable conditions

As a licensed Pennsylvania medical care provider, you must follow guidelines for reportable conditions found on the Pennsylvania Bulletin at pacodeandbulletin.gov. Follow these when you identify a patient with any diagnosis on the list located at https://www.pa.gov/en/agencies/health/healthcare-and-public-health-professionals/reportable-diseases.html.

To report these conditions electronically, go to health.pa.gov/topics/Reporting-Registries/Pages/PA-NEDSS.aspx.

If you have questions related to this requirement, call the Enhanced Member Support Unit (EMSU) formerly the Special Needs Unit hotline at **1-877-844-8844**.

Appointment standards (PA DHS access and availability standards)

Comply with the following appointment availability standards:

Primary care

PCPs should arrange appointments for:

- After-hours care phone number: 24 hours, 7 days a week
- Emergency care: Immediately or referred to an emergency facility
- Urgent care appointment: within 24 hours
- Routine care appointment: within 10 business days
- EPSDT/Bright Futures appointments: within 45 days of enrollment
- Health assessments, general physical exams and first exams: within 3 weeks of enrollment
- New members with HIV or AIDS: within 7 days of enrollment
- New Supplemental Security Income (SSI) members: within 45 days of enrollment
- In-office waiting for appointments: not to exceed 1 hour of the scheduled appointment time

Specialty care

Specialists should arrange appointments for:

- Urgent care: within 24 hours of request
- Routine care: within 10 business days of referral
- New members who have HIV or AIDS: within 7 days of enrollment unless the member is under active care of the specialist
- New SSI members: within 45 days of enrollment unless the member is already under the active care of the specialist

Prenatal care

Prenatal care providers should arrange OB/GYN appointments for:

- After-hours care: Obstetricians are expected to respond to calls within 30-45 minutes for non-emergent symptomatic conditions and within 15 minutes for crisis situations
- High-risk pregnancies: within 24 hours of identification of high-risk status or immediately if an emergency exists
- First trimester: within 10 business days
- Second trimester: within 5 business days
- Third trimester: within 4 business days

UnitedHealthcare Community Plan periodically conducts surveys to check appointment availability and access standards. All care providers must participate in all activities related to these surveys.

Provider Directory

You are required to tell us, within 5 business days, if you can no longer accept new patients to prevent any Provider Directory inaccuracy. Ask the potential new patient to contact UnitedHealthcare Community Plan for additional help finding a care provider.

We are required to contact all participating care providers annually and independent physicians every 6 months. We require you to confirm your information is accurate or provide us with applicable changes.

We allow you up to 45 business days to contact us. If you don't, we notify you that if you continue to be nonresponsive, we will remove you from our directory after 10 business days.

If we receive notification the information is inaccurate, you may be subject to corrective action.

In addition to outreach for annual or bi-annual attestations, we reach out if we receive a report of incorrect care provider information. We are required to confirm your information. To help ensure we have your most current information:

- Delegated care providers – submit changes to your designated submission pathway
- Non-delegated care providers – visit **UHCprovider.com/attestation** to view ways to update and verify your provider demographic data

Find the medical, dental and mental health care provider directory at **UHCprovider.com/findprovider**.

Care provider attestation

Confirm your data every quarter through the **UnitedHealthcare Provider Portal** or by calling **Provider Services** at **1-800-600-9007**. If you have received the upgraded My Practice Profile and have editing rights, access the **UnitedHealthcare Provider Portal** for My Practice Profile to make many of the updates required in this section.

When you submit demographic updates, list only those addresses where a member may make an appointment and see the health care provider. On-call and substitute health care providers who are not regularly available to provide covered services at an office or practice location should not be listed at that address.

Prior authorization request

Prior authorization is the process of requesting approval from UnitedHealthcare Community Plan to cover costs. Prior authorization requests may include procedures, services, and/or medication.

Coverage may only be provided if the service or medication is deemed medically necessary, or meets specific requirements provided in the benefit plan.

You should take the following steps before providing medical services and/or medication to UnitedHealthcare Community Plan members:

- Verify eligibility using the **UnitedHealthcare Provider Portal** or by calling **Provider Services** at **1-800-600-9007**. Not doing so may result in claim denial.
- Check the member's ID card each time they visit. Verify against photo identification if this is your office practice.
- Get prior authorization:
  1. To access the Prior Authorization app, go to **UHCprovider.com**, then click Sign In.
  2. Select the **Prior Authorization and Notification app.**
  3. View notification requirements.

Identify and bill other insurance carriers when appropriate.

You can obtain prior authorization by calling **1-800-600-9007** Monday-Friday, 8 a.m. - 5 p.m. ET.

For any discharge or urgent needs, call **1-800-600-9007**.

Identify and bill other insurance carriers when appropriate.

If you have questions on the **UnitedHealthcare Provider Portal** see chat options and contact information between 7 a.m.– 9 p.m. ET, Monday-Friday.

Requirements for primary care provider and specialists serving in primary care provider role

Specialties include internal medicine, pediatrics or obstetrics/gynecology

Primary care provider's (PCPs) are an important partner in the delivery of care, and PA Department of Human Services (DHS) members may seek services from any participating care provider. The Pennsylvania DHS program requires members be assigned to PCPs. We encourage members to develop a relationship with a PCP who can maintain all their medical records and provide overall medical management. These relationships help coordinate care and provide the member a "medical home."

The PCP plays a vital role as a case manager in the UnitedHealthcare Community Plan system by improving health care delivery in 4 critical areas: access, coordination, continuity and prevention. As such, the PCP manages initial and basic care to members, makes recommendations for specialty and ancillary care, and coordinates all primary care services delivered to our members. The PCP must provide 24 hours a day, 7 days a week coverage and backup coverage when they are not available.

Medical doctors (MDs), doctors of osteopathy (DOs), nurse practitioners (NPs) and physician assistants (PAs) from any of the following practice areas can be PCPs:

- General practice
- Internal medicine
- Family practice
- Pediatrics
- Obstetrics/gynecology

NPs may enroll with the state as solo providers, but PAs cannot. They must be part of a group practice.

Members may change their assigned PCP by contacting **Member Services**.

Customer service is available 7 a.m.–7 p.m. ET, Monday–Friday.

We ask members who don't select a PCP during enrollment to select one. UnitedHealthcare Community Plan may auto-assign a PCP to complete the enrollment process.

Females have direct access (without a referral or authorization) to any OB/GYNs, midwives, PAs, or NPs for women's health care services and any non-women's health care issues discovered and treated in the course of receiving women's health care services. This includes access to ancillary services ordered by women's health care providers (lab, radiology, etc.) in the same way these services would be ordered by a PCP.

UnitedHealthcare Community Plan works with members and care providers to help ensure all members understand, support, and benefit from the primary care case management system. The coverage will include availability of 24 hours a day, 7 days a week. During non-office hours, access by phone to a live voice (i.e., an answering service, care provider on-call, hospital switchboard, PCP's nurse triage) will immediately page an on-call medical professional so referrals can be made for non-emergency services. **Recorded messages are not acceptable.**

Consult with other appropriate care providers to develop individualized treatment plans for our members with special health care needs.

- Use lists supplied by the UnitedHealthcare Community Plan identifying members who appear to be due preventive health procedures or testing
- Submit all accurately coded claims or encounters timely
- Provide all well-baby/well-child services
- Coordinate each UnitedHealthcare Community Plan member's overall course of care
- Accept UnitedHealthcare Community Plan members at your primary office location at least 20 hours a week for a 1 MD practice and at least 30 hours per week for a 2 or more MD practice
- Be available to members by telephone any time
- Tell members about appropriate use of emergency services
- Discuss available treatment options with members

Responsibilities of primary care providers and specialists serving in primary care provider role

Specialties include internal medicine, pediatrics or obstetrics/gynecology

In addition to meeting the requirements for all care providers, PCPs must:

- Offer office visits on a timely basis, according to the standards outlined in the Timeliness Standards for Appointment Scheduling section of this guide
- Conduct a baseline examination during the UnitedHealthcare Community Plan member's first appointment
- Treat UnitedHealthcare Community Plan members' general health care needs, using nationally recognized clinical practice guidelines
- Refer services requiring prior authorization to Provider Services or our Clinical or Pharmacy departments as appropriate
- Admit UnitedHealthcare Community Plan members to the hospital when necessary. Coordinate their medical care while they are hospitalized.
- Respect members' advance directives. Document in a prominent place in the medical record whether a member has an advance directive form.
- Provide covered benefits consistently with professionally recognized standards of health care and in accordance with UnitedHealthcare Community Plan standards. Document procedures for monitoring members' missed appointments as well as outreach attempts to reschedule missed appointments.
- Transfer medical records upon request, providing copies of medical records to members upon request at no charge
- Allow timely access to UnitedHealthcare Community Plan member medical records per contract requirements. Purposes include medical record keeping audits, HEDIS or other quality measure reporting, and quality of care investigations. Such access does not violate HIPAA.
- Maintain a clean and structurally sound office that meets applicable Occupational Safety and Disabilities (ADA) standards

- Comply with the PA DHS Access and Availability standards for scheduling emergency, urgent care and routine visits. Appointment Standards are covered in Chapter 2 of this manual.

Primary care provider checklist

- Verify eligibility and benefits on the **UnitedHealthcare Provider Portal**, or call **Provider Services** at **1-800-600-9007**
- Check the member's ID card at the time of service. Verify member with photo identification. Plan participating specialists when needed.
- Get prior authorization from UnitedHealthcare Community Plan, if required. Visit **UHCprovider.com/priorauth.**
- Refer patients to UnitedHealthcare Community Plan care providers
- Identify and bill other insurance carriers when appropriate
- Bill all services provided to a UnitedHealthcare Community Plan member either electronically or on a CMS 1500 claim form

Rural health clinic, federally qualified health center or primary care clinic as primary care provider

Members may choose a rural health clinic (RHC), a federally qualified health center (FQHC) or a primary care clinic (PCC) as their PCP.

- **Rural Health Clinic:** The RHC program helps increase access to primary care services for Medicaid and Medicare members in rural communities. RHCs can be public, nonprofit or for-profit health care facilities. They must be located in rural, underserved areas.
- **Federally Qualified Health Center:** An FQHC is a center or clinic that provides primary care and other services. These services include:
  - Preventive (wellness) health services from a PA, NP, social worker or other care provider.
  - Mental health services
  - Immunizations (shots)
  - Home nurse visits
- **Primary Care Clinic:** A PCC is a medical facility focusing on the initial treatment of medical ailments. In most cases, the conditions seen at the clinic are not serious or life threatening. If a condition is discovered at a primary care clinic that may be dangerous, the PCC may refer the member to a specialist. Doctors at these clinics are usually internists, family physicians and pediatricians.

Specialist responsibilities

In addition to applicable requirements for all care providers, specialists must:

- Contact the PCP to coordinate the care/services
- Provide specialty care medical services to UnitedHealthcare Community Plan members recommended by their PCP or who self-refer
  - Members can self-refer for in-network:
    - Dental
    - Vision
    - OB/GYN
    - Chiropractor care
  - Members can self-refer to any qualified care provider or facility for:
    - Family planning
    - Emergency services
- Verify the eligibility of the member before providing covered specialty care services
- Provide only those covered specialty care services, unless otherwise authorized
- Provide the PCP copies of all medical data, reports and discharge summaries resulting from the specialist's care
- Note all findings and recommendations in the member's medical record. Share this information in writing with the PCP.
- Maintain staff privileges at 1 UnitedHealthcare Community Plan participating hospital at a minimum
- Report infectious diseases, lead toxicity and other conditions as required by state and local laws
- Comply with the Pennsylvania DHS Access and Availability standards for scheduling routine visits. Appointment standards are covered in Chapter 2 of this manual.
- Provide anytime coverage. PCPs and specialists serving in the PCP must have arrangements for phone coverage by another UnitedHealthcare Community Plan participating PCP or obstetrician. UnitedHealthcare Community Plan tracks and follows up on all instances of PCP or obstetrician unavailability.

Specialists may use medical residents in all specialty care settings under the supervision of fully credentialed UnitedHealthcare Community Plan specialty attending care providers.

UnitedHealthcare Community Plan also conducts periodic access surveys to monitor for after-hours access. PCPs and obstetricians serving in the PCP role must take part in all survey-related activities.

Ancillary care provider responsibilities

Ancillary providers include freestanding radiology, freestanding clinical labs, home health, hospice, dialysis, durable medical equipment, infusion care, therapy, ambulatory surgery centers, freestanding sleep centers and other non-care providers. PCPs and specialists must use the UnitedHealthcare Community Plan ancillary network.

UnitedHealthcare Community Plan participating ancillary providers should maintain sufficient facilities, equipment, and personnel to provide timely access to medically necessary covered services.

Ancillary care provider checklist

- Verify eligibility and benefits on the **UnitedHealthcare Provider Portal**, or call **Provider Services** at **1-800-600-9007**
- Check the member's ID card at the time of service. Verify member with photo identification.
- Get prior authorization from UnitedHealthcare Community Plan, if required. Visit **UHCprovider.com/priorauth.**
- Identify and bill other insurance carriers when appropriate

Chapter 3: Care provider office procedures

Key contacts

Topic	Link	Phone number
Member benefits	**UHCCommunityPlan.com/PA**	**1-800-414-9025**
Member handbook	**UHCCommunityPlan.com/pa/medicaid/community-plan-for-families** > Member Information > Member Handbook in English and Spanish	
Provider Services	**UHCprovider.com**	**1-800-600-9007**
Prior authorization	**UHCprovider.com/priorauth**	**1-800-600-9007**
D-SNP	**UHCprovider.com/PA** > Medicare > **Dual Complete® Special Needs Plans**	**1-800-600-9007**

Member benefits

View member benefit coverage information online at **UHCprovider.com/eligibility**. Members may also access **UHCCommunityPlan.com/PA** for benefits. The following benefits are not all-inclusive.

Find medical policies and coverage determination guidelines on **UHCprovider.com/PAcommunityplan** > Policies and Clinical Guidelines.

*Copayments are only applicable to CHIP members enrolled in low cost or full cost CHIP	**Community Plan for Families Medical Assistance: No copayments**		**UnitedHealthcare Community Plan for Kids Children's Health Insurance Program: Copayments may apply***
Services	**Children**	**Adults**	**CHIP plan**
Abortions	Covered. Must meet current federal and state guidelines and be medically necessary.		Covered. Must meet current federal and state guidelines and be medically necessary.
Allergy testing	Covered.		Covered.
Audiology	Covered.		Covered. 1 routine hearing and audiometric examination per calendar year. One hearing aid or device per ear every 2 calendar years. No limit on the purchase of hearing aids or devices. Copayments apply only when services are rendered by a specialist provider.
Autism services	Covered.		Copays may apply to some services. No limit.

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Services	**Children**	**Adults**	**CHIP plan**
Ambulance services (emergency)	Covered.		Covered.
Ambulatory surgical centers (ASCs)	Covered. May require prior authorization. Depends on service.		Covered. Some services may require prior authorization.
Birth control services	Covered.		Covered.
Blood & blood plasma	Covered.		Covered.
Bone mass measurement (bone density)	Covered.		Covered.
Chemotherapy	Covered.		Covered.
CRNP	Covered.		Covered.
Crisis support	Please contact your Behavioral Health Managed Care Organization (see the end of Chapter 3)		Covered.
Chiropractic services	Covered.		Covered; limited to 20 visits per calendar year.
Colorectal screening exams	Covered.		Covered.
Cosmetic services	Not covered.		Not covered.
Custodial services	Not covered.		Not covered.

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Services	**Children**	**Adults**	**CHIP plan**
Dental services	Covered. Prior authorization needed for some services.	Covered. Prior authorization needed for some services. Key Limitations: • Dentures: 1 per lifetime • Exams/prophylaxis: 1 per 180 days • Crowns, periodontics and endodontics: Only via approved benefit limit exception	No lifetime maximum. Requires prior authorization and proof of medical necessity to be covered. To find a dental provider, go to **UHCprovider.com/findprovider** > Dental Providers by state.
Diabetic education, home visits & monitoring	Covered.		Covered.
Diabetic supplies & equipment	Covered.		Covered.
Durable medical equipment	Covered. Prior authorization needed if over $500.		Covered; some services may require prior authorization. No Limit.
Emergency services	Covered.		Covered. Copays may apply to some services.
EPSDT/Bright Futures services & immunizations (younger than age 21)	Covered.	Not covered.	Covered.

*Copayments are only applicable to CHIP members enrolled in low cost or full cost CHIP	Community Plan for Families Medical Assistance: No copayments		UnitedHealthcare Community Plan for Kids Children's Health Insurance Program: Copayments may apply*
Services	**Children**	**Adults**	**CHIP plan**
Eyeglasses/ contact lenses*	Daily-wear contacts or standard glasses (in-plan frames). **Frames and lenses:** Members under age 21 are covered for 4 lenses and 2 frames per year. Regular single vision, bifocal or trifocal lenses. Polycarbonate lenses: Covered. In-plan frames are covered in full. Out-of-plan frames are covered up to $20; member must pay cost over $20. **Contact lenses:** 1 pair soft daily wear contacts or medically necessary contact covered in lieu of glasses, including contact lens exam/ evaluation. Medically necessary contact lenses are covered when such lenses provide better management of a visual or ocular condition than can be achieved with spectacle lenses, including, but not limited to the diagnosis of: Unilateral Aphakia; or Keratoconus when vision with glasses is less than 20/40; or Corneal transplant when vision with glasses is less than 20/40; or Anisometropia that is greater than or equal to 4.00 diopter. Medically necessary exceptions can be made for children under 21.	Daily-wear contacts or standard glasses (in-plan frames). **Frames and lenses:** Members age 21 and over are covered for 2 lenses and 1 frame per year. Regular single vision, bifocal or trifocal lenses. Polycarbonate lenses: Covered for adults who are blind in 1 eye and +/-6.00 prescription. In-plan frames are covered in full. Out-of-plan frames are covered up to $20; member must pay cost over $20. **Contact lenses:** 1 pair soft daily wear contacts or medically necessary contacts covered in lieu of glasses, including contact lens exam/ evaluation. Medically necessary contact lenses are covered when such lenses provide better management of a visual or ocular condition than can be achieved with spectacle lenses, including, but not limited to the diagnosis of: Unilateral Aphakia; or Keratoconus when vision with glasses is less than 20/40; or Corneal transplant when vision with glasses is less than 20/40; or Anisometropia that is greater than or equal to 4.00 diopter.	**Frames and lenses:** 1 set of eyeglass lenses may be plastic or glass, single vision, bifocal, trifocal, lenticular lens powers and/or oversize lenses, fashion and gradient tinting, oversized glass-grey #3 prescription sunglass lenses, polycarbonate prescription lenses with scratch resistance coating and low-vision items. **Frequency of eye exam:** 1 routine examination and refraction every 12 months. Includes dilation, if professionally indicated. No cost to member In-Network. Out-of-Network – no coverage*. **Frequency of lens and frame replacement:** 1 pair of eyeglasses every 12 months, when medically necessary for vision correction. **Lenses:** In-Network – 1 pair covered in full every 12 months. Out-of-Network – no coverage.* **Frames:** In-plan frames are available at no cost to member. Non-plan frames: Expenses in excess of $130 allowance payable by member. Additionally, a discount of 20% is available for amounts over $130.** Out-of-Network – No coverage.* Replacement of lost, stolen, broken frames and lenses (1 original and 1 replacement per calendar year, when deemed medically necessary).

*Copayments are only applicable to CHIP members enrolled in low cost or full cost CHIP	Community Plan for Families Medical Assistance: No copayments		UnitedHealthcare Community Plan for Kids Children's Health Insurance Program: Copayments may apply*
Services	**Children**	**Adults**	**CHIP plan**
Eyeglasses/ contact lenses* (continued)			**Contact lenses:** 1 prescription every 12 months – in lieu of eyeglasses when medically necessary for vision correction. Additionally, a discount of 15% is available for amounts over $130.** In some instances, participating providers charge separately for the evaluation, fitting, or follow-up care relating to contact lenses. Should this occur and the value of the contact lenses received is less than the allowance, the difference up to the $130 allowance may be applied toward the cost of evaluation, materials, fitting and follow-up care. You will be responsible for any amounts over $130. *Out-of-Network exclusion only applies if child is in their coverage area at time of eyeglass/contact replacement. If child is unexpectedly out of the area, e.g., vacation, and they need replacement contacts or eyeglasses, their expenses can be sent to the plan for reimbursement. Expenses in excess of $600 for medically necessary contact lenses, with pre-approval. These conditions include: Aphakia, pseudophakia or keratoconus, if the patient has had cataract surgery or implant, or corneal transplant surgery, or if visual activity is not correctable to 20/40 in the worse eye by use of spectacle lenses in a frame but can be improved to 20/40 in the worse eye by use of contact lenses. **Low vision:** 1 comprehensive low-vision evaluation every 5 years, with a maximum charge of $300; maximum low-vision aid allowance of $600 with a lifetime maximum of $1,200 for items such as high-power spectacles, magnifiers and telescopes; and follow-up care – 4 visits in any 5-year period, with a maximum charge of $100 per visit. Providers will obtain the necessary pre-authorization for these services.

*Copayments are only applicable to CHIP members enrolled in low cost or full cost CHIP	Community Plan for Families Medical Assistance: No copayments		UnitedHealthcare Community Plan for Kids Children's Health Insurance Program: Copayments may apply*
Services	**Children**	**Adults**	**CHIP plan**
Federally qualified health center/ rural health clinic	Covered.	Covered (except from dental services as defined above).	Covered.
Family planning	Covered.		Covered.
Gender confirmation services	Covered; prior authorization needed for some services. Members under the age of 18 may not be eligible for some surgical treatments.	Covered; prior authorization needed for some services	Covered; prior authorization needed for some services.
Hearing exams	Covered.		1 routine hearing and audiometric examination per calendar year. Copayments apply when services are rendered by a specialist provider.
Hearing aids & batteries	Covered. Prior authorization needed.	Not covered.	One hearing aid or device per ear every 2 calendar years. No cost limit.
HIV/AIDS testing	Covered.		Covered.
Home assessment	Covered. Prior authorization needed.		Covered.
Home adaptation	Not covered.		Not covered.
Home delivered meals	Not covered.		Not covered.
Home health care & infusion therapy	Covered. Prior authorization needed.	Unlimited first 28 days; 15 days per month following.	Covered. Some services may require prior authorization.
Hospice care	Covered.	Covered. Respite care may not exceed a total of 5 days in a 60-day certification period.	Covered. Some services may require prior authorization.
Immunizations	Covered.		Covered.
Incontinence supplies	Covered.		Covered.

*Copayments are only applicable to CHIP members enrolled in low cost or full cost CHIP	Community Plan for Families Medical Assistance: No copayments		UnitedHealthcare Community Plan for Kids Children's Health Insurance Program: Copayments may apply*
Services	**Children**	**Adults**	**CHIP plan**
Independent clinic	Covered.		Covered.
Infertility	Not covered.		Not covered.
Inpatient drug and alcohol	Please contact your Behavioral Health Managed Care Organization (see the end of Chapter 3)		Covered. No Limit. No referral needed. Some services may require prior authorization, or be subject to notification and concurrent reviews.
Inpatient acute hospital	Covered. Prior authorization needed for non-emergent admission.		Covered. No Limit. Some services may require prior authorization, or be subject to notification and concurrent reviews.
Inpatient rehabilitation hospital	Covered. Prior authorization needed.		Covered. No Limit. Some services may require prior authorization, or be subject to notification and concurrent reviews.
Inpatient psychiatric hospital	Please contact your Behavioral Health Managed Care Organization (see the end of Chapter 3)		Covered. No limit. No referral needed. Some services may require prior authorization, or be subject to notification and concurrent reviews.
Intermediate care facility (IID/ORC)	Please contact your Behavioral Health Managed Care Organization (see the end of Chapter 3)		Covered.
Lab tests & X-rays**	Covered.		Covered. Some services may require prior authorization.
Mammograms	Covered.		Covered.
Maternity services	Covered.		Covered.
Mobile mental health treatment	Please contact your Behavioral Health Managed Care Organization (see the end of Chapter 3)		Covered.
Medical supplies	Covered.		Covered.
Methadone maintenance	Please contact your Behavioral Health Managed Care Organization (see the end of Chapter 3)		Covered.

*Copayments are only applicable to CHIP members enrolled in low cost or full cost CHIP	**Community Plan for Families Medical Assistance: No copayments**		**UnitedHealthcare Community Plan for Kids Children's Health Insurance Program: Copayments may apply***
Services	**Children**	**Adults**	**CHIP plan**
Non-emergency medical transport	Covered. Some services provided by **Medical Assistance Transportation Program**.	Covered. Some services provided by **Medical Assistance Transportation Program**.	Not covered.
Nutritional supplements	Covered.		Covered. Includes medical foods.
Optometrist services	Covered. Eyeglass or contact lens exams: 2 each year.		Covered. One every 12 months. Additional exams are covered if medically necessary.
Outpatient drug and alcohol services	Please contact your Behavioral Health Managed Care Organization (see the end of Chapter 3)		Covered. No Limit.
Outpatient hospital clinic	Covered.		Covered.
Outpatient psychiatric clinic	Please contact your Behavioral Health Managed Care Organization (see the end of Chapter 3)		Covered.
Organ transplant evaluation	Covered. Prior authorization needed.		Covered.
Orthodontia	Covered. Prior authorization needed.	Not covered	Covered. No annual maximum. Some services will require prior authorization and proof of medical necessity in order to be covered. Some services may be limited based upon age or quantity.
Orthopedic shoes	Covered.		Covered.
Pain clinic services	Covered. May require prior authorization. Depends on service.	Covered. May require prior authorization. Depends on service.	Covered.
Pap smears & pelvic exams	Covered.		Covered.

*Copayments are only applicable to CHIP members enrolled in low cost or full cost CHIP	Community Plan for Families Medical Assistance: No copayments		UnitedHealthcare Community Plan for Kids Children's Health Insurance Program: Copayments may apply*
Services	**Children**	**Adults**	**CHIP plan**
Personal emergency response systems	Not covered.		Not covered.
Peer support	Please contact your Behavioral Health Managed Care Organization		Not covered.
Care provider office visits (including medical/surgical services provided by a dentist)	Covered.		Covered. No limit.
Podiatrist services: Medically necessary, routine & preventive	Covered. May require prior authorization. Depends on service.		Excluded, except as necessary for the treatment of diabetes or medically necessary due to severe peripheral vascular disease.
Prescription drugs	Covered.		Covered, copays may apply.
Primary care provider	Covered.		Covered. No copay required for Well Child visits.
Preventive services	Covered.		Covered.
Private duty nursing	Covered. Prior authorization needed.	Not covered.	Not covered.
Prostate cancer screenings	Covered.		Covered.
Prosthetics and orthotics	Covered. Prior authorization needed for items with a value greater than $500.00.	Covered. Prior authorization needed for items with a value greater than $500.00. Orthopedic Shoes and Hearing Aids are not covered. Coverage for low vision aids is limited to 1 per 2 calendar years. Coverage for an eye ocular is limited to 1 per calendar year.	Covered. Limits may apply.

*Copayments are only applicable to CHIP members enrolled in low cost or full cost CHIP	Community Plan for Families Medical Assistance: No copayments		UnitedHealthcare Community Plan for Kids Children's Health Insurance Program: Copayments may apply*
Services	**Children**	**Adults**	**CHIP plan**
Psychiatric partial hospital	Please contact your Behavioral Health Managed Care Organization (see the end of Chapter 3)		Covered.
Radiation therapy	Covered.		Covered.
Radiology scans (PET, MRI, MRA, CT)	Covered. Prior authorization needed.		Covered.
Renal dialysis (kidney treatment)	Covered.	Initial training for home dialysis is limited to 24 sessions per patient per calendar year. Backup visits to the facility limited to no more than 75 per calendar year.	Covered.
Reproductive health (procedures & devices)	Covered.		Covered.
Residential treatment facility (non-hospital residential D&A)	Please contact your Behavioral Health Managed Care Organization (see the end of Chapter 3).		Covered. No limit. Some services may require prior authorization, or be subject to notification and concurrent reviews.
Second opinions (medical & surgical)	Covered.		Covered.
Short procedure unit (SPU)	Covered. May require prior authorization. Depends on service.		Covered.
Skilled nursing care (home visits)	Covered. Prior authorization needed.	Covered. Prior authorization needed. Limits may apply.	Covered. Limits may apply.
Skilled nursing facility	Covered. Prior authorization needed.		Covered. Some services may require prior authorization, or be subject to notification and concurrent reviews.
Targeted case management – behavioral health	Please contact your Behavioral Health Managed Care Organization (see the end of Chapter 3). Limited to individuals identified in the target group.		Limited to individuals identified in the target group.

*Copayments are only applicable to CHIP members enrolled in low cost or full cost CHIP	Community Plan for Families Medical Assistance: No copayments		UnitedHealthcare Community Plan for Kids Children's Health Insurance Program: Copayments may apply*
Services	**Children**	**Adults**	**CHIP plan**
Targeted case management – other than behavioral health	Covered. Limited to individuals identified in the target group.		Limited to individuals identified in the target group.
Transportation help	Available to and from MA covered services. See information under **Medical Assistance Transportation Program in Appendix C**.		Not covered.
Tobacco cessation counseling	Covered.		Covered.
Therapy (physical, occupational, speech (PT, OT, ST)) (includes rehabilitative and habilitative)	Covered.	Covered. Only when provided by a hospital, outpatient clinic, or home health provider.	Covered. **Physical Therapy** – limited to 30 visits per year combined rehabilitative and habilitative. **Speech Therapy** – limited to 30 visits per year combined rehabilitative and habilitative. **Occupational Therapy** – limited to 30 visits per year combined rehabilitative and habilitative.
Urgent care	Covered.		Covered. Copays may vary depending on the facility where services are provided.

Exceptions to the medical assistance adult benefit limits

Exceptions can be granted if:

- The member has a serious chronic illness or health condition and without the additional service, their life would be in danger; or
- The member has a serious chronic illness or health condition and without the additional service, their health would get much worse; or
- The member would need more expensive services if the exception was not granted; or,
- It would be against the law to deny the service.

For details on submitting benefit limit exception requests for dental benefits, please call **1-800-508-4876**.

Assignment to primary care provider panel roster

Once a member is assigned a PCP, view the panel rosters electronically by signing into the **UnitedHealthcare Provider Portal**.

Each month, PCP panel size is monitored by reviewing PCP to member ratio reports. When a PCP's panel approaches the max limit, we remove it from auto-assignment. The state requires PCPs to send notice when their panels reach 85% capacity. To update the PCP panel limits, send a written request.

1. Go to **UHCprovider.com.**
2. Select Sign In on the top right.
3. Log in.
4. Click on Community Care.

The Community Care Roster has member contact information, clinical information to include HEDIS measures/Gaps in Care, is in an Excel format with customizable field export options, and can be pulled at the individual practitioner or TIN level. You may also use **Document Library** for member contact information in a PDF at the individual practitioner level.

View the **Document Library Interactive User Guide** to see the basic steps you'll take to access letters and secure reports.

Choosing a primary care provider

Each enrolled UnitedHealthcare Community Plan member either chooses or is assigned a PCP. The assignment considers the distance to the PCP, the PCP's capacity and if the PCP is accepting new members. UnitedHealthcare Community Plan will assign members to the closest and appropriate PCP.

Depending on the member's age, medical condition and location, the choice of PCP may cover a variety of practice areas, such as family practice, general practice, internal medicine, pediatrics and obstetrics. If the member changes the initial PCP assignment, the effective date will be the day the member requested the change. If a member asks UnitedHealthcare Community Plan to change the PCP at any other time, the change will be effective on the request date.

Copayments

There are no co-payments for UnitedHealthcare Community Plan of Pennsylvania Medicaid members.

Co-payments may apply for some services for UnitedHealthcare Community Plan of Pennsylvania CHIP members enrolled in low cost, or full cost CHIP.

Member assignment

Assignment to UnitedHealthcare Community Plan

PA DHS assigns eligible members to UnitedHealthcare Community Plan daily. We manage the member's care on the date the member is enrolled until the member is disenrolled from UnitedHealthcare Community Plan. PA DHS makes disenrollment decisions, not UnitedHealthcare Community Plan. Disenrollment usually takes effect at month's end, but at times may occur mid-month.

At enrollment time, each member receives a welcome packet that includes a copy of the UnitedHealthcare Community Plan Member Handbook. The handbook explains the member's health care rights and responsibilities through UnitedHealthcare Community Plan.

Download a copy of the Member Handbook at **UHCCommunityPlan.com** or call **Provider Services** at **1-800-600-9007**.

Immediate enrollment changes

Immediate enrollment into managed care means the responsible payer for members, including newborns, may change from fee for service (FFS) to Medicaid Managed Care during hospitalization. To avoid delays in claims processing and payment, have the payer assignment of newborns checked daily.

Get eligibility information by calling **Provider Services** at **1-800-600-9007**.

Unborn enrollment changes

Encourage your members to notify the PA DHS when they know they are expecting. DHS notifies Managed Care Organizations (MCOs) daily of an unborn when PA Medicaid learns a woman associated with the MCO is expecting. The MCO or you may use the online change report through the PA website to report the baby's birth. With that information, DHS verifies the birth through the mother. The MCO and/or the care provider's information is taken as a lead. To help speed up the process, the mother should notify DHS when the baby is born.

Newborns may get UnitedHealthcare Community Plan-covered health services beginning on their date of birth. Check eligibility daily until the mother has enrolled her baby in a managed care plan.

Primary care provider selection

Although unborn children cannot be enrolled with an MCO until birth, ask your members to select and contact a PCP for their baby prior to delivery. This will help avoid the delays and confusion that can occur with deferred PCP selections.

UnitedHealthcare Community Plan members can go to **myuhc.com/communityplan** to look up a care provider.

Member eligibility

UnitedHealthcare Community Plan serves members enrolled with Pennsylvania's DHS, the state's Medicaid program. The DHS determines program eligibility. An individual who becomes eligible for the DHS program either chooses or is assigned to one of the DHS-contracted health plans.

Member ID card

The member should present their member ID card whenever seeking UnitedHealthcare Community Plan covered services. Medicaid members should also present their Pennsylvania ACCESS card. No member should be denied services because of failure to have a member ID card at the time of service. Verify the identity of the person presenting the ID card against some form of photo ID, such as a driver's license, if this is your office practice.

If a fraud, waste and abuse event arises from a care provider or a member's ID card, file a report at **uhc.com/fraud**. Or you may call the **Fraud, Waste and Abuse Hotline** at **1-844-359-7736**.

The member ID card displays the UnitedHealthcare Community Plan logo and the UnitedHealthcare Community Plan Member Services number.

The member ID card also displays:

- The member's PCP name and telephone number
- The member's name and UnitedHealthcare Community Plan ID number
- Copayment requirements, if applicable

The back of the member ID card has the:

- Telephone number for you to verify eligibility and obtain prior authorization
- Mailing address for claims
- Pharmacy Help Desk phone number for pharmacy claim issues

If a member does not bring their card, verify eligibility:

- Online at **UHCprovider.com**
- By calling **1-800-600-9007**

Also document the call in the member's chart.

Member ID numbers

Each member receives a 9-digit UnitedHealthcare Community Plan member identification number. Use this number to communicate with UnitedHealthcare Community Plan about a specific subscriber/member. The Pennsylvania DHS Medicaid Number is also on the member ID card.

Primary care provider - initiated transfers

A PCP may wish to transfer a member after not being able to create or maintain a professional relationship with them. To do so, the PCP must send a written request to the medical director or their designee noting the member's name and the circumstances

supporting the request. Do not request a transfer unless you have attempted and documented interventions. This includes contacting the PCP office and UnitedHealthcare Community Plan to educate the member about their rights and responsibilities. A PCP may not request a change because of the member's condition or needed services unless the PCP cannot deliver quality care to the member. If the medical director or their designee approves the transfer, the PCP must provide services to the member for 30 days from the date of the letter. For more information, contact your provider advocate or call **Provider Services** at **1-800-600-9007**.

Verifying member enrollment

Verify member eligibility prior to providing services. Determine eligibility in the following ways:

- **UnitedHealthcare Provider Portal**: access the **UnitedHealthcare Provider Portal** directly or through **UHCprovider.com/eligibility**
- **Provider Services** at **1-800-600-9007** is available from 7 a.m. - 5 p.m. ET, Monday-Friday
- Eligibility Verification System (EVS): For Medicaid members, obtain eligibility status information through the Pennsylvania's EVS

Eligibility Verification System

You can access Eligibility Verification System (EVS) through:

- Telephone at **1-800-766-5387**
- Point of Sale (POS) Device
- Personal Computer (PC)
- Mainframe Computer

To request EVS software, call **1-800-248-2152**. There is a shipping and handling charge. Specifications for customizing a computer system to access EVS is available at dhs.pa.gov.

UnitedHealthcare Dual Complete

UnitedHealthcare Dual Complete® (D-SNP) is a Medicare Advantage plan for members who qualify for both Medicare and Medicaid.

For general information about D-SNP, go to **uhc.com/medicaid/dsnp**.

For information regarding UnitedHealthcare Dual Complete, please see the Medicare Products chapter of the Administrative Guide for Commercial, Medicare Advantage and D-SNP at **UHCprovider.com/guides**. For Pennsylvania-specific D-SNP information, go to **UHCprovider.com/PA** > Medicare > **Pennsylvania Dual Complete® Special Needs Plan**.

Chapter 4: Medical management

Key contacts

Topic	Link	Phone number
Referrals	**UHCprovider.com/eligibility**	**1-800-600-9007**
Prior authorization	**UHCprovider.com/priorauth**	**1-800-600-9007**
Pharmacy	**professionals.optumrx.com**	**1-800-600-9007**
Healthy first Steps	**uhchealthyfirststeps.com**	**1-800-599-5985**

Medical management improves the quality and outcome of health care delivery. We offer the following services as part of our medical management process.

Ambulance services

Emergency ambulance transportation

An emergency is a serious, sudden medical or behavioral condition that may include severe pain. Without immediate attention, the affected person could suffer major:

- Injury to their overall health
- Impairment to bodily functions or
- Dysfunction of a bodily organ or part

Emergency transports (in- and out-of-network) are covered. They do not require an authorization.

Bill ambulance transport as a non-emergency transport when it doesn't meet the definition of an emergency transport. This includes all scheduled runs and transports to nursing facilities or the member's residence.

Non-emergent air ambulance requires prior authorization.

For authorization, go to **UHCprovider.com/priorauth** or call **Provider Services** at **1-800-600-9007.**

Non-emergent transportation

UnitedHealthcare Community Plan Medicaid members who need to be monitored may get non-emergent ambulance transportation. Members may get transportation when they are bed-confined before, during and after transport.

For non-urgent appointments, members must call for transportation at least 3 days before their appointment. **Appendix C** in this manual lists contact phone numbers by county.

Non-emergency medical transportation

Non-emergency medical transportation (NEMT) must be requested at least 3 business days in advance. Schedule NEMT up to 2 weeks in advance.

Contact Medical Assistance Transportation Program (MATP) for non-emergency transports. Refer to the appendix for phone numbers based on county.

Requesting services

Non-emergency medical transportation services are available through MATP. Transportation is provided by taxi, van, bus or public transit, depending on a member's medical needs. Wheelchair service is provided if required by medical necessity.

Abuse reporting

You are required by law to report suspected abuse.

- For suspected child abuse or neglect, call ChildLine at 1-800-932-0313. You can also report electronically at compass.state.pa.us/cwis.

- For suspected adult abuse or neglect, visit dhs.pa.gov > Adult Protective Services
- For suspected abuse or neglect of individuals ages 60 and older, visit aging.pa.gov > Protective Services

Resources and information

- Pennsylvania Code Suspected Child Abuse Mandated Reporting Requirements: pacode.com
- Child protection in Pennsylvania: KeepKidsSafe.pa.gov
- Identification of child abuse and neglect: childwelfare.gov/topics/can/identifying/
- Call 1-800-490-8505 if you are concerned about individuals ages 18-59 with disabilities, or individuals older than 60

Cardiology

We use the prior authorization process to help support compliance with evidence-based and professional society guidance for cardiology procedures.

You must obtain prior authorization for the following cardiology procedures:

- Diagnostic catheterizations
- Electrophysiology implant procedures
- Echocardiograms
- Stress echocardiograms

Cardiology procedures do not require prior authorization if performed in the following places of service:

- Emergency rooms
- Hospital observation units
- Urgent care centers
- Inpatient settings

If you do not complete the entire prior authorization process before performing the procedure, we will reduce or deny the claim. Do not bill the member for claims we deny for this reason.

Request prior authorization online or by phone:

- **Online – UHCprovider.com/cardiology** > Sign In
- **Phone – 1-866-889-8054** 7 a.m. - 7 p.m. local time, Monday–Friday

Make sure the medical record is available.

For the most current list of CPT codes that require prior authorization, a prior authorization crosswalk and/or the evidence-based clinical guidelines, go to **UHCprovider.com/cardiology** > Sign In > Specific cardiology programs.

For the most currently listing of CPT codes that require prior authorization, a prior authorization crosswalk, and or the evidence-based clinical guidelines, go to **UHCprovider.com/cardiology** > Sign In > Specific Cardiology Programs.

Durable medical equipment

Durable medical equipment (DME) is equipment that provides therapeutic benefits to a member because of certain medical conditions and/or illnesses. DME consists of items which are:

- Primarily used to serve a medical purpose
- Not useful to a person in the absence of illness, disability or injury
- Ordered or prescribed by a care provider
- Reusable
- Repeatedly used
- Appropriate for home use
- Determined to be medically necessary

We now cover Home Accessibility DME. Covered items may include stair glides, wheelchair ramps and vertical lifts. This does not cover structural home modifications. For more information, call the Enhanced Member Support Unit (formerly the Special Needs Unit) at **1-877-844-8844**.

See our Coverage Determination Guidelines at **UHCprovider.com/policies** > For Community Plans > Medical & Drug Policies and Coverage Determination Guidelines for Community Plan.

Emergency/urgent care services

While UnitedHealthcare Community Plan covers emergency services, we ask that you tell members about appropriate ER use. A PCP should treat non-emergency services such as sprains/strains, stomachaches, earaches, fevers, cough, colds and sore throats.

Covered services include:

- Hospital emergency department room, ancillary and other care service by in and out-of-network care providers
- Medical examination

- Stabilization services
- Access to designated Level I and Level II trauma centers or hospitals meeting the same levels of care for emergency services
- Emergency ground or air transportation
- Emergency dental services, limited to broken or dislocated jaw, severe teeth damage, and cyst removal

We pay out-of-network care providers for emergency services at the current program rates at the time of service. We try to negotiate acceptable payment rates with out-of-network care providers for covered post-stabilization care services for which we must pay.

Prior notification is not required for emergency services.

Emergency room care

For an emergency, the member should seek immediate care at the closest ER. If the member needs help getting to the ER, they may call 911. No referral is needed. Members have been told to call their PCP as soon as possible after receiving emergency care. They pay no out-of-pocket cost for ER or emergency ambulance services. PCPs must promptly see members who did not require or receive emergency services for the symptoms prompting the attempted ED visit.

UnitedHealthcare Community Plan covers these services regardless of the emergency care provider's relationship with UnitedHealthcare Community Plan.

Urgent care (non-emergent)

Urgent care services are covered.

For a list of urgent care centers, contact **Provider Services** at **1-800-600-9007**.

Emergency care resulting in admissions

Prior authorization is not required for emergency services.

Deliver emergency care without delay. Notify UnitedHealthcare Community Plan about admission within 24 hours, unless otherwise indicated. Use the Prior Authorization and Notification tool on the **UnitedHealthcare Provider Portal** or at **UHCprovider.com/priorauth**, EDI 278N transaction at **UHCprovider.com/edi**, or call **Provider Services** at **1-800-600-9007**.

Nurses review emergency admissions within 1 business day of notification.

UnitedHealthcare Community Plan makes UM determinations based on appropriateness of care and benefit coverage existence using evidence-based, nationally recognized or internally developed clinical criteria. UnitedHealthcare Community Plan does not reward you or reviewers for issuing coverage denials and does not financially incentivize Utilization Management staff to support service underutilization. Care determination criteria is available upon request by contacting **Provider Services** at **1-800-600-9007** (UM Department, etc.).

The criteria are available in writing upon request or by calling **Provider Services** at **1-800-600-9007**. For policies and protocols, go to **UHCprovider.com/policies** > **For Community Plans**.

If a member meets an acute inpatient level of stay, admission starts at the time you write the order.

Facility admission notification requirements

Facilities are responsible for admission notification for the following inpatient admissions (even if an advanced notification was provided prior to the actual admission date):

- Planned/elective admissions for acute care
- Unplanned admissions for acute care
- Skilled nursing facility (SNF) admissions
- Admissions following outpatient surgery
- Admissions following observation

Family planning

Family planning services are preventive health, medical, counseling and educational services that help members manage their fertility and achieve the best reproductive and general health. UnitedHealthcare Community Plan members may access these services without a referral. They may also seek family planning services at the care provider of their choice, which may be out of network. The following services are included:

- Annual gynecological examination
- Annual pap smear
- Contraceptive supplies, devices and medications for specific treatment
- Contraceptive counseling
- Laboratory services

Blood tests to determine paternity are covered **only** when the claim indicates tests were necessary for legal support in court.

Non-covered items include:

- Reversal of voluntary sterilization
- Hysterectomies for sterilization
- In-vitro fertilization, including:
  - GIFT (Gamete intrafallopian transfer)
  - ZIFT (zygote intrafallopian transfer)
  - Embryo transport
- Infertility services, if given to achieve pregnancy
  Note: Diagnosis of infertility is covered. Treatment is not.
  - Morning-after pill (i.e., Plan B One Step, EContra EZ). These are covered under the member's pharmacy benefit and do not require prior authorization

Fertility treatment

We do not cover any costs, drugs, procedures or devices associated with fertility treatment or reversal of sterilization procedures.

Parenting/child birth education programs

- Child birth education is covered
- Parenting education is not covered

Voluntary sterilization

In-network treatment with consent is covered. The member needs to give consent 30 days before surgery, be mentally competent and be at least 21 years old at the time of consent for:

- Tubal ligation
- Vasectomy

Out-of-network services require prior authorization.

View the DHS Regulations for more information on sterilization.

Health education

This program is a proactive approach to help members manage specific conditions and support them as they take responsibility for their health.

The program goals are to:

- Provide members with information to manage their condition and live a healthy lifestyle
- Improve the quality of care, quality of life and health outcomes of members
- Help individuals understand and actively participate in the management of their condition, adherence to treatment plans, including medications and self-monitoring
- Reduce unnecessary hospital admissions and ER visits
- Promote care coordination by collaborating with providers to improve member outcomes
- Prevent disease progression and illnesses related to poorly managed disease processes
- Support member empowerment and informed decision making
- Effectively manage their condition and co-morbidities, including depression, cognitive deficits, physical limitations, health behaviors and psychosocial issues

Our program makes available population-based, condition-specific health education materials, websites, interactive mobile apps and newsletters that include recommended routine appointment frequency, necessary testing, monitoring and self-care. We send health education materials, based upon evidence-based guidelines or standards of care, directly to members that address topics that help members manage their condition. Our program provides personalized support to members in case management. The case manager collaborates with the member to identify educational opportunities, provides the appropriate health education and monitors the member's progress toward management of the condition targeted by the health education program.

Programs are based upon the findings from our Health Education, Cultural and Linguistic Group

Needs Assessment (GNA) and will identify the health education, cultural and linguistic needs.

Hospice

UnitedHealthcare Community Plan provides in-home hospice and short-stay inpatient hospice. These services require prior authorization.

Home hospice

UnitedHealthcare Community Plan covers benefits for routine home care every day the member is at home, under hospice and not receiving continuous home care. We cover care provider hospice at the member's home during a medical crisis. A medical crisis is when a member requires continuous nursing care to manage symptoms.

Respite hospice

Inpatient hospital or nursing facility respite care is covered for the hospice care provider each day the member is in an inpatient facility and receiving respite care. Hospice inpatient respite care is short-term inpatient care provided to the member when necessary to relieve the caregiver. Hospice inpatient respite care is restricted to 5 days per month. This includes the day of admission but not the day of discharge.

Inpatient hospice

Inpatient care is covered during a sudden medical crisis. General inpatient care may be necessary for pain control or acute/chronic symptom management not provided in any other setting. Inpatient hospice care includes a hospital or an in-network hospice inpatient facility that meets the hospice standards for staffing and member care. Inpatient care is short-term and restricted to 10 days per month.

Members receiving inpatient hospice services through a residential facility are not covered under Managed Medicaid. DHS covers residential inpatient hospice services. DHS will cover hospice care provider benefits for both the hospice services provided and the facility residential services.

Laboratory

Use a UnitedHealthcare Community Plan in-network laboratory when referring members for lab services not covered in the office. Medically necessary laboratory services ordered by a PCP, other care providers or dentist in one of these laboratories do not require prior authorization except as noted on our prior authorization list.

For more information on our in-network labs, go to **UHCprovider.com/findprovider** > **Preferred Lab Network**.

When submitting claims, have a Clinical Laboratory Improvement Amendment number (CLIA #). Otherwise, claims will deny. CLIA standards are national and not Medicaid-exclusive. CLIA applies to all providers rendering clinical laboratory and certain other diagnostic services.

See the **Billing and Encounters** chapter for more information.

Maternity/pregnancy/ well-child care

Pregnancy notification risk screening

Notify UnitedHealthcare Community Plan immediately of a member's confirmed pregnancy to help ensure appropriate follow-up and coordination by the Healthy First Steps program.

Call Healthy First Steps at **1-800-599-5985**.

Healthy First Steps strives to:

- Identify expectant members early and enroll them in case management
- Assess the member's risk level and provide member-specific needs that support the care provider's plan of care
- Help members understand the importance of early and ongoing prenatal care and direct them to receiving it
- Multidisciplinary support for pregnant members to overcome social and psychological barriers to prenatal care
- Increase the member's understanding of pregnancy and newborn care
- Encourage pregnancy and lifestyle self-management

and informed health care decision-making
- Encourage appropriate pregnancy, postpartum and infant care provider visits
- Foster a care provider-member collaboration before and after delivery as well as for nonemergent settings
- Encourage members to stop smoking with our Quit For Life tobacco cessation program
- Help identify and build the member's support system, including referrals to community resources and pregnancy support programs

Program staff act as a liaison between members, care providers and UnitedHealthcare for care coordination.

Healthy First Steps-maternal care model

The Healthy First Steps (HFS)-maternal care model strives to:

- Increase early identification of expectant mothers and facilitate case management enrollment. Make every effort to have pregnant members come in during the first trimester.
- Assess the member's risk level and provide member-specific needs that support the care provider's plan of care
- Help members understand the importance of early and ongoing prenatal care and direct them to receiving it. Help ensure members get timely prenatal care in the first trimester.
- Multidisciplinary support for pregnant women to overcome social and psychological barriers to prenatal care
- Increase the member's understanding of pregnancy and newborn care
- Encourage pregnancy and lifestyle self-management and informed healthcare decision-making
- Encourage appropriate pregnancy, postpartum and infant care provider visits
- Foster a care provider-member collaboration before and after delivery as well as for non-emergent settings
- Encourage members to stop smoking with our Quit for Life tobacco program
- Help identify and build the mother's support system including referrals to community resources and pregnancy support programs. We offer our Family Visiting Program to any pregnant woman as well as families with a child younger than 18 months old. This program provides support to build strong healthy families. For more information, call our Enhanced Member Support Unit (formerly the Special Needs Unit) at **1-877-844-8844**
- Act as a liaison between members, care providers and UnitedHealthcare Community Plan for care coordination

Pregnancy/maternity

Bill the initial pregnancy visit as a separate office visit. You may bill global days if the mother has been a UnitedHealthcare Community Plan member for 3 or more consecutive months or had 7 or more prenatal visits.

Pregnant UnitedHealthcare Community Plan members should receive care from participating care providers only. UnitedHealthcare Community Plan considers exceptions to this policy if:

1. the woman was in her second or third trimester of pregnancy when she became a UnitedHealthcare Community Plan member, and
2. if she has an established relationship with a non-participating obstetrician.

UnitedHealthcare Community Plan must approve all out-of-plan maternity care and continuity of care. Call **1-800-600-9007** or go to **UHCprovider/priorauth**. For more information about prior authorization requirements, go to **UHCprovider.com/PAcommunityplan** > **Prior Authorization and Notification**.

Members do not need a referral from her PCP for OB/GYN care. Perinatal home care services are available for members when medically necessary.

Maternity admissions

All maternity admissions require notification. Days in excess of 48 hours for vaginal deliveries and 96 hours for C-section require clinical information and medical necessity review.

Submit maternity admission notification by using the EDI 278N transaction at **UHCprovider.com/edi**, the online Prior Authorization and Notification tool at **UHCprovider.com/priorauth**, or by calling **Provider Services** at **1-800-600-9007**.

Provide the following information within 1 business day of the admission:

- Date of admission
- Member's name and Medicaid ID number
- Obstetrician's name, phone number, care provider ID
- Facility name (care provider ID)
- Vaginal or cesarean delivery

If available at time of notification, provide the following birth data:

- Date of delivery
- Sex
- Birth weight
- Gestational age
- Baby name

Non-routine newborn care (e.g., unusual jaundice, prematurity, sepsis, respiratory distress) is covered but requires prior authorization. Infants remaining in the hospital after mother's discharge require separate notification and will be subject to medical necessity review.

The midwife (CNM) must be a licensed registered nurse recognized by the Board of Nurse Examiners as an advanced practice nurse (APN) in nurse-midwifery and certified by the American College of Nurse-Midwives. A CNM must identify a licensed care provider or group of care providers with whom they have arranged for referral and consultation if complications arise. The CNM may furnish obstetrical maternity services on an outpatient basis. This can be done under a physician's supervision through an NP, PA or licensed professional nurse. If handled through supervision, the services must be within the staff's scope of practice or licensure as defined by state law.

You do not have to be present when services are provided. However, you must assume professional responsibility for the medical services provided and help ensure approval of the care plan.

For additional pregnant member and baby resources, see **Healthy First Steps Rewards** in **Chapter 6**.

Post maternity care

UnitedHealthcare Community Plan covers post-discharge care to the mother and her newborn. Post-discharge care consists of a minimum of 2 visits, at least 1 in the home, according to accepted maternal and neonatal physical assessments. These visits must be conducted by a registered professional nurse with experience in maternal and child health nursing or a care provider. The first post-discharge visit should occur within 24 to 48 hours after the member's discharge date. Prior authorization is not required for home health care visits for post-partum follow-up. The attending care provider decides the location and post-discharge visit schedule.

Newborn enrollment

The hospital is responsible to notify the county of all deliveries, including UnitedHealthcare Community Plan members. The hospital provides significant support to the enrollment process by providing required birth data at the time of admission.

Bright Futures assessment

Bright Futures is a national health promotion and prevention initiative, led by the American Academy of Pediatrics. It is supported by the U.S. DHHS, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB).

The Bright Futures Guidelines informs all preventive care screenings and well-child visits. You may incorporate Bright Futures into health programs such as home visits, child care and school-based health clinics. Materials developed for families are also available.

The primary goal of Bright Futures is to support primary care practices (medical homes) in providing well-child and adolescent care based on Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents.

Settings for Bright Futures implementation include:

- Private practices
- Hospital-based or hospital-affiliated clinics
- Resident continuity clinics
- School-based health centers
- Public health clinics
- Community health centers
- Indian Health Service clinics
- Other primary care facilities

A complementary goal is to provide home visitors, public health nurses, early child care and education professionals (including Head Start), school nurses, and

nutritionists with an understanding of Bright Futures materials so that they can align their health promotion efforts with the recommendations in the Bright Futures Guidelines. This objective will ensure that patients receive information and support that is consistent from family and youth perspectives.

Other women's health services

Covered services include:

- Post-partum care visit between the 7th and 84th day after delivery
- Birth control services and counseling
- Annual pap smear beginning at the age of 21 or at the onset of sexual intercourse
- Annual pelvic exam beginning at age of 18 or earlier if sexually active
- Sexually transmitted disease testing beginning at age 16, or at the onset of sexual intercourse
- Mammogram screening
- Family planning services
- Birth control

Women being discharged from a hospital postpartum may have 2 home nursing visits with a physician's order. Additional visits require prior authorization.

Hysterectomies

Hysterectomies cannot be reimbursed if performed for sterilization. Members who get hysterectomies for medical reasons must be told, orally and in writing, they will no longer be able to have children.

All hysterectomy claims (surgeon, assistant surgeon, anesthesiologist, hospital) must be accompanied by a consent form. The member should sign and date the form stating she was told before the surgery that the procedure will result in permanent sterility.

Find the form on **UHCCommunityPlan.com**.

See "Sterilization consent form" section for more information.

Exception: PA DHS does not require informed consent if:

1. As the care provider performing the hysterectomy, you certify in writing the member was sterile before the procedure. You must also state the cause of the sterility.
2. You certify, in writing, the hysterectomy was performed under a life-threatening emergency in which prior acknowledgment was not possible. Include a description of the emergency.

UnitedHealthcare Community Plan requires, along with your claim, a copy of the signed medical assistance hysterectomy statement. Mail the claim and documentation to claims administration identified on the back of the member's ID card. Reimbursement is made upon completion of documentation requirements and UnitedHealthcare Community Plan review. The member may not be billed if consent forms are not submitted.

Pregnancy termination services

Termination of pregnancy is a covered benefit when the abortion is necessary to preserve the woman's life or when the result from rape or incest.

You must complete the Medical Assistance Physician Certification for an Abortion Consent Form (MA3) prior to performing the procedure. This form must be completed for both Medical Assistance and CHIP Program members.

Allowable pregnancy termination services do not require a referral from the member's PCP. Members must use the UnitedHealthcare Community Plan provider network.

Sterilization and hysterectomy procedures

Reimbursement for sterilization procedures are based on the member's documented request. This policy helps ensure UnitedHealthcare Community Plan members thinking about sterilization are fully aware of the details and alternatives. It also gives them time to consider their decision. In addition, the State Medical Assistance Program must have documented evidence that all the sterilization requirements have been met before making a payment. The member must sign the Medical Assistance Consent Form at least 30 days, but not more than 180 days, before the procedure. The member must be at least 21 years old when they sign the form.

The member must not be mentally incompetent or live in a facility treating mental disorders. The member may agree to sterilization at the time of premature delivery or

emergency abdominal surgery if at least 72 hours have passed since signing the consent form. However, in the case of premature delivery, they must have signed the form at least 30 days before the expected delivery date. If the requirements are not met for both sterilization procedures and hysterectomies, UnitedHealthcare Community Plan cannot pay the care provider, anesthetist or hospital.

Sterilization informed consent

A member has only given informed consent if the PA Department of Social Services Medical Assistance Consent Form for sterilization (MA 31) is properly filled out. Other consent forms do not replace the Medical Assistance Consent Form. Be sure the member fully understands the sterilization procedure and has been told of other family planning options. Informed consent may not be obtained while the member is in labor, seeking an abortion, or under the influence of alcohol or other substances that affect awareness.

Sterilization consent form

Use the consent form for sterilization:

- **Complete all applicable sections of the form.** Complete all applicable sections of the consent form before submitting it with the billing form. The PA Medical Assistance Program cannot pay for sterilization procedures until all applicable items on the consent form are completed, accurate and follow sterilization regulation requirements.
- Your statement section should be completed after the procedure, along with your signature and the date. This may be the same date of the sterilization or a date afterward. If you sign and date the consent form before performing the sterilization, the form is invalid.
- The state's definition of "shortly before" is not more than 30 days before the procedure. Explain the procedure to the member within that time frame. However, do not sign and date the form until after you perform the procedure.

You may also find the form on **UHCCommunityPlan.com**.

Have 3 copies of the consent form:

1. For the member.
2. To submit with the Request for Payment form.
3. For your records.

Neonatal Intensive Care Unit Case Management

The Neonatal Intensive Care Unit (NICU) Case Management program manages inpatient and post-discharge NICU cases to improve outcomes and lower costs. Our dedicated team of NICU case managers, social workers and medical directors offer both clinical care and psychological services.

The NICU Case Management program helps ensure NICU babies get quality of care and efficiency in treatment. Newborns placed in the NICU are eligible upon birth. High risk newborns placed in the NICU are eligible upon birth for NICU Case Management services.

The NICU Case Management team works closely with neonatologists, Utilization Management nurses and social workers to support and coordinate needed care for NICU infants and their families, as appropriate.

Inhaled nitric oxide

Use the guidelines for inhaled nitric oxide (iNO) therapy at **UHCprovider.com/policies** > For Community Plans > Medical and Drug Policies for Community Plan. Search for "Inhaled Nitric Oxide Therapy..

Oncology

Prior authorization

For information about our oncology prior authorization program, including radiation and chemotherapy guidelines, requirements and resources, go to **UHCprovider.com/oncology** > Sign In, or call Optum at **1-888-397-8129** Monday-Friday 7am – 7pm CT.

Radiology

We use the prior authorization process to help support compliance with evidence-based and professional society guidance for radiology procedures.

You must obtain prior authorization for the following advanced imaging procedures if you provide them in an office or outpatient setting:

- Computerized tomography (CT)
- Magnetic resonance imaging (MRI)
- Magnetic resonance angiography (MRA)
- Positron-emission tomography (PET)
- Nuclear medicine
- Nuclear cardiology

Advanced imaging procedures do not require prior authorization if performed in the following places of service:

- Emergency rooms
- Hospital observation units
- Urgent care centers
- Inpatient settings

If you do not complete the entire prior authorization process before performing the procedure, we will reduce or deny the claim. Do not bill the member for claims we deny for this reason.

Request prior authorization online or by phone at:

- **Online** – **UHCprovider.com/radiology** > Sign In
- **Phone** – **1-866-889-8054** from 7 a.m.–7 p.m. local time, Monday–Friday. Make sure the medical record is available.

For a current list of CPT codes that require prior authorization, a prior authorization crosswalk table and/or the evidence-based clinical guidelines, go to **UHCprovider.com/radiology** > Sign In > Specific Radiology Programs.

Screening, brief interventions and referral to treatment services

Screening, brief interventions and referral to treatment (SBIRT) services are covered when:

- Provided by, or under the supervision of, a certified care provider or other certified licensed healthcare professional within the scope of their practice
- Determining risk factors related to alcohol and other drug use disorders, providing interventions to enhance patient motivation to change, and making appropriate referrals as needed
- An Evaluation and Management (E/M) exam occurs, which is not billable with a separate code. You may provide a brief intervention on the same day as a full screen in addition to the E/M exam. You may also perform a brief intervention on subsequent days. Brief interventions are limited to 4 sessions per patient, per provider per calendar year.

What is included in screening, brief interventions and referral to treatment?

Screening: With just a few questions on a questionnaire or in an interview, you can identify members who have alcohol or other drug (substance) use problems and determine how severe those problems already are. Three of the most widely used screening tools are the Alcohol Use Disorders Identification Test (AUDIT), the Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST) and the Drug Abuse Screening Test (DAST).

Brief intervention: If screening results indicate at risk behavior, individuals receive brief interventions. The intervention educates them about their substance use, alerts them to possible consequences and motivates them to change their behavior.

Referral to treatment: Refer members whose screening indicates a severe problem or dependence to a licensed and certified behavioral health agency for assessment and treatment of a substance use disorder. **This includes coordinating with the Alcohol and Drug Program in the county where the member resides for treatment.**

SBIRT services will be covered when all of the following are met:

- The billing and servicing providers are SBIRT certified
- The billing provider has an appropriate taxonomy to bill for SBIRT
- The diagnosis code is Z71.41
- The treatment or brief intervention does not exceed the limit of 4 encounters per client, per provider, per year

The SBIRT assessment, intervention, or treatment takes places in one of the following places of service:

- Office
- Urgent care facility
- Outpatient hospital
- ER – hospital
- FQHC
- Community mental health center

- Indian health service – freestanding facility
- Tribal 638 freestanding facility
- Homeless shelter

For more information about E/M services and outreach, see the DHHS Evaluation and Management Services at cms.gov > Medicare > Payment > Fee schedules > Physician Fee Schedule > Evaluation & Management Visits > Evaluation and Management Services MLN Publication > Evaluation and Management Services-Updated 08/29/2023.

Medication-assisted treatment

Medication-assisted treatment (MAT) combines behavioral therapy and medications to treat opioid use disorders (OUD). The Food and Drug Administration (FDA)-approved medications for OUD include Buprenorphine, Methadone, and Naltrexone.

To prescribe buprenorphine, you must have a current registration with the United States Drug Enforcement Agency (DEA) and be authorized to prescribe buprenorphine in the state.

As a medical care provider, you may provide MAT services even if you don't offer counseling or behavioral health therapy in-house. However, you must refer your patients to a qualified care provider for those services. If you need help finding a behavioral health care provider, call the number on the back of the member's health plan ID card or search for a behavioral health professional on **liveandworkwell.com**.

To find a medical MAT care provider in Pennsylvania:

1. Go to **UHCprovider.com/findprovider.**
2. Click on "Medical Care Directory."
3. Click on "Medicaid Plans."
4. Click on applicable state.
5. Select applicable plan.
6. Type "Medication Assisted Treatment" in the search bar and click "search."

If you have questions about MAT, call **Provider Services** at **1-800-600-9007**, and enter your TIN. Say "representative," then "representative" again. Say "something else" to speak to a representative.

Pharmacy

Preferred Drug List

UnitedHealthcare Community Plan uses the Statewide Preferred Drug List (PDL) and determines and maintains its Supplemental PDL of covered medications. These lists apply to all UnitedHealthcare Community Plan of Pennsylvania members. Specialty drugs on the PDL are identified by a "SP" in the "Requirements and Limits" section of each page.

You must prescribe Medicaid members drugs listed on the PDL. We may not cover brand-name drugs not on the PDL if an equally effective generic drug is available and is less costly unless prior authorization is followed.

If a member requires a non-preferred medication, call the Pharmacy Prior Authorization department at **1-800-310- 6826**. You may also use the online Prior Authorization and Notification tool on the **UnitedHealthcare Provider Portal.**

We provide you PDL updates before the changes go into effect. Change summaries are posted on **UHCprovider.com**. Find the PDL and Pharmacy Prior Notification Request form at **UHCprovider.com/priorauth**.

Pharmacy prior authorization

For medications that require prior authorization (including step therapy) and the medication is not filled before a prior authorization is secured, the pharmacist must dispense a 15 day supply if the medication qualifies as ongoing, or a 72 hour supply of a new medication. The rules apply to non-preferred PDL drugs and to those affected by a clinical prior authorization edit.

To request pharmacy prior authorization, call pharmacy prior authorization at 1-800-310-6826. We provide notification for prior authorization requests within 24 hours of request receipt.

To request pharmacy prior authorization, call Pharmacy Prior Authorization at **1-800-310-6826**. We provide notification for prior authorization requests within 24 hours of request receipt.

Specialty pharmacy medications

The Specialty Pharmacy Management Program provides high-quality, cost-effective care for our members. A specialty pharmacy medication is a high-cost drug that generally has 1 or more of the following characteristics:

- Used by a small number of people
- Treats rare, chronic, and/or potentially life-threatening diseases
- Has special storage or handling requirements such as needing to be refrigerated
- May need close monitoring, ongoing clinical support and management, and complete patient education and engagement
- May not be available at retail pharmacies
- May be oral, injectable or inhaled

Specialty pharmacy network requirements

The Specialty Pharmacy Management Program provides high-quality, cost-effective care for our members. A specialty pharmacy medication is a high-cost drug that generally has 1 or more of the following characteristics:

- Used by a small number of people
- Treats rare, chronic and/or potentially life-threatening diseases
- Has special storage or handling requirements such as needing to be refrigerated
- May need close monitoring, ongoing clinical support and management, and complete patient education and engagement
- May not be available at retail pharmacies
- May be oral, injectable or inhaled

Specialty pharmacy medications are available through our specialty pharmacy network. For more information about specialty pharmacy medications, go to **UHCprovider.com/priorauth**.

This procedure does not apply to:

- Network hospitals that are exempt because medication pricing is the same as or less than the specialty pharmacy. Exemption status is communicated to you by mail through the Network contracting team.
- Members who have Medicare or another health benefit plan as the primary payer and UnitedHealthcare Community Plan as the secondary payer

For more information about specialty pharmacy medications, go to UHCprovider.com/pacommunityplan > **Pharmacy Resources and Physician Administered Drugs**.

Using non-network specialty pharmacies

We may deny, in whole or in part, any claim when you use a non-participating specialty pharmacy, wholesaler, or direct purchase from the manufacturers without prior approval from us. Hospitals may also be subject to other administrative actions based on their Agreement.

To join our specialty pharmacy network, or to be considered for listing as a designated supplier for the affected products, email **NationalAncillaryStrategy_DL@ds.uhc.com** to discuss their participation in our Medication Sourcing Expansion.

Tuberculosis screening and treatment; direct observation therapy

Guidelines for tuberculosis (TB) screening and treatment and direct observation therapy (DOT) should follow the recommendations of the American Thoracic Society (ATS) and the Centers for Disease Control and Prevention (CDC).

The PCP determines the risk for developing TB as part of the initial health assessment. Testing is offered to all members at increased risk unless they have documentation of prior positive test results or currently have active TB under treatment. You will coordinate and collaborate with local health departments (LHDs) for TB screening, diagnosis, treatment, compliance and follow-up of members. PCPs must comply with all applicable state laws and regulations relating to the reporting of confirmed and suspected TB cases to the LHD. The PCP must report known or suspected cases of TB to the LHD TB Control Program within 1 day of identification.

Medical management guidelines

Admission authorization and prior

The following table lists medical management notification requests and the amount of time required for a decision, approval or denial.

Type of request	Decision TAT	Practitioner notification of approval	Written practitioner/ member notification of denial
Inpatient/outpatient non-urgent pre-service	14 calendar days from receipt of request for routine review	Notice must be sent the same day if decision is made prior to 4 p.m. and next business day if after 4 p.m.	Within 2 business days of the decision
Inpatient/outpatient urgent/expedited pre-service	Within 24 hours from receipt of request	Within 24 hours from receipt of request	Within 24 hours from receipt of request
Non-urgent post-service (inpatient concurrent review)	Contract is silent	Notice must be sent within 1 business day from receipt of necessary information, not to exceed 72 hours	Notified within 24 hours of determination and member notification within 2 business days
Inpatient retrospective review	14 calendar days from receipt of request for routine review	Notice must be sent within 24 hours from receipt of request	Within 24 hours of determination and member notification within 2 business days

authorization guidelines

All prior authorizations must have the following:

- Patient name and ID number
- Ordering care provider name and TIN/NPI
- Rendering care provider and TIN/NPI
- ICD clinical modification (CM)
- Anticipated date(s) of service
- Type of service (primary and secondary) procedure code(s) and volume of service, when applicable
- Service setting
- Facility name and TIN/NPI, when applicable

If you have questions, go to your state's prior auth page: **UHCprovider.com/PAcommunityplan** > **Prior Authorization and Notification Resources**.

Medicaid recipient restriction program

If you suspect a member is misusing or abusing the Medicaid benefit by obtaining prescriptions from multiple care providers or requesting controlled substances for questionable indications, you should call the Fraud and Abuse Hotline at **1-844-347-8477** (**1-844-DHS-TIPS**).

We monitor non-compliant members through the Recipient Restriction Program. This program makes members go to a single pharmacy and/or care provider when obtaining prescriptions.

If you notice that a member has stolen a prescription pad or has forged a prescription, report it immediately to the Fraud and Abuse Hotline.

We investigate issues involving potential misuse or abuse of prescription drugs, including:

1. Informing the Department of Human Services of member's activity.
2. Informing the appropriate provider network of the member's activity.
3. Enrolling the member in the UnitedHealthcare Community Plan Pharmacy Recipient Restriction Program, upon approval from Department of Human Services.

Peer-to-peer

We have a reconsideration line as a place for professional clinical discussions. It is dedicated to care providers to discuss a determination that was not approved at the level of care requested. Call **1-800-955-7615**.

Case management

We provide case management services to members with complex medical conditions or serious psychosocial issues. The Medical Case Management Department assesses members who may be at risk for multiple hospital admissions, increased medication use, or would benefit from a multidisciplinary approach to medical or psychosocial needs.

Refer members for case management by calling the Enhanced Member Support Unit (formerly the Special Needs Unit) at **1-877-844-8844**. Additionally, UnitedHealthcare Community Plan provides the **Healthy First Steps Program** in **Chapter 6**, which manages women with high-risk pregnancies.

Concurrent review guidelines

UnitedHealthcare Community Plan requires you to chart progress notes for each day of an inpatient stay. This includes acute and sub-acute medical, acute rehabilitation, skilled nursing facilities (SNFs), home health care and ambulatory facilities. We perform a record review or phone review for each day's stay using InterQual, CMS or other nationally recognized guidelines to help clinicians make informed decisions in health care settings. You must work with UnitedHealthcare Community Plan for all information, documents or discussion requests. This includes gathering clinical information on a member's status for concurrent review and discharge planning. When criteria are not met, the case is sent to a medical director.

UnitedHealthcare Community Plan denies payment for days that do not have a documented need for acute care services. Failure to document results in payment denial to the facility and you.

Concurrent review details

Concurrent review is notification within 24 hours or 1 business day of admission. It finds medical necessity

clinical information for a continued inpatient stay, including review for extending a previously approved admission. Concurrent review may be done by phone or record review.

Your cooperation is required with all UnitedHealthcare Community Plan requests for information, documents or discussions related to concurrent review and discharge planning including primary and secondary diagnosis, clinical information, care plan, admission order, member status, discharge planning needs, barriers to discharge and discharge date. When available, provide clinical information by access to Electronic Medical Records (EMR).

Your cooperation is required with all UnitedHealthcare Community Plan requests from our interdisciplinary care coordination team and/or medical director to support requirements to engage our members directly face-to-face or by phone. You must return/respond to inquiries from our interdisciplinary care coordination team and/or medical director.

UnitedHealthcare Community Plan uses InterQual, (We previously used MCG.) CMS guidelines, or other nationally recognized guidelines to assist clinicians in making informed decisions in many health care settings. This includes acute and sub-acute medical, long-term acute care, acute rehabilitation, SNFs, home health care and ambulatory facilities.

Determination of medical necessity

Medically necessary services or supplies are those necessary to:

1. Prevent the onset of an illness, condition, or disability. Reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury, or disability.
2. Assist the member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the member and those functional capacities that are appropriate for a member of the same age.

The determination is based on medical information provided by the care provider who evaluated the member. We make determinations on a timely basis, as required by the urgency of the situation.

An UnitedHealthcare Community Plan care manager can authorize, but not deny, a service or supply. If the care manager cannot determine the need based on the information given, the case is referred to the medical director.

If the medical director determines the service or supply is medically necessary, the care manager assigns an authorization number and sets the next review date.

If the medical director denies or limits the request, we call you. Our employees are not compensated for denial of services. Information on how to obtain criteria used to make the decision is included in all denial letters.

You may contact the medical director to have the decision reconsidered, based on medical information. You may make a written request for a copy of the criteria applied and a description of the process for denial. The medical director can help immediately in urgent or emergency cases and on a timely basis for all other cases.

If, after discussion with you, the attending physician or designee, the medical director or their designee determines the service or supply is reasonable, the case manager is notified. They call the facility's utilization review department.

We will not retroactively deny reimbursement for a provided covered service if you relied upon the written or oral authorization of UnitedHealthcare Community Plan prior to providing the service to the member, except in cases where there was material misrepresentation or fraud.

For members younger than 21, we complete a medical necessity review for all requested services and items.

Determination process

Benefit coverage for health services is determined by the member specific benefit plan document, such as a Certificate of Coverage, Schedule of Benefits, or Summary Plan Description, and applicable laws.

You may freely communicate with members about their treatment, regardless of benefit coverage limitations.

Evidence-based clinical guidelines

UnitedHealthcare Community Plan uses evidence-based clinical guidelines to guide our quality and health management programs. For more information on our guidelines, go to **UHCprovider.com**.

Medical and drug policies and coverage determination guidelines

Find medical and drug policies and guidelines at **UHCprovider.com/policies** > **For Community Plans**.

Referral guidelines

You should coordinate member referrals for medically necessary services beyond the scope of your practice. Monitor the referred member's progress and help ensure they are returned to your care as soon as appropriate.

We require prior authorization of all out of-network referrals. The nurse reviews the request for medical necessity and/or service. If the case does not meet criteria, the nurse routes the case to the medical director for review and determination. Out-of-network referrals are approved for, but not limited to, the following:

- Continuity of care issues
- Necessary services are not available within network

UnitedHealthcare Community Plan monitors out-of-network referrals on an individual basis. Care provider or geographical location trends are reported to Network Management to assess root causes for action planning.

Continuity of care when the care provider leaves the network

Continue to provide services to members who are under your care at the time of termination. A member may continue an ongoing course of treatment with you for a transitional period of up to 90 days from the date the member was notified of your participation termination. We can extend this, if clinically appropriate.

During pregnancy: Services can extend through post-partum for care related to delivery. Services during this period are covered under the same terms and conditions applicable to participating care providers.

PCPs: Provide services to the members assigned to you through the end of the month in which termination is effective. If we end your agreement for cause, we are not responsible for services provided to members after the date of termination.

Reimbursement

UnitedHealthcare Community Plan authorization helps ensure reimbursement for all covered services. You should:

- Determine if the member is eligible on the date of service by using the **UnitedHealthcare Provider Portal** or on **UHCprovider.com**, contacting UnitedHealthcare Community Plan's **Provider Services** at **1-800-600-9007**, or the PA Medicaid Eligibility System
- Submit documentation needed to support the medical necessity of the requested procedure
- Be aware the services provided may be outside the scope of what UnitedHealthcare Community Plan has authorized
- Determine if the member has other insurance that should be billed first

UnitedHealthcare Community Plan will not reimburse:

- Services UnitedHealthcare Community Plan decides are not medically necessary
- Non-covered services
- Services provided to members not enrolled on the dates of service

Second opinion benefit

If a UnitedHealthcare Community Plan member asks for a second opinion about a treatment or procedure, UnitedHealthcare Community Plan will cover that cost. Scheduling the appointment for the second opinion should follow the access standards established by the PA DHS. These access standards are defined in **Chapter 2**. The care provider giving the second opinion must not be affiliated with the attending care provider.

Criteria:

- The member's PCP refers the member to an in-network care provider for a second opinion. Care providers will forward a copy of all relevant records to the second opinion care provider before the appointment. The care provider giving the second opinion will then forward their report to the member's PCP and treating care provider, if different. The member may help the PCP select the care provider.
- If an in-network care provider is not available, UnitedHealthcare Community Plan will arrange for a consultation with a non-participating care provider. The participating provider should contact UnitedHealthcare Community Plan at **1-800-600-9007**.
- Once the second opinion has been given, the member and the PCP discuss information from both evaluations
- If follow-up care is recommended, the member meets with the PCP before receiving treatment

Services requiring prior authorization

All care providers, facilities and agencies providing services that require prior authorization should call **Provider Services** at **1-800-600-9007** Monday-Friday, 8 a.m. - 5 p.m. ET or enter request into I-Exchange®, a web-based authorization system. For any discharge or urgent needs, call **1-800-600-9007**.

Clinical review for all inpatient admissions must be provided within 2 business days of the admission.

For a list of services that require prior authorization, go to **UHCprovider.com/pacommunityplan** > **Prior Authorization and Notification**.

Authorization of care for new members

For adult members (ages 21 or older), we honor plans of care (including DME, medical supplies, prosthetic and orthotic appliances, and any other on-going services) started prior to a new member's enrollment for a period of up to 60 days, or until the PCP evaluates the member and establishes a new plan of care.

For any member younger than the age of 21, information on ongoing courses of treatment when transferring enrollment is found in Medical Assistance Bulletins 99-96-01 and 99-03-13. Medical Assistance Bulletins may be viewed at: dhs.pa.gov.

Seek prior authorization within the following time frames

- **Emergency or Urgent Facility Admission:** 1 business day
- **Inpatient Admissions; After Ambulatory Surgery:** 1 business day
- **Non-Emergency Admissions and/or Outpatient Services (except maternity):** at least 14 business days beforehand; if the admission is scheduled fewer than 5 business days in advance, use the scheduled admission time

Utilization management guidelines

UM is based on a member's medical condition and is not influenced by monetary incentives. UnitedHealthcare Community Plan pays its network PCPs and specialists on a FFS basis. We also pay in-network hospitals and other types of care providers in the UnitedHealthcare Community Plan network on a FFS basis. The plan's UM staff works with care providers to help ensure members receive the most appropriate care in the place best suited for the needed services. Our staff encourages appropriate use and discourages underuse. The UM staff does not receive incentives for UM decisions.

Hospital utilization management

Prior authorization for an inpatient stay is not a guarantee of approval. We conduct concurrent reviews to confirm prior requested procedure/service was performed and was the reason for the admission.

We approve or deny inpatient stays per our clinical guidelines.

If clinical information does not support the level of care requested, the case is sent to the Medical Director for a Medical Necessity determination.

All initial clinical reviews must be received within 1 business day of notification of the admission. Failure to provide clinical review within 1 business day of notification may result in an administrative denial.

In the case of a denial, we tell the facility by phone within 1 business day after we received all the clinical information. A written notification of the denial is sent within 2 business days of the final determination. You may request a peer-to-peer review by calling **1-800-514-4910** within 2 business days of the decision or within 2 business days of discharge.

Utilization management appeals

UM appeals are considered medically necessary appeals. They contest UnitedHealthcare Community Plan's UM decisions. This includes such things as UnitedHealthcare Community Plan's admission, extension of stay, level of care, or other health care services determination. They do not include benefit appeals, which are appeals for non-covered services. Any member, their designee or care provider who is dissatisfied with a UnitedHealthcare Community Plan UM decisions may file a UM appeal. See **Appeals** in **Chapter 12** for more details.

Chapter 5: Early, Periodic Screening, Diagnosis and Treatment (EPSDT)/Bright Futures/prevention

Key contacts

Topic	Link	Phone number
EPSDT – American Academy of Pediatrics	brightfutures.aap.org	1-866-843-2271
Vaccines for Children	health.pa.gov	1-888-646-6864

The **Early and Periodic Screening, Diagnostic and Treatment (EPSDT)/Bright Futures** benefit provides comprehensive and preventive health care services for children younger than age 21 who are enrolled in Medicaid and CHIP.

Follow the EPSDT/Bright Futures schedule for all eligible UnitedHealthcare Community Plan members to age 21, including pregnant women. EPSDT/Bright Futures screening includes immunizations, hearing, vision, speech screening and nutritional assessments; dental screening; and growth and development tracking.

For complete details about diagnoses codes as well as full and partial screening, examination, and immunization requirements, go to the **EPSDT schedule**. Also review the AAP/Bright Futures Periodicity website at aap.org.

Developmental disability services and coordination with county intellectual disability office

Developmental disabilities are severe and chronic disabilities due to a mental or physical impairment that begins before the member reaches adulthood. These disabilities include intellectual disability, cerebral palsy, epilepsy, autism, and disabling conditions related to intellectual disability or requiring similar treatment. The Office of Developmental Programs (ODP) is responsible for a system of diagnosis, counseling, case management, and community support of persons with intellectual disability, cerebral palsy, epilepsy, and autism for children older than 36 months to adulthood.

Referral – If you determine supportive services would benefit the member, refer the member to ODP for approval and assignment of a County Supports Coordinator who is responsible for scheduling an intake assessment. Determination of eligibility is the responsibility of the County Intellectual Disability Office Interdisciplinary Team. While the County Intellectual Disability Office does not provide overall case management for their clients, they must assure access to health, developmental, social, and educational services from birth throughout the lifespan of individual who has a developmental disability.

Continuity of Care – The County Intellectual Disability Office will determine the most appropriate setting for eligible home and community-based services and will coordinate these services for the member in collaboration with the PCP and health plan coordinator. The Care Coordinator and PCP continue to provide and manage primary care and medically necessary services. If the member does not meet criteria for the program or placement is not currently available, UnitedHealthcare will continue care coordination as needed to support the member's screening, preventive, medically necessary, and therapeutic covered services.

Early Intervention Services

Pennsylvania's Early Intervention Services provides support and services to families with children, from birth to age 5, with developmental delays and disabilities. The services build on the natural learning opportunities that occur within the daily routines of a child and their family.

Parents who have questions about their child's development may contact the Early Intervention Services helpline at 1-800-692-7288.

The helpline assists families in locating resources, educating them about child development for children ages birth to age 5 and providing early intervention services to children who qualify.

Full screening

A full EPSDT/Bright Futures screen includes:

1. Comprehensive health and developmental history that assesses for both physical and mental health, as well as for substance use disorders.
2. Comprehensive, unclothed physical examination.
3. Appropriate immunizations, in accordance with the schedule for pediatric vaccines established by the Advisory Committee on Immunization Practices.
4. Laboratory testing (including blood lead screening appropriate for age and risk factors.)
5. Health education and anticipatory guidance for both the child and caregiver.
6. Hearing, vision, and dental screenings and testing.

Without all these components, you cannot bill for a full screen. You may only bill for a partial screen.

Interperiodic screens

Interperiodic screens are medically necessary screens outside the standard schedule that do not require the full screen. Use this screen to start expanded health care visit (HCV) services. Office visits and full or partial screenings happening on the same day by the same care provider are not covered unless medical necessity is noted in the member's record.

Interperiodic screens are often used for school and athletic physicals. A physical exam may be needed for a certificate stating a child is physically able to take part in school athletics. This also applies for other school physicals when required for educational purposes.

Lead screening/treatment

UnitedHealthcare Community Plan reminds care providers that the EPSDT/Bright Futures members are required to have a venous blood lead screening by 12 months and again at 24 months. If lead levels are determined to be elevated (>3.5 micrograms per deciliter), you can refer for an Environmental Lead Investigation. UnitedHealthcare is contracted, statewide, with Accredited Environmental Technologies (AET).

Physicians can make direct referrals to AET by calling **1-800-969-6238**. Specific questions can be directed to our Lead Coordinator through the Enhanced Member Support Unit (formerly the Special Needs Unit) at **1-877-844-8844**. You can also go to **UHCprovider.com/pacommunityplan** > **Bulletins and Newsletters**.

Physicians should also refer to Early Intervention Services at 1-800-692-7288.

Safe/care exams

UnitedHealthcare Community Plan helps ensure members seen for physical examinations for determination of abuse or neglect are able to receive such services. These services are performed by a trained examiner in a timely manner in accordance with the Child Protective Services Law. See keepkidssafe.pa.gov website for additional follow-up information.

Targeted case management

Targeted case management (TCM) consists of case management services for specified targeted groups to access medical, social, educational, and other services provided by a regional center or local governmental health program as appropriate.

Identification – The 5 target populations include:

- Children younger than 21 years at risk for medical compromise
- Medically fragile individuals
- Individuals in frail health, older than 18 years and at risk of institutionalization
- Members in jeopardy of negative health or psychosocial outcomes
- Members infected with a communicable disease, including tuberculosis, HIV/AIDS, etc., or who have been exposed to communicable diseases, until the risk of exposure has passed

Continuity of Care – UnitedHealthcare Community Plan is responsible for coordinating the member's health care with the TCM care provider and for determining the medical necessity of diagnostic and treatment services recommended by the TCM care provider that are covered services under the contract.

Vaccines for Children program (Medicaid only)

The vaccines for children (VFC) program provides immunizations. Immunizations offered in the state VFC program must be ordered by your office. We do not reimburse for the vaccine ordered by the VFC Program, but we reimburse for administering the vaccine.

Vaccine administration fees are reimbursable when submitted with an appropriate CPT and modifier code. We cannot reimburse for private stock vaccines when they are available through VFC.

For more information, call Vaccines for Children program at 1-888-646-6864. Information can also be accessed at the Pennsylvania Department of Health website at health.pa.gov.

Any child through 18 years of age who meets at least one of the following criteria is eligible for the VFC Program:

- Eligible for Medicaid
- American Indian or Alaska Native, as defined by the Indian Health Services Act
- Uninsured
- Underinsured. (These children have health insurance, but the benefit plan does not cover immunizations. Children in this category may not only receive vaccinations from a FQHC or RHC. They cannot receive vaccinations from a private care provider using a VFC-supplied vaccine).

Chapter 6: Value-added services

Key contacts

Topic	Link	Phone number
Provider Services	**UHCprovider.com**	**1-800-600-9007**
Healthy First Steps	**uhchealthyfirststeps.com**	**1-800-219-3224**

We offer the following services to our UnitedHealthcare Community Plan members. If you have questions or need to refer a member, call **Provider Services** at **1-800-600-9007** unless otherwise noted.

Chronic condition management

Disease management programs for members with chronic conditions include materials specific to the disease, management, signs and symptoms, recommended routine appointment frequency, necessary testing and monitoring, and the importance of self-care. All materials are based upon evidence-based guidelines/standards. All printed materials are written at a 6th grade reading level. They are available in English and Spanish and can be requested in any language. The materials are designed to support members as they begin to take responsibility for their health. They provide information necessary to successfully manage their condition and live a healthy lifestyle. Resources and tools are available to support members and caregivers with conditions common to children with special health care needs and help them manage their illness.

Identification – The health plan uses claims data (e.g., hospital admissions, ER visits, pharmacy claims) to identify members with gaps in care and/or chronic conditions.

Referral - PCPs may make referrals to support practice-based interventions by contacting the Enhanced Member Support Unit (formerly the Special Needs Unit) at **1-877-844-8844**.

Healthy First Steps

Healthy First Steps® is our educational program for our pregnant and postpartum members. Educational materials have been created to educate members to follow positive health actions during and after pregnancy such as immunizations, visits, and EPSDT/ Bright Futures screenings for the child. Members should call our member service department to be connected to our healthy first steps nurses.

Members self-enroll on a smartphone or computer. They can go to **uhchealthyfirststeps.com** and click on "Register." Or call **1-800-599-5985**.

Babyscripts

BabyScripts™ is our incentive program for prenatal and postpartum members who are incentivized for registering through an app, and seeing their OB/GYN provider for prenatal and postpartum care. There is a simplified sign on, a real time verification of pregnancy and daily educational content -3 rewards can be earned: a $50 gift card for registering and a $25.00 gift card for a prenatal visit and a $25.00 gift card for a postpartum visit.

Mobile apps

Our apps are available at no charge to our members. For example, **Health4Me** enables users to review health benefits, access claims information and locate in-network providers.

NurseLine

NurseLine is available at no cost to our members 24 hours a day, 7 days a week. Members may call NurseLine to ask if they need to go to the urgent care center, the ER or to schedule an appointment with their PCP. Our nurses also help educate members about staying healthy. Call to reach a nurse:

- **1-844-222-7341** (HealthChoices)
- **1-877-440-0253** (CHIP)
- **1-877-440-9407** (D-SNP)

On My Way

This online program helps young adults who are either transitioning from foster care or from their parents/guardians home to independent living. On my way teaches skills on budgeting, housing, job training and attending college.

Pediatric asthma care

We recognize the challenge of managing pediatric members with asthma diagnoses. There are resources for specialized programs to provide remediation in the home. These services also provides education on triggers, environmental remediation, and medications.

School-based services

School districts sometimes provide basic health services or offer programs to promote healthy behaviors. These programs vary from district to district. Contact our Enhanced Member Support Unit (formerly the Special Needs Unit) at **1-877-844-8844** to locate these services.

State-funded program

The Women, Infants and Children supplemental nutrition program (WIC) provides federal grants for supplemental foods, health care referrals, and nutrition education for low-income pregnant, postpartum women. It also covers infants and children up to age 5 who are at nutritional risk.

To learn more about WIC, call **1-800-WIC-WINS**. Or go to pawic.com.

Substance use disorder behavioral health advocate

Our substance use disorder (SUD) behavioral health advocate (BHA) works with members to develop coping skills. Skills include encouragement, safety and a sense of responsibility for their own recovery. This benefit also emphasizes support to those with a behavioral health diagnosis while working through SUD treatment and recovery.

Eligible members are identified through predictive modeling and claims data, a health risk assessment (HRA) or your referral. The program has no age limitation.

Tobacco cessation

Nicotine replacement products (medicine, patches, and gum) are a covered benefit for members. None of these medications need a prior-authorization. Members can also have up to 70 tobacco cessation counseling visits per year. You can refer members to the PA Quit Line at 1-800-QUIT-NOW or pa.quitlogix.org.

UnitedHealthcare Doctor Chat— virtual visits

Members will have access to UnitedHealthcare Doctor Chat, an innovative, chat-first platform supported by live video to connect with a doctor from their computer or mobile device for non-emergent care. A board-certified emergency medicine physician will assess the severity of the enrollee's situation, provide treatment (including prescriptions) and recommend additional care. Virtual visits can improve access to care, reduce health disparities and reduce avoidable use of the ED. This program highlights our commitment to bring forward looking solutions to expand and deliver access to care.

Chapter 7: Mental health and substance use

Key contacts

Topic	Link	Phone number
Behavioral health/Provider Express	**providerexpress.com**	**1-877-614-0484**
Provider Services	**UHCprovider.com**	**1-800-600-9007**

All Medicaid members receive their mental health and substance abuse services through a contracted behavioral health managed care organization for their county. See **How to Contact Us** section in **Chapter 1**. CHIP members receive mental health and substance abuse services through Optum Behavioral Health.

The national Optum network manual generally applies to all types of business. Some sections may apply differently based on state law.

The National Optum Behavioral Health manual is located on **providerexpress.com**.

This chapter does not replace the national Optum network manual. Rather, it supplements the national manual by focusing on Medicaid's specific services and procedures.

You must have an NPI number to see Medicaid members and receive payment from UnitedHealthcare Community Plan.

How to join our network: Credentialing information is available at **providerexpress.com** > Clinical Resources > Guidelines/Policies & Manuals > Credentialing Plans > Optum

Covered services

UnitedHealthcare Community Plan offers UnitedHealthcare Community Plan members are covered for behavioral health services for mental, emotional and substance use disorders. We offer care management to help members, clinicians, and PCPs using and offering behavioral health services. We provide information and tools for mental health and substance abuse diagnoses, symptoms, treatments, prevention and other resources in one place **liveandworkwell.com** It can be accessed through a link on **myuhc.com**, and includes mental health and well-being information, articles on health conditions, addictions and coping, and provides an option for members to take self-assessments on a variety of topics, read articles and locate community resources.

For member resources, go to **providerexpress.com**. Click on the Live and Work Well (LAWW) link at the bottom of the page. LAWW includes tools to help members address mental health and substance use issues. Access the site using the guest access code "Clinician."

Benefits include:

- Crisis stabilization services (includes treatment crisis intervention).
- Inpatient psychiatric hospital (acute and sub-acute).
- Psychiatric residential treatment facility.
- Outpatient assessment and treatment:
  - Partial hospitalization
  - Social detoxification
  - Day treatment
  - Intensive outpatient
  - Medication management
  - Outpatient therapy (individual, family, or group), including injectable psychotropic medications
  - SUD treatment
  - Psychological evaluation and testing
  - Initial diagnostic interviews
  - Hospital observation room services (up to 23 hours and 59 minutes in duration)

  - Child-parent psychotherapy
  - Multi-systemic therapy
  - Functional family therapy
  - Electroconvulsive therapy
  - Telehealth
- Rehabilitation services
- Day treatment/intensive outpatient
- Dual-disorder residential
- Intermediate residential (SUD)
- Short-term residential
- Community support
- Psychiatric residential rehabilitation
- Secure residential rehabilitation

Training resources and materials

We provide the following resources to assist you in your practice and to help your patients.

- **Behavioral health toolkits**
- **Provider training materials**
- **Network provider manuals**

Addressing the opioid epidemic

Combating the opioid epidemic must include prevention, treatment, recovery and harm reduction. We engage in strategic community partnerships and approaches for special populations with unique risks, such as pregnant women and infants. We use our robust data infrastructure to identify needs, drive targeted actions, and measure progress. Finally, we help ensure our approaches are trauma-informed and reduce harm where possible.

Brief summary of framework

- Prevention:
  - Prevent OUDs before they occur through pharmacy management, provider practices, and education
- Treatment:
  - Access and reduce barriers to evidence-based and integrated treatment
- Recovery:
  - Support case management and referral to person-centered recovery resources
- Harm reduction:
  - Access to Naloxone and facilitating safe use, storage, and disposal of opioids
- Strategic community partnerships and approaches:
  - Tailor solutions to local needs
- Enhanced solutions for pregnant mom and child:
  - Prevent neonatal abstinence syndrome and supporting moms in recovery
- Enhanced data infrastructure and analytics:
  - Identify needs early and measure progress

Increasing education and awareness of opioids

It is critical you are up-to-date on the cutting edge research and evidence-based clinical practice guidelines. We keep OUD-related trainings and resources available on our **UnitedHealthcare Provider Portal** to help ensure you have the information you need, when you need it. For example, state-specific Behavioral Health Toolkits are developed to provide access to clinical practice guidelines, free substance use disorders/OUD assessments and screening resources, and other important state-specific resources. Additionally, Pain Management Toolkits are available and provide resources to help you identify our members who present with chronic physical pain and may also be in need of behavioral health services to address the psychological aspects of pain. Continuing education is available and includes webinars such as, “The Role of the Health Care Team in Solving the Opioid Epidemic,” and “The Fight Against the Prescription Opioid Abuse Epidemic.” While resources are available, we also work to help ensure you have the educational resources you need. For example, our Drug Utilization Review Provider Newsletter includes opioid trends, prescribing, and key resources.

Access these resources at **UHCprovider.com/pharmacy**. Click “Opioid Programs and Resources - Community Plan” to find a list of tools and education.

Prevention

We are invested in reducing the abuse of opioids, while facilitating the safe and effective treatment of pain. Preventing OUD before they occur through improved pharmacy management solutions, improved care provider prescribing patterns, and

member and care provider education is central to our strategy.

Supply limit on long-acting opioids

Prior authorization is required for greater than or equal to 50 MME per day.

Our prior authorization criteria matches the CDC's recommendations for the treatment of chronic non-cancer pain. Prior authorization applies to all long-acting opioids. The CDC guidelines on long-acting opioids are available online at cdc.gov > More CDC Topics > Injury, Violence & Safety > Prescription Drug Overdose > CDC Guideline for Prescribing Opioids for Chronic Pain. For more information, access our website at **liveandworkwell.com**.

Pharmacy lock-in

Pharmacy lock-ins minimize drug abuse. Pharmacy lock-ins identify and manage members who meet criteria indicative of potential prescription medication misuse or abuse, and specific therapeutic categories with the potential for high abuse, (e.g. narcotic analgesics, narcotic containing cough and cold preparations, sedative hypnotics, central nervous system stimulants, muscle relaxants, controlled substances). When lock-in is determined appropriate, a member is placed into a lock-in where they can only receive prescriptions from a single pharmacy for at least 1 year.

Expanding medication assisted treatment access and capacity

Evidence-based medication assisted (MAT) treatment is central to OUD treatment. MAT takes a chronic condition approach and incorporates medication use in addition to other services, such as counseling, cognitive behavioral therapies, and recovery support, to provide a comprehensive approach to OUD. We expand MAT access and help ensure we have an adequate member MAT network.

To find a MAT provider in Pennsylvania:

1. Go to **UHCprovider.com/findprovider**.
2. Select the care provider information.
3. Click on "Search for a Behavioral Health Provider".
4. Enter "(city)" and "(state)" for options.
5. Refine the search by selecting "Medication Assisted Treatment".

We contract with OUD Centers of Excellence (where available), which are designated as premier facilities to help ensure people with OUD stay in treatment and receive appropriate follow-up care and supports within their communities.

To find medical MAT care providers, see the MAT section in the **Medical management** chapter.

Chapter 8: Member rights and responsibilities

Key contacts

Topic	Link	Phone number
Member Services	**UHCCommunityPlan.com/PA**	**1-800-414-9025**
Member handbook	**UHCComunityPlan.com/PA** > Community Plan > Member benefits	**1-800-414-9025**

Privacy regulations

HIPAA privacy regulations offer full federal protection to protect member health care information. These regulations control the internal and external uses and disclosures of such data. They also create member rights.

Access to protected health information

Members may access their medical records or billing information either through you or us. If their information is electronic, they may ask that you or we send a copy in an electronic format. They may also ask that a copy of their information be provided to a third party.

Amendment of protected health information

Our members have the right to ask that you or we change protected health information (PHI) they believe to be inaccurate or incomplete. The member request must be in writing and explain why they want the change. You or we must act on the request within 60 days, or may extend another 30 days with written notice. If denying the request, provide certain information to the member explaining the denial reason and actions the member must take.

Accounting of disclosures

Our members have the right to request an accounting of certain disclosures of their PHI, made by you or us, during 6 years prior to the request. This accounting must include disclosures by business associates. It will not include disclosures made:

- For treatment, payment and health care operations purposes
- To members or pursuant to member's authorization
- To correctional institutions or law enforcement officials
- For which federal law does not require us to give an accounting

Right to request restrictions

Members have the right to ask you to restrict the use and disclosures of their PHI for treatment, payment and health care operations. For example, members may request to restrict disclosures to family members or to others who are involved in their care or payment. You may deny this request. If you approve restriction, document the request and restriction details. You will be required to abide by the restriction.

Right to request confidential communications

Members have the right to request communications from you or us be sent to a separate location or other means. You must accommodate reasonable requests, especially if the member states disclosure could endanger them. Requests for confidential communication do not require a member explanation. Keep a written copy of the request.

Member rights and responsibilities

The following information is in the Member handbook at the following link under the Member Information tab: **UHCCommunityPlan.com/pa/medicaid/community-plan-for-families**.

Member rights

Members have the right to:

- Request information on advance directives
- Be treated with respect, dignity and privacy
- Receive courtesy and prompt treatment
- Receive cultural assistance, including having an interpreter during appointments and procedures
- Receive information about us, rights and responsibilities, their benefit plan and which services are not covered
- Know the qualifications of their care provider
- Give their consent for treatment unless unable to do so because life or health is in immediate danger
- Discuss any and all treatment options with you
- Refuse treatment directly or through an advance directive
- Be free from any restraint used as discipline, retaliation, convenience or force them to do something they do not want to do
- Receive medically necessary services covered by their benefit plan
- Receive information about in-network care providers and choose one from our network
- Change care providers at any time for any reason
- Tell us if they are not satisfied with their treatment or with us; they can expect a prompt response
- Tell us their opinions and concerns about services and care received
- Register grievances or complaints concerning the health plan or the care provided
- Appeal any payment or benefit decision we make
- Review the medical records you keep and request changes and/or additions to any area they feel is needed
- Receive information about their condition, understand treatment options, regardless of cost or whether such services are covered, and talk with you when making decisions about their care
- Get a second opinion with an in-network care provider
- Expect care providers are not kept from advising them about health status, medical care or treatment, regardless of benefit coverage
- Make suggestions about our member rights and responsibilities policies
- Get more information upon request, such as on how our health plan works and a care provider's incentive plan, if they apply
- Get emergency services when you need them from any provider without our approval
- Ask for a DHS Fair Hearing
- Get information about services that we or a care provider does not cover because of moral or religious objections and about how to get those services

Member responsibilities

Members should:

- Understand their benefits so they can get the most value from them
- Show you their Medicaid member ID card
- Prevent others from using their ID card
- Understand their health problems and give you true and complete information
- Ask questions about treatment
- Work with you to set treatment goals
- Follow the agreed-upon treatment plan
- Get to know you before they are sick
- Keep appointments or tell you when they cannot keep them
- Treat your staff and our staff with respect and courtesy
- Get any approvals needed before receiving treatment
- Use the ER only during a serious threat to life or health

- Notify us of any change in address or family status
- Make sure you are in-network
- Follow your advice and understand what may happen if they do not follow it
- Give you and us information that could help improve their health
- Make a good-faith effort to pay your copayments (for applicable services for UnitedHealthcare Community Plan of Pennsylvania CHIP members enrolled in low cost, or full cost CHIP).
- Report fraud and abuse to the DHS Fraud and Abuse Reporting Hotline

Our member rights and responsibilities help uphold the quality of care and services they receive from you. The 3 primary member responsibilities as required by the National Committee for Quality Assurance (NCQA) are to:

1. Supply information (to the extent possible) to UnitedHealthcare Community Plan and to you that is needed for you to provide care.
2. Follow care to which they have agreed.
3. Understand their condition and take part in developing mutually agreed-upon treatment goals, to the degree possible.

Medical record charting standards

You are required to keep complete and orderly medical records, in paper or electronic format, which fosters efficient and quality member care. You are subject to our periodic quality medical record review.

You must maintain medical records in a detailed and comprehensive manner which conforms to good professional medical practice, permits effective professional medical review and medical audit processes, and facilitates an adequate system for follow-up treatment. Medical records must be legible, signed, and dated.

You must maintain medical records in paper form for at least 2 years before they are converted to any other form, and all forms must be readily available for review. You must maintain and preserve medical records for a minimum of 10 years from the termination of the provider agreement.

You will make medical records or copies of medical records available to UnitedHealthcare Community Plan, agents of the Pennsylvania Department of Human Services, the CMS, and any external quality review organization for purposes of assessing the quality of care rendered.

Members or their representative are entitled to 1 free copy of their medical record. Additional copies may be available at member cost. Medical records are generally kept for a minimum of 5 years unless federal requirement mandate a longer time frame (i.e., immunization and tuberculosis records required for lifetime).

The following are basic requirements for an acceptable medical records system:

- Records are stored in a central file in locked, fireproof cabinets
- If a computerized medical records system is utilized, the provider has established and enforces policies and procedures for saving, storing, securing, protecting, and retrieving medical record
- Records are organized in a logical manner, by individual patient or family, or other acceptable medical records filing system

We adopted the medical record keeping and documentation standards of the National Committee for Quality Assurance. You must comply with these standards.

Medical record review

On an ad hoc basis, we conduct a review of our members' medical records. We expect you to achieve a passing score of 80% or better. To achieve this score, the medical records you maintain should contain an initial health assessment, including a baseline comprehensive medical history. This assessment should be completed in less than 2 visits, with ongoing physical assessments occurring on following visits. It should also include:

- Problem list with:
  - Past and present medical and surgical intervention
  - Significant medical conditions with date of onset and resolution
- Entries dated and the author identified
- Legible entries
- Medication allergies and adverse reactions (or note if none are known)
- Easily known past medical history. This should include serious illnesses, injuries and operations (for members seen 3 or more times). For children and adolescents (18 years or younger), this includes prenatal care, birth, operations and childhood illnesses.
- Medication record, including names of medication, dosage, amount dispensed and dispensing instructions
- Copy of advance directive, or other document as allowed by state law, or notate member does not want one
- History of physical examination (including subjective and objective findings)
- Unresolved problems from previous visit(s) addressed in subsequent visits; Diagnosis and treatment plans consistent with finding
- Lab and other studies as appropriate
- Member education, counseling and/or coordination of care with other care providers

- Notes regarding the date of return visit or other follow-up
- Consultations, lab, imaging and special studies initialed by PCP to indicate review.
- Consultation and abnormal studies including follow-up plans.

Medical record documentation standards

If a care provider scores less than 80% during the initial review of medical records, we will request 5 more medical records. We would only review the 5 additional medical records for those elements the provider received a “NO” on the initial phase of review. Upon secondary review , if a data element scores 80% or above, the data is recalculated as a “yes” in the initial scoring. If Upon secondary review a data element scores below 80% the original calculation remains.

Chapter 10: Quality management program and compliance information

Key contacts

Topic	Link	Phone number
Credentialing	Medical: Network management support team Chat, with a live advocate, is available 7 a.m.-7 p.m. CT at **UHCprovider.com/chat**. Chiropractic: **myoptumhealthphysicalhealth.com**	**1-800-600-9007**
Fraud, Waste and Abuse (Payment Integrity)	**uhc.com/fraud**	**1-844-359-7736**

What is the Quality Improvement program?

UnitedHealthcare Community Plan's comprehensive Quality Improvement program falls under the leadership of the CEO and the chief medical officer. A copy of our Quality Improvement program is available upon request.

The program consists of:

- Identifying the scope of care and services given
- Developing clinical guidelines and service standards
- Monitoring and assessing the quality and appropriateness of services given to our members based on the guidelines
- Promoting wellness and preventive health, as well as chronic condition self-management
- Maintaining a network of providers that meets adequacy standards
- Striving for improvement of member health care and services
- Monitoring and enhance patient safety
- Tracking member and provider satisfaction and take actions as appropriate

As a participating care provider, you may offer input through representation on our Quality Improvement Committees and your provider services representative/ provider advocate.

Cooperation with quality-improvement activities

You must comply with all quality-improvement activities. These include:

- Providing requested timely medical records
- Cooperating with quality-of-care investigations For example, responding to questions and/or completing quality-improvement action plans
- Participating in quality audits, such as site visits and medical record standards reviews, and taking part in the annual HEDIS® record review
- Providing requested medical records for quality activities at no cost (or as indicated in your Agreement with us). You may provide records during site visits or by email or secure email.
- Completing practitioner appointment access and availability surveys

We require your cooperation and compliance to:

- Allow the plan to use your performance data
- Offer Medicaid members the same number of office hours as commercial members (or don't restrict office hours you offer Medicaid members)

Care provider satisfaction

Every year, UnitedHealthcare Community Plan conducts care provider satisfaction assessments as part of our quality improvement efforts. We assess and promote your satisfaction through:

- Annual satisfaction surveys
- Regular visits.
- Town hall meetings

Our chief concern with the survey is objectivity. That's why UnitedHealthcare Community Plan engages independent market research firm Center for the Study of Services (CSS) to analyze and report findings.

Survey results are reported to our Quality Management Committee. It compares the results year over year as well as to other UnitedHealthcare Community Plan plans across the country. The survey results include key strengths and improvement areas. Additionally, we carry out improvement plans as needed.

Clinical practice guidelines

UnitedHealthcare Community Plan has identified evidence-based clinical guidelines and resources to guide our quality and health management programs. You are encouraged to visit **UHCprovider.com/cpg** to view the guidelines, as they are an important resource to guide clinical decision-making.

Credentialing standards

UnitedHealthcare Community Plan credentials and re-credentials you based on applicable Pennsylvania statutes and the NCQA. The following items are required to begin the credentialing process:

- A completed credentialing application, including Attestation Statement
- Current medical license
- Current Drug Enforcement Administration (DEA) certificate
- Current professional liability insurance

We verify information from primary sources regarding licensure, education and training. We also verify board certification and malpractice claims history.

Credentialing and recredentialing process

UnitedHealthcare Community Plan's credentialing and recredentialing process determines whether you are a good fit for the UnitedHealthcare Community Plan provider network. You must go through the credentialing and recredentialing process before you may treat our members.

Care providers subject to credentialing and recredentialing

UnitedHealthcare Community Plan evaluates the following practitioners:

- MDs (Doctors of Medicine)
- DOs (Doctors of Osteopathy)
- DDSs (Doctors of Dental Surgery)
- DMDs (Doctors of Dental Medicine)
- DPMs (Doctors of Podiatric Surgery)
- DCs (Doctors of Chiropractic)
- CNMs (Certified Nurse Midwives)
- CRNPs (Certified Nurse Practitioners)
- Behavioral Health Clinicians (Psychologists, Clinical Social Workers, Masters Prepared Therapists)

Excluded from this process are practitioners who:

- Practice only in an inpatient setting
- Hospitalists employed only by the facility and/or
- NPs and PAs who practice under a credentialed UnitedHealthcare Community Plan care provider

Health facilities

Facility providers such as hospitals, home health agencies, SNFs and ambulatory surgery centers are also subject to applicable credentialing and licensure requirements.

Facilities must meet the following requirements or verification:

- State and federal licensing and regulatory requirements and NPI number
- Have a current unrestricted license to operate
- Have been reviewed and approved by an accrediting body
- Have malpractice coverage/liability insurance that meets contract minimums
- Agree to a site visit if not accredited by the Joint Commission (JC) or other recognized accrediting agency
- Have no Medicare/Medicaid sanctions

UnitedHealthcare Community Plan does not make credentialing and recredentialing decisions based on race, ethnic/national identity, gender, age, sexual orientation or the type of procedure or patient in which the practitioner specializes.

The National Credentialing Center (NCC) completes these reviews. Find applications on the Council for Affordable Quality Healthcare (CAQH) website at caqh.org.

Go to **UHCprovider.com/join** to submit a participation request.

For chiropractic credentialing, call **1-800-873-4575** or go to **myoptumhealthphysicalhealth.com**.

Submit the following supporting documents to CAQH after completing the application:

- Curriculum vitae
- Medical license
- DEA certificate
- Malpractice insurance coverage
- IRS W-9 form

Peer review

Credentialing process

A peer review committee reviews all credentialing applications and makes a final decision. The decisions may not be appealed if they relate to mandatory criteria at the time of credentialing. We will notify you of the decision in writing within 60 calendar days of the review.

Recredentialing process

UnitedHealthcare Community Plan recredentials practitioners every 3 years. This process helps assure you update time-limited documentation and identify legal and health status changes. We also verify that you follow UnitedHealthcare Community Plan's guidelines, processes and care provider performance standards. You are notified before your next credentialing cycle to complete your application on the CAQH website. Not responding to our request for recredentialing information results in administrative termination of privileges as a UnitedHealthcare Community Plan care provider. You have 3 chances to answer the request before your participation privileges are terminated.

Performance review

As part of the recredentialing process, UnitedHealthcare Community Plan looks in its Quality Management database for information about your performance. This includes member complaints and quality of care issues.

Applicant rights and notification

You have the right to review information you submitted to support your credentialing/recredentialing application. This excludes personal or professional references or peer review protected information. You have the right to correct erroneous information you find. Submit updated information directly to your CAQH credentialing application. If the Network Resource Management Team finds erroneous information, a representative will contact you by phone or in writing. You must submit corrections within 30 days of notification by phone, or in writing to the number or address provided.

You also have the right to receive the status of your credentialing application, please chat with a live advocate. It is available 7 a.m.–7 p.m. ET at **UHCprovider.com/chat.**

Confidentiality

All credentialing information collected during the review process is kept confidential. It is only shared with your approval or as required by law with those involved in the credentialing process.

Resolving disputes

If your concern is about a UnitedHealthcare Community Plan procedure, such as the credentialing or Care Coordination process, we will resolve it by following the procedures in that plan. If you are still dissatisfied, please follow the dispute resolution provisions in your Agreement.

If we have a concern about our Agreement with you, we will send you a letter. If the issue can't be resolved this way, please follow the dispute resolution provisions in your Provider Agreement.

If a member has authorized you in writing to appeal a clinical or coverage determination on their behalf, that appeal follows the member appeals process as outlined in the member handbook and **Chapter 12** of this manual.

Health Insurance Portability and Accountability Act compliance – your responsibilities

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 aims to improve the efficiency and effectiveness of the United States health care system. While the Act's core goals were to maintain insurance coverage for workers and fight health care fraud and abuse, its Administrative Simplification provisions have had the greatest impact on how the health care industry works. UnitedHealthcare Community Plan is a "covered entity" under these regulations. So are all care providers who conduct business electronically.

Transactions and code sets

If you conduct business electronically, submit claims using the standard formats adopted under HIPAA. Otherwise, submit claims using a clearinghouse.

Unique identifier

HIPAA also requires unique identifiers for employers, care providers, health plans and individuals for use in standard transactions.

National Provider Identifier

The NPI is your standard unique identifier. It is a 10-digit number with no embedded intelligence that covered entities must accept and use in standard transactions. While HIPAA only requires you to use the NPI in electronic transactions, many state agencies require it on FFS claims and on encounter submissions. For this reason, UnitedHealthcare Community Plan requires the NPI on paper transactions.

The NPI number is issued by the National Plan and Provider Enumeration System (NPPES). Share it with all affected trading partners, such as care providers to whom you refer patients, billing companies and UnitedHealthcare Community Plan.

Privacy of individually identifiable health information

The privacy regulations limit how health plans, pharmacies, hospitals and other covered entities can use members' medical information. The regulations protect medical records and other identifiable health information. This includes electronic, paper or spoken data.

They enhance members' rights by giving them access to their health information and controlling its inappropriate use. They also improve health care delivery by extending the privacy efforts of states and health systems to a national level.

Security

Covered entities must meet basic security measures:

- Help ensure the confidentiality, integrity and availability of all electronic PHI the covered entity creates,
- Protect against any reasonably anticipated threats, uses or disclosures of information not permitted or required under the Privacy Regulations, and
- Help ensure compliance with the security regulations by the covered entity's staff

UnitedHealthcare Community Plan expects you to comply with all HIPAA regulations.

Find additional information on HIPAA regulations at cms.hhs.gov.

Ethics and integrity

UnitedHealthcare Community Plan is dedicated to conducting business honestly and ethically with you, members, suppliers and government officials and agencies. Making sound decisions as we interact with you, other care providers, regulators and others is necessary for our continued success and that of our business associates. It's also the right thing to do.

Compliance program

As a segment of UnitedHealth Group, UnitedHealthcare Community Plan is governed by the UnitedHealth Group Ethics and Integrity program. The UnitedHealthcare Community Plan Compliance program incorporates the required 7 elements

of a compliance program as outlined by the U.S. Sentencing Guidelines:

1. Oversight of the Ethics and Integrity program.
2. Development and implementation of ethical standards and business conduct policies.
3. Creating awareness of the standards and policies by educating employees.
4. Assessing compliance by monitoring and auditing.
5. Responding to allegations of violations.
6. Enforcing policies and disciplining confirmed misconduct or serious neglect of duty.
7. Reporting mechanisms for workers to alert management and/or the Ethics and Integrity program staff to violations of law, regulations, policies and procedures, or contractual obligations.

UnitedHealthcare Community Plan has compliance officers for each health plan. In addition, each health plan has a compliance committee consisting of senior managers from key organizational areas. The committee provides program direction and oversight.

Reporting and auditing

Report any unethical, unlawful or inappropriate activity by a UnitedHealthcare Community Plan employee to a UnitedHealthcare Community Plan senior manager or directly to the Compliance Office.

UnitedHealthcare Community Plan's Special Investigations Unit (SIU) is an important part of the Compliance program. The SIU focuses on prevention, detection and investigation of potentially fraudulent and abusive acts committed by care providers and members. This department oversees coordination of anti-fraud activities.

To facilitate the reporting process of questionable incidents involving members or care providers, call our **Fraud, waste and abuse hotline** at **1-844-359-7736** or go to **uhc.com/fraud**.

Please refer to the Fraud, Waste and Abuse section of this manual for additional details about the UnitedHealthcare Community Plan Fraud, Waste and Abuse program.

An important aspect of the Compliance program is assessing high-risk areas of UnitedHealthcare Community Plan operations and implementing reviews to help ensure compliance with law, regulations and policies/contracts. When informed of potentially inappropriate or fraudulent practices within the plan or by you, UnitedHealthcare Community Plan will conduct an investigation. You must cooperate with the company and government authorities. This means giving access to pertinent records (as required by your applicable Provider Agreement and this manual) as well as access to office staff. If we establish activity in violation of law or regulation, we will advise appropriate governmental authorities.

If you become the subject of a government inquiry or investigation, or a government agency requests documents relating to your operations (other than a routine request for documentation), you must provide UnitedHealthcare Community Plan with the details. You must also reveal what triggered the inquiry.

Extrapolation audits of corporate-wide billing

UnitedHealthcare Community Plan will work with the State of Pennsylvania to perform "individual and corporate extrapolation audits." This may affect all programs supported by dual funds (state and federal funding) as well as state-funded programs, as requested by the PA Department of Health and Human Services.

Record retention, reviews and audits

You must maintain an adequate record-keeping system for recording services, charges, dates and all other commonly accepted information for services rendered to our members. Records must be kept for at least 10 years from the close of the PA program agreement between the state and UnitedHealthcare Community Plan or another period as required by law. If records are under review, they must be retained until the audit is complete. UnitedHealthcare Community Plan and its affiliated entities (including OptumHealth) will request and obtain prior approval from you for the records under review or inspection. You agree to refund the state any overpayment disclosed by any such audit.

If any litigation, claim, negotiation, audit or other action involving the records has been started before the 10-year period ends, you agree to keep the records until 1 year after the resolution of all issues

that come from it. The state may also perform financial, performance and other special audits on such records during business hours throughout your Provider Agreement.

To help ensure members receive quality services, you must also comply with requests for on-site reviews conducted by the state. During these reviews, the state will address your capability to meet PA program standards.

You must cooperate with the state or any of its authorized representatives, the Pennsylvania Department of Health and Human Services, the CMS, the Office of Inspector General, or any other agency prior-approved by the state, at any time during your Provider Agreement.

These entities may, at all reasonable times, enter your premises. You agree to allow access to and the right to audit, monitor and examine any relevant books, documents, papers and records to otherwise evaluate (including periodic information systems testing) your performance and charges.

We will perform reviews and audits without delaying your work. If you refuse to allow access, this will constitute a breach of your provider Agreement.

Delegating and subcontracting

If you delegate or subcontract any function, the delegate or subcontractor must include all requirements of your applicable provider Agreement and this manual.

Office site quality

UnitedHealthcare Community Plan and affiliates monitor complaints for quality of care (QOC) and services concerning participating care providers and facilities. Complaints about you or your site are recorded and investigated. We conduct appropriate follow-up to assure that members receive care in a safe, clean and accessible environment. For this reason, UnitedHealthcare Community Plan has set Clinical Site Standards for all PCP office sites to help ensure facility quality.

UnitedHealthcare Community Plan requires you and your facilities meet the following site standards:

- Clean and orderly overall appearance
- Available handicapped parking
- Handicapped accessible facility
- Available adequate waiting room space
- Adequate exam rooms for providing member care
- Privacy in exam rooms
- Clearly marked exits
- Accessible fire extinguishers
- Post file inspection record in the last year

Criteria for site visits

The following table outlines the criteria used to require a site visit. When the threshold is met, we conduct a site visit according to UnitedHealthcare Community Plan policy.

QOC issue	Criteria	Threshold
Issue may pose a substantive threat to patient's safety	Access to facility in poor repair to pose a potential risk to patients Needles and other sharps exposed and accessible to patients Drug stocks accessible to patients Other issues determined to pose a risk to patient safety	1 complaint
Issues with physical appearance, physical accessibility and adequacy of waiting and examination room space	Office facilities are dirty; smelly or otherwise in need of cleaning Office exams rooms do not provide adequate privacy	2 complaints in 6 months
Other	All other complaints concerning the office facilities	3 complaints in 6 months

Chapter 11: Billing and submission

Key contacts

Topic	Link	Phone number
Claims	**UHCprovider.com/claims**	**1-866-633-4449**
National Plan and Provider Enumeration System (NPPES)	nppes.cms.hhs.gov	1-800-465-3203
EDI	**UHCprovider.com/EDI**	**1-866-633-4449**

Our claims process

For claims, billing and payment questions, go to **UHCprovider.com**.

We follow the same claims process as UnitedHealthcare. See the Our Claims Process chapter of the Administrative Guide for Commercial, Medicare Advantage and D-SNP on **UHCprovider.com/guides**.

Claims process from submission to payment

1. You submit EDI claims to a clearinghouse or paper claims to us. We scan paper claims.
2. All claims are checked for compliance and validated.
3. Claims are routed to the correct claims system and loaded.
4. Claims with errors are manually reviewed.
5. Claims are processed based on edits, pricing and member benefits.
6. Claims are checked, finalized and validated before sending to the state.
7. Adjustments are grouped and processed.
8. Claims information is copied into data warehouse for analytics and reporting.
9. We make payments as appropriate.

National Provider Identifier

HIPAA requires you have a unique National Provider Identifier (NPI). The NPI identifies you in all standard transactions

If you have not applied for an NPI, contact National Plan and Provider Enumeration System (NPPES). Once you have an identifier, report it to UnitedHealthcare Community Plan, call **Provider Services** at **1-800-600-9007**.

Your clean claims must include your NPI and federal TIN.

General billing guidelines

We only consider reimbursing claims if you met billing and coverage requirements. Submitting a referral does not guarantee we will pay you. Payment depends on the member's coverage on the date(s) of service, medical necessity, plan rules about limitations and exclusions, and UnitedHealthcare Community Plan policies. We don't reimburse excessive, inappropriate or non-covered charges. To comply with applicable standards, policies and law, we may adjust previous payments for services and audit claims. We may seek reimbursement for over-payments or offset future payments as allowed by law.

Modifier codes

Use the appropriate modifier codes on your claim form. Find our modifier reference policies in our **Community Plan Reimbursement Policies** by searching for "modifier." The modifier must be used based on the date of service.

Member ID card for billing

The member ID card has both the UnitedHealthcare Community Plan member ID and the state Document Control Number (DCN). UnitedHealthcare Community Plan prefers you bill with the member ID.

Acceptable claim forms

UnitedHealthcare Community Plan only processes claims submitted on CMS 1500 and UB-04 claim forms.

Use the CMS 1500 form for ancillary services, ambulatory surgery centers, urgent care centers and hospital services.

Use the UB-04 form for hospital inpatient and outpatient services, dialysis services, skilled nursing homes inpatient services, long-term care facilities, hospice services and other health care services

Clean claims and submission requirements

Complete a CMS 1500 or UB-04 form whether you submit an electronic or a paper claim. Claims must be submitted within 180 days of the date of service (or discharge) or in accordance with your provider agreement. Clean claims have:

- A health service provided by an eligible health care provider to a covered UnitedHealthcare Community Plan member
- All the required documentation, including correct diagnosis and procedure codes
- The correct amount claimed

We may require additional information for some services, situations or state requirements.

Submit any services completed by NPs or PAs who are part of a collaborative agreement. Use their tax ID and NPI, and we will process the claims just like other physicians'.

For more information about ICD-10 coding and social determinants of health protocol and how they apply to the members you treat, see the Specific Protocols chapter in the UnitedHealthcare Care Provider Administrative Guide for Commercial, Medicare Advantage (including Dual Complete Special Needs Plans) at **UHCprovider.com/guides**. You can also visit **UHCprovider.com/policies.** Under Additional Resources, choose **Protocols** > Social Determinants of Health ICD-10 Coding Protocol.

Electronic claims submission and billing

You should submit all your claims electronically, unless the claim requires invoice documentation. You may submit claims by electronic data interchange (EDI). EDI offers less paperwork, reduced postage, less time spent handling claims and faster turnaround.

- Our payer ID is 87726
- Clearinghouse Acknowledgment Reports and Payer-Specific Acknowledgment Reports identify claims that don't successfully transmit
- We follow CMS National Uniform Claim Committee (NUCC) and National Uniform Billing Committee (NUBC) guidelines for HCFA 1500 and UB-04 forms

For more information, contact **EDI Claims**.

Electronic Data Interchange companion documents

UnitedHealthcare Community Plan's Electronic Data Interchange (EDI) companion documents are intended to share information within Implementation Guides (IG) adopted by HIPAA. The companion documents identify the data content requested when it is electronically transmitted. UnitedHealthcare Community Plan uses companion documents to:

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

The companion document provides general information and specific details pertinent to each transaction. These documents should be shared with your software vendor for any programming and field requirements.

The companion documents are located on **UHCprovider.com/edi** > **EDI transaction and code sets**.

Clearinghouse and status reports

Software vendor reports only show the claim left your office and was either accepted or rejected. They don't confirm the claim status. Acknowledgment reports confirm the information you sent has been received. Review your reports, clearinghouse acknowledgment reports and the status reports to reduce processing delays and timely filing penalties.

For clearinghouse options, go to **UHCprovider.com/edi** > **EDI Clearinghouse Options**.

e-Business support

Call **Provider Services** at **1-800-600-9007** for help with online billing, claims, Electronic Remittance Advices (ERAs), Electronic Funds Transfers (EFTs). For all of our claims and payment options, such as business support and EDI claims, go to Chapter 1 under Online Services.

For further information about EDI online, go to **UHCprovider.com/resourcelibrary** to find **Electronic Data Interchange** menu

Electronic payment solution: OptumPay

UnitedHealthcare has launched the replacement of paper checks with electronic payments and will no longer be sending paper checks for provider payment. You will have the option of signing up for Automated Clearing House (ACH)/direct deposit, our preferred method of payment, or to receive a Virtual Card payment (Virtual Card). The only alternative to a Virtual Card is direct deposit. Both of these options allow you to get paid quickly and securely.

Why choose Automated Clearing House/ direct deposit?

- Direct deposit puts payment directly into your bank account
- Easy and fast way to get paid
- Improved financial control; no paper checks or remittance information to lose or misplace
- Ability to track information on online portal

What does this mean to you?

- If your practice/healthcare organization is still receiving paper checks, you can enroll in ACH/direct deposit for your claim payments now. If you don't elect to sign up for ACH/direct deposit, a Virtual Card will be automatically sent in place of paper checks.
- To sign up for the ACH/direct deposit option, go to **UHCprovider.com/payment**
- If your practice/healthcare organization is already enrolled and receiving your claim payments through AHC/direct deposit from Optum Pay™ or receiving Virtual Cards there is no action you need to take
- If you do not enroll in ACH/direct deposit and currently receive your correspondence electronically, your remittance and Virtual Card statement will be available online through Document Library
- Exclusions may apply in certain states or markets where paper checks will remain the primary method of payment. For more information on virtual cards and exclusions, go to **UHCprovider.com/payment**

All regulated entities have a Management Agreement with United HealthCare Services, Inc. (UHS), under which UHS provides a whole host of administrative services (many of which are provided to UHS by an Optum entity and then passed through to the regulated entities), including those of a financial nature. Those agreements are filed with the DOI in the regulated entity's state of domicile for approval.

Completing the CMS 1500 claim form

Companion documents for 837 transactions are on **UHCprovider.com/ resourcelibrary**, to find the **EDI** section..

Visit the National Uniform Claim Committee website to learn how to complete the CMS 1500 form.

Completing the UB-04 form

Bill all hospital inpatient, outpatient and ER services using revenue codes and the UB-04 claim form:

- Include ICD CM diagnosis codes
- Identify other services by the CPT/HCPCS and modifiers

Capitated services

Capitation is a payment arrangement for care providers. If you have a capitation agreement with us, we pay you a set amount for each member assigned to

you per period. We pay you whether that person seeks care. In most instances, the capitated care provider is either a medical group or an Independent Practice Association (IPA). In a few instances, however, the capitated care provider may be an ancillary provider or hospital. We use the term "medical group/IPA interchangeably with the term "capitated care providers." Capitation payment arrangements apply to participating physicians, care providers, facilities and ancillary providers who are capitated for certain UnitedHealthcare Community Plan products. This applies to all benefit plans for members:

1. Who have been assigned to or who have chosen a care provider who receives a capitation payment from UnitedHealthcare Community Plan for such member, and
2. Who are covered under an applicable benefit plan insured by or receiving administrative services from UnitedHealthcare Community Plan.

Additionally, capitated care providers may be subject to any or all delegated activities. Capitated care providers should refer to their Delegation Grids within their participation agreements to determine which delegated activities the capitated providers are performing on behalf of UnitedHealthcare Community Plan.

For capitated services, include all services related to an inpatient stay on the UB-04 when a member is admitted to the hospital they received ER treatment, observation or other outpatient hospital services.

We deny claims submitted with service dates that don't match the itemization and medical records. This is a billing error denial.

Electronic Visit Verification system for personal care services and home health care services

The 21st Century Cures Act and CMS require states to use an Electronic Visit Verification system (EVV) for all personal care services (PCS). Beginning January 2024, EVV is now also being used for home health care services (HHCS). With this requirement, all visits must be timestamped using EVV tools to record the member and caregiver information, location of the service, date of the service and the type of service performed.

This means all UnitedHealthcare Community Plan® network care providers must use EVV to submit all PCS and home health claims. Use HHAeXchange's free EVV system and billing tool to meet this requirement.

Failure to comply with EVV requirements will result in claim denials. To ensure your agency is set up to use the HHAeXchange portal, please go to hhaexchange.com and complete a provider questionnaire. If you have questions about HHAeXchange, please email support@HHAeXchange.com.

Form reminders

- Note the attending provider's name and identifiers for the member's medical care and treatment on institutional claims for services other than non-scheduled transportation claims
- Send the referring provider's NPI and name on outpatient claims when this care provider is not the attending provider
- Include the attending provider's NPI in the attending provider name and identifiers fields (UB-04 FL76 or electronic equivalent) of your claims
- Behavioral health care providers can bill using multiple site-specific NPIs

Subrogation and coordination of benefit

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

- **Subrogation:** We may recover benefits paid for a member's treatment when a third party causes the injury or illness
- **COB:** We coordinate benefits based on the member's benefit contract and applicable regulations

UnitedHealthcare Community Plan is the payer of last resort. Other coverage should be billed as the primary carrier. When billing UnitedHealthcare Community Plan, submit the primary payer's Explanation of Benefits or remittance advice with the claim.

Hospital and clinic method of billing professional services

Hospital and clinics must bill for professional services bill on a CMS 1500. The servicing provider's name is placed in box 31, and the servicing provider's group NPI number is placed in box 33a.

Global days

Global days include the billable period involving pre-operative visits, the procedure itself, and post-operative visits in which the care provider performs all necessary services. The visits must be performed by the same or

another care provider reporting the same TIN in either an inpatient hospital, outpatient hospital, ambulatory surgical center (ASC), or physician's office.

For reimbursement, we follow CMS guidelines and the National Physician Fee Schedule (NPFS) Relative Value File to determine global days values. To learn more about billing for global days and their values, read our global days policy on **UHCprovider.com/policies** > For Community Plans > **Reimbursement Policies for Community Plan** > Global Days Policy, Professional-Reimbursement Policy-UnitedHealthcare Community Plan.

Correct Coding Initiative

UnitedHealthcare Community Plan performs coding edit procedures based on the Correct Coding Initiative (CCI) and other nationally recognized sources.

Comprehensive and component codes

Comprehensive and component code combination edits apply when a code pair(s) appears to be related. These edits can be further broken down to explain the bundling rationale. Some of the most common causes for denials in this category are:

- **Separate procedures:** Only report these codes when performed independently:
  - **Most extensive procedures:** You can perform some procedures with different complexities. Only report the most extensive service.
  - **With/without services:** Don't report combinations where 1 code includes and the other excludes certain services
  - **Medical practice standards:** Services part of a larger procedure are bundled
  - **Laboratory panels:** Don't report individual components of panels or multichannel tests separately

Clinical Laboratory Improvements Amendments

Submit your laboratory claims with the Clinical Laboratory Improvements Amendments (CLIA) number. In box 23 of the CMS 1500 claim form, enter the 10-digit CLIA certification number for laboratory services billed by an entity performing CLIA-covered procedures.

If you bill electronically, report the CLIA number in Loop 2300 or 2400, REF/X4,02. For more information about the CLIA number, contact the CMS CLIA Central Office at 1-410-786-3531 or go to the cms.gov.

Billing multiple units

When billing multiple units:

- If the same procedure is repeated on the same date of service, enter the procedure code once with the appropriate number of units.
- The total bill charge is the unit charge multiplied by the number of units.

National Drug Code

Claims must include:

- National Drug Code (NDC) and unit of measurement for the drug billed.
- HCPCS/CPT code and units of service for the drug billed.
- Actual metric decimal quantity administered.

Submit the NDC on all claims with procedure codes for care provider-administered drugs in outpatient clinical settings. The claims must show the NDC that appears on the product. Enter the identifier N4, the 11-digit NDC code, unit/basis of measurement qualified, and metric decimal quantity administered. Include HCPCS/CPT codes.

Medical necessity

UnitedHealthcare Community Plan only pays for medically necessary services. See Chapter 4 for more information about medical necessity.

Place of Service codes

Go to CMS.gov for Place of Service codes.

Asking about a claim

You can ask about claims through Provider Services and the **UnitedHealthcare Provider Portal.**

Provider Services

Provider Services helps resolve claims issues. Have the following information ready before you call:

- Member's ID number
- Date of service

- Procedure code
- Amount billed
- Your ID number
- Claim number

Allow Provider Services 45 days to solve your concern. Limit phone calls to 5 issues per call.

UnitedHealthcare Provider Portal

Go to **UHCprovider.com** and sign in to view your claims transactions.

Resolving claim issues

To resolve claim issues, contact Provider Services through the **UnitedHealthcare Provider Portal**, or resubmit the claim by mail.

Mail paper claims and adjustment requests to:

UnitedHealthcare Community Plan
P.O. Box 5240
Kingston, NY 12402-5240

Allow up to 30 days for UnitedHealthcare Community Plan to receive payment for initial claims and adjustment requests.

For paper claims

Submit a screen shot from your accounting software that shows when you submitted the claim. The screen shot must show the correct:

- Member name
- Date of service
- Claim date submission (within the timely filing period)

Timely filing

Timely filing issues may occur if members give the wrong insurance information when you treat them. This results in receiving:

- A denial/rejection letter from another carrier
- Another carrier's explanation of benefits
- A letter from another insurance carrier or employer group saying that the member either has no coverage or had their coverage terminated before the date of service

All of the above must include documentation the claim is for the correct member and the correct date of service. A submission report alone is not considered proof of timely filing for electronic claims. They must be accompanied by an acceptance report.

The date on the other carrier's payment correspondence starts the timely filing period for submission to UnitedHealthcare Community Plan.

To be timely, you must receive the claim within the timely filing period from the date on the other carrier's correspondence. If we receive the claim after the timely filing period, it will not meet the criteria.

If a claim is rejected, and corrections are not received within 90 days from date of service or close of business from the primary carrier, the clam is considered late billed. It will be denied timely filing.

Timely filing limits	
Initial claims	180 days
Resubmissions/ corrections	365 days
COB submissions after primary payment	365 days
COB resubmissions	365 days

Balance billing

UnitedHealthcare Community Plan members must NEVER receive a bill or a balance bill for covered services. Sending bills or balance bills to UnitedHealthcare Community Plan members for covered services is a violation of your Participating Provider Agreement with UnitedHealthcare Community Plan and violates Pennsylvania State law and regulation.

If you don't know who your provider advocate is, connect with a live advocate via chat on **UHCprovider.com/chat**, available 7 a.m.-7 p.m. ET.

Chapter 12: Claim reconsiderations, appeals and grievances

There are several ways to work with us to resolve claims issues or disputes. We base these processes on state and federal regulatory requirements and your agreement. Non-network care providers should refer to applicable appeals and grievances laws, regulations and state Medicaid contract requirements.

For claims, billing and payment questions, go to **UHCprovider.com/claims**. We no longer use fax numbers. Please use our online options or phone number.

The following grid lists the types of disputes and processes that apply:

Appeals and grievances standard definitions and process requirements

Situation	Definition	Who may submit?	Submission address	Online form for mail	Contact phone number	Website (care providers only) for online submissions	Care provider filing time frame	UnitedHealthcare Community Plan response time frame
Care provider claim resubmission	Creating a new claim. If a claim was denied and you resubmit the claim (as if it were a new claim), then you will normally receive a duplicate claim rejection on your resubmission.	Care provider	**UnitedHealthcare Community Plan** P.O. Box 5240 Kingston, NY 12402-5240	**UHCprovider.com/claims**	**1-800-600-9007**	For online submissions using the UnitedHealthcare Provider Portal, go to: **Pre- and post-service appeals and reconsiderations.**	Within 60 days of remittance	30 business days
Care provider claim reconsideration (step 1 of informal dispute)	Overpayment, underpayment, payment denial, or an original or corrected claim determination you do not agree with.	Care provider	Most care providers in your state must submitappeal requests electronically. For further information on reconsiderations, see the **Reconsiderations and Appeals interactive guide.** For those care providers exempted from this requirement, requests may be submitted at the following address: **UnitedHealthcare Community Plan** P.O. Box 5240 Kingston, NY 12402-5240		**1-800-600-9007**	For online submissions using the UnitedHealthcare Provider Portal, go to: **Pre- and post-service appeals and reconsiderations.**	Time frame listed in your contract	30 calendar days

Appeals and grievances standard definitions and process requirements

Situation	Definition	Who may submit?	Submission address	Online form for mail	Contact phone number	Website (care providers only) for online submissions	Care provider filing time frame	UnitedHealthcare Community Plan response time frame
Care provider claim informal appeal (step 2 of informal dispute)	A second review in which you did not agree with the outcome of the reconsideration.	Care provider	Most care providers in your state must submit appeal requests electronically. For further information on appeals, see the **Reconsiderations and Appeals interactive guide.** For those care providers exempted from this requirement, requests may be submitted at the following address: **UnitedHealthcare Community Plan** P.O. Box 31364 Salt Lake City, UT 84131-0364		**1-800-600-9007**	For online submissions using the UnitedHealthcare Provider Portal, go to: **Pre- and post-service appeals and reconsiderations.**	Time frame listed in your contract	30 to 60 calendar days
Care provider claim formal appeal	A review in which you did not agree with the outcome of the informal appeal.	Care provider	**UnitedHealthcare Community Plan** P.O. Box 31364 Salt Lake City, UT 84131-0364		**1-800-600-9007**	For online submissions using the UnitedHealthcare Provider Portal, go to: **Pre- and post-service appeals and reconsiderations.**	Time frame listed in your informal appeal notice	45 calendar days

These definitions and process requirements are subject to modification by state contract or regulations. States may impose more stringent requirements. UnitedHealthcare Community Plan and its contracted care providers may agree to more stringent requirements within provider agreements than described in the standard process..

Denial

Your claim may be denied for administrative or medical necessity reasons.

An **administrative denial** is when we didn't get notification before the service, or the notification came in too late.

Denial for **medical necessity** means the level of care billed wasn't approved as medically necessary.

If a claim is denied for these reasons, you may be able to request a claim reconsideration or file an appeal.

Other top reasons for denial include:

Duplicate claim – This is one of the most common reasons for denial. It means resubmitting the same claim information. This can reset the clock on the time it takes to pay a claim.

Claim lacks information. Basic information is missing, such as a person's date of birth; or information incorrect, such as spelling of a name. You can resubmit this type of claim with the correct information.

Eligibility expired. Most practices verify coverage beforehand to avoid issues, but sometimes that doesn't happen. One of the most common claim denials involving verification is when a patient's health insurance coverage has expired and the patient and practice were unaware. Also, in a lot of cases, practices may check eligibility when an appointment is made, but between the appointment being made and the actual visit, coverage can be dropped. We recommend an eligibility check again once the patient has arrived.

Claim not covered by UnitedHealthcare Community Plan. Another claim denial you can avoid is when procedures are not covered by us. You can easily avoid this problem by using real-time verification.

Time limit expired. This is when you don't send the claim in time.

Claim correction

What is it?

A corrected claim replaces a previously denied submitted claim due to an error. A denied claim has been through claim processing and determined it can't be paid.

When to use:

Submit a corrected claim to fix or void one that has already processed.

How to use:

View the **appeals and grievances grid** for submission information.

Additional information

- When correcting or submitting late charges on 837 institutional claims, use bill type xx7: Replacement of Prior Claim
- Do not submit corrected or additional information charges using bill type xx5: Late Charge Claim
- To void a claim, use bill type xx8

Resubmitting a claim

What is it?

When you resubmit a claim, you create a new claim in place of a rejected one. A rejected claim has not been processed due to problems detected before processing.

When to use it:

Resubmit the claim if it was rejected. Since rejected claims have not been processed yet, there is no appeal - the claim needs to be corrected through resubmission.

Common reasons for rejected claims:

Some common causes of claim rejections happen due to:

- Errors in member demographic data – name, age, date of birth, sex or address
- Errors in care provider data
- Wrong member insurance ID
- No referring care provider ID or NPI number

How to use:

To resubmit the claim, follow the same submission instructions as a new claim. To mail your resubmission, provide all claim information to:

UnitedHealthcare Community Plan
P.O. Box 5240
Kingston, NY 12402-5240

Claim reconsideration (step 1 of informal dispute)

What is it?

Claim issues include overpayment, underpayment, denial, or an original or corrected claim determination you do not agree with. A claim reconsideration request

is the quickest way to address your concern about whether the claim was paid correctly. When you send a reconsideration, please send additional support information.

When to use:

Reconsiderations can be done repeatedly, but should include new information each time. Submit a claim reconsideration when you think a claim has not been properly processed.

For administrative denials:

- In your reconsideration request, please ask for a medical necessity review and include all relevant medical records.

For medical necessity denials:

- In your request, please include any additional clinical information that may not have been reviewed with your original claim
- Show how specific information in the medical record supports the medical necessity of the level of care performed – for example, inpatient instead of observation

How to use:

View the **appeals and grievances grid** for submission information.

Questions about your appeal or need a status update? Call **Provider Services** at **1-800-600-9007**. If you filed your appeal online, you should receive a confirmation email or feedback through the secure **UnitedHealthcare Provider Portal.**

Tips for successful claims resolution

To help process claim reconsiderations:

- Do not let claim issues grow or go unresolved. Call **Provider Services** at **1-800-600-9007** if you can't verify a claim is on file
- Do not resubmit validated claims on file unless submitting a corrected claim
- 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
- 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.
- When submitting adjustment requests, provide the same information required for a clean claim. Explain the dispute, what should have been paid and why.
- Refer to your contract for submission deadlines concerning third-party claims. Once you have billed the other carrier and received an EOB, submit the claim to UnitedHealthcare Community Plan. Attach a copy of the EOB to the submitted claim. The EOB must be complete to understand the paid amount or the denial reason.

Valid proof of timely filing documentation (reconsideration)

What is it?

Proof of timely filing occurs when the member gives incorrect insurance information at the time of service. It includes:

- A denial or rejection letter from another insurance carrier
- Another insurance carrier's explanation of benefits
- Letter from another insurance carrier or employer group indicating:
  - Coverage termination prior to the date of service of the claim
  - No coverage for the member on the date of service of the claim

A submission report is not proof of timely filing for electronic claims. It must be accompanied by an acceptance report. Timely filing denials are often upheld due to incomplete or wrong documentation submitted with a reconsideration request. You may also receive a timely filing denial when you do not submit a claim on time.

How to use:

Submit a reconsideration request electronically, phone or mail with the following information:

- **Electronic claims:** Include the EDI acceptance report stating we received your claim.
- **Mail reconsiderations:** Submit a screen shot from your accounting software that shows the date you submitted the claim. The screen shot must show:
  - Correct member name
  - Correct date of service
  - Claim submission date

Additional information:

Timely filing limits can vary based on state requirements and contracts. If you do not know your timely filing limit, refer to your Provider Agreement.

Informal appeals (step 2 of dispute)

What is it?

An appeal is a review of a reconsideration claim. It is a 1-time formal review of a processed claim that was partially paid or denied.

When to use/file:

If you do not agree with the outcome of the claim reconsideration decision in step 1, use the claim appeal process.

How to use:

Submit related documents with your appeal. These may include a cover letter, medical records and additional information. Send your information electronically or by mail. View the **appeals and grievances grid** for submission information.

- Submit a screenshot from your accounting software that shows the date you submitted the claim. The screenshot must show:
  - Correct member name
  - Correct date of service
  - Claim submission date

Timely filing limits can vary based on state requirements and contracts. If you do not know your timely filing limit, refer to your Provider Agreement.

Overpayment

What is it?

An overpayment happens when we overpay a claim you don't dispute.

How to use:

If you or UnitedHealthcare Community Plan finds an overpaid claim, send us the overpayment within the time specified in your contract. If your payment is not received by that time, we may apply the overpayment against future claim payments in accordance with our Agreement and applicable law.

If you prefer we recoup the funds from your next payment, call **Provider Services** at **1-800-600-9007**.

If you prefer to mail a refund, send an Overpayment Return Check or the Overpayment Refund/Notification form.

Also send a letter with the check. Include the following:

- Name and contact information for the person authorized to sign checks or approve financial decisions
- Member identification number
- Date of service
- Original claim number (if known)
- Date of payment
- Amount paid
- Amount of overpayment
- Overpayment reason
- Check number

Where to send:

Mail refunds with an Overpayment Return Check or the Overpayment Refund/Notification form to:

UnitedHealthcare Community Plan
ATTN: Recovery Services
P.O. Box 740804
Atlanta, GA 30374-0800

Instructions and forms are on **UHCprovider.com/claims.**

If you do not agree with the overpayment findings, submit a dispute within the required timeframe as listed in your contract.

If you disagree with a claim adjustment or our decision not to make a claim adjustment, you can appeal. See Dispute section in this chapter. We make claim adjustments without requesting additional information from you. You will see the adjustment on the EOB or Provider Remittance Advice (PRA). When additional information is needed, we will ask you to provide it.

Sample overpayment report

***The information provided is sample data only for illustrative purposes.**
Please populate and return with the data relevant to your claims that have been overpaid.

Member ID	Date of service	Original claim #	Date of payment	Paid amount	Amount of overpayment	Reason for overpayment
11111	01/01/24	14A000000001	01/31/24	$115.03	$115.03	Double payment of claim
2222222	02/02/24	14A000000002	03/15/24	$77.29	$27.19	Contract states $50.00, claim paid $77.29
3333333	03/03/24	14A000000003	04/01/24	$131.41	$98.56	You paid 4 units, we billed only 1
44444444	04/04/24	14A000000004	05/02/24	$412.26	$412.26	Member has other insurance
55555555	05/05/24	14A000000005	06/15/24	$332.63	$332.63	Member terminated

Member grievances and complaints procedure

When to use:

You may act on the member's behalf with their written consent. You may provide medical records and supporting documentation as appropriate.

Where to send:

You or the member may call or mail the information within 60 calendar days from the date of the adverse benefit determination.

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

Phone – **1-800-587-5187** TTY **711**

For standard appeals, if you appeal by phone, you must follow up in writing, ask the member to sign the written appeal and mail it to UnitedHealthcare Community Plan. Expedited appeals do not need to be in writing.

How to use:

Whenever we deny a service, you must provide the member with UnitedHealthcare Community Plan appeal rights. The member has the right to:

- Review the case file before and during the appeal process. The file includes medical records and any other documents.
- Send written comments or documents considered for the appeal
- Ask for an expedited grievance if waiting for this health service could harm the member's health
- Ask for continuation of services during the appeal. However, the member may have to pay for the health service if it is continued or if the member should not have received the service. As the care provider, you cannot ask for a continuation. Only the member may do so.

We resolve a standard grievance 30 calendar days from the day we receive it.

We resolve an expedited grievance 72 hours from when we receive it.

We may extend the response up to 14 calendar days if the following conditions apply:

1. Member requests can take longer.
2. We request additional information and explain how the delay is in the member's interest.

If submitting the appeal by mail, you must complete the Authorization of Review (AOR) form-Claim Appeal.

A copy of the form is online at **providerforms.uhc.com**.

- Receive a copy of the rule used to make the decision
- Present evidence, and allegations of fact or law, in person and in writing

Member grievance

What is a grievance?

A request to have a physical health managed care organization (PH-MCO) or utilization review entity reconsider a decision concerning the medical necessity and appropriateness of a covered service. A grievance may be filed regarding a PH-MCO's decision to:

1. Deny, in whole or in part, payment for a service or item;
2. Deny or issue a limited authorization of a requested service or item, including a determination based on the type or level of service or item;
3. Reduce, suspend or terminate a previously authorized service or item;
4. Deny the requested service or item but approve an alternative service or item; and
5. Deny a request for a benefit limit exception (BLE)

The term does not include a complaint.

Pennsylvania Act 68 allows you, with written permission from the member, to act on their behalf to file a grievance. A form the member can use to give consent is available in Appendix A. The form, or a document containing the same information the form provides, signed by the member, must be sent with the grievance. If you are acting on behalf of the member, you may not bill them for those denied services. Information on member complaints, grievances, and state fair hearings can be found in section 8 of the UnitedHealthcare Community Plan for Families Member Handbook.
A copy of the handbook can be found at **UHCCommunityPlan.com**.

What is a complaint?

A dispute or objection regarding a particular provider or the coverage operations, or management of a PH-MCO, which has not been resolved by the PH-MCO and has been filed with the PH-MCO or with Pennsylvania Insurance Department's Bureau of Managed Care (BMC), including:

- A denial because the requested service or item is not a covered service; which does not include BLE;
- The failure of the PH-MCO to provide a service or item in a timely manner, as defined by the Department;
- The failure of the PH-MCO to decide a complaint or grievance within the specified time frames;
- A denial of payment by the PH-MCO after a service or item has been delivered because the service or item was provided without authorization by a provider not enrolled in the MA program;
- A denial of payment by the PH-MCO after a service or item has been delivered because the service or item provided is not a covered service for the member; or
- A denial of a member's request to dispute a financial liability, including cost sharing, co-payments, premiums, deductibles, coinsurance and other member financial liabilities

The term does not include a grievance.

When to use:

A complaint can be filed if there is a dispute or objection regarding a particular provider or the coverage operations, or management of. You may provide medical records and supporting documentation as appropriate. You may act on the member's behalf with their written consent.

Where to send:

You or the member may call or mail the information within 60 calendar days from the date of the adverse benefit determination.

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

Phone – **1-800-587-5187** TTY **711**.

Call the **Fraud, waste and abuse hotline** at **1-844-359-7736** to report questionable incidents involving plan members or care providers. You can also go to **uhc.com/fraud**. to learn more or to report and track a concern.

Fraud, waste and abuse

UnitedHealthcare Community Plan's Anti-Fraud, Waste and Abuse Program focuses on prevention, detection and investigation of false and abusive acts committed by you and plan members. The program also helps identify, investigate and recover money UnitedHealthcare Community Plan paid for such claims. We also refer suspected fraud, waste and abuse cases to law enforcement, regulatory and administrative agencies according to state and federal law. UnitedHealthcare Community Plan seeks to protect the ethical and financial integrity of the company and its employees, members, care providers, government programs and the public. In addition, it aims to protect member health.

UnitedHealthcare Community Plan includes applicable federal and state regulatory requirements in its Anti-Fraud, Waste and Abuse Program. We recognize state and federal health plans are vulnerable to fraud, waste and abuse. As a result, we tailor our efforts to the unique needs of its members and Medicaid, Medicare and other government partners. This means we cooperate with law enforcement and regulatory agencies in the investigation or prevention of fraud, waste and abuse.

An important aspect of the Compliance Program is reviewing our operation's high- risk areas. Then we implement reviews and audits to help ensure compliance with law, regulations and contracts.
You are contractually obligated to cooperate with the company and government authorities.

Find the PA DHS information on Fraud, Waste and Abuse at dhs.pa.gov or call **1-844-347-8477**.Also find out how we follow federal and state regulations around false claims at **UHCprovider.com/PAcommunityplan** > Integrity of Claims, Reports, and Representations to the Government.

The Deficit Reduction Act (DRA) has provisions reforming Medicare and Medicaid and reducing fraud within the federal health care programs. Every entity that receives at least $5 million in annual Medicaid payments must have written policies for entity employees and contractors. They must provide detailed information about false claims, false statements and whistleblower protections under applicable federal and state fraud and abuse laws. As a participating care provider with UnitedHealthcare Community Plan, you and your staff are subject to these provisions.

This policy details our commitment to compliance with the federal and state false claims acts. It provides a detailed description of these acts and of organizational mechanisms that detect and prevent fraud, waste and abuse. It also details how whistleblowing employees are protected. UnitedHealthcare Community Plan prohibits retaliation if a report is made in good faith.

Exclusion checks

First-tier, downstream and related entities (FDRs), must review federal (HHS-OIG and GSA) and state exclusion lists before hiring/contracting employees (including temporary workers and volunteers), the CEO, senior administrators or managers, and sub-delegates. Employees and/or contractors may not be excluded from participating in federal health care programs. FDRs must review the federal and state exclusion lists every month. For more information or access to the publicly accessible, excluded party online databases, please see the following links:

- Health and Human Services – Office of the Inspector General OIG List of Excluded Individuals and Entities (LEIE)
- General Services Administration (GSA) System for Award Management

In accordance with 42 CFR § 455.436, Federal and State databases are checked upon enrollment and re-enrollment on providers against the LEIE, SAM, NPPES, SSA DMF and Pennsylvania Medicheck List. Ongoing monitoring of Medicare/Medicaid sanctions and license actions are conducted using State and Federal databases such as the LEIE, SAM, Pennsylvania Medicheck List and state licensing boards.

What you need to do for exclusion checks

Review applicable exclusion lists and maintain a record of exclusion checks for 10 years. UnitedHealthcare Community Plan or CMS may ask for documentation to verify they were completed.

Pennsylvania medical assistance hotline to report fraud and abuse

DHS has a hotline to report suspected fraud and abuse committed by any entity providing services to Medical Assistance recipients.

The hotline number is **1-844-347-8477** and (**1-844-DHS-TIPS)**. It is available 8:30 a.m. - 3:30 p.m. ET, Monday-Friday. Voicemail is available at all other times. Callers may remain anonymous.

Provider fraud includes:

- Billing services not rendered
- Billing separately for services instead of an available combination code
- Misrepresenting the service or supplies rendered (e.g., billing brand-named for generic drugs)
- Upcoding to more expensive service than was rendered
- Billing more time or units of service than provided
- Billing incorrect provider or service location
- Altering claims
- Submitting false data on claims, such as date of service or care provider
- Billing services provided by unlicensed or unqualified persons
- Billing used items as new

Pennsylvania medical assistance provider self-audit protocol

The Pennsylvania Medical Assistance Provider Self Audit Protocol allows you to disclose overpayments or improper payments of MA funds. This is done through the reporting fraud website.

Chapter 13: Care provider communications and outreach

Key contacts

Topic	Link	Phone number
Provider education	**UHCprovider.com/resourcelibrary**	**1-800-600-9007**
News and bulletins	**UHCprovider.com/news**	**1-800-600-9007**
Care provider manuals	**UHCprovider.com/guides**	**1-800-600-9007**

Communication with care providers

UnitedHealthcare is on a **multi-year effort** to enhance our digital delivery channels and transition paper transactions to electronic, whenever possible. Our goal is to make it easier for you to work with us and reduce the time it takes for you to perform claim and clinical activities. We may provide electronic notice of policy, protocol and payment policy changes, news and other important updates.

Accordingly, there are a number of ways clinicians, practice managers, administrative staff, facilities and hospitals can stay up to date on items of interest from UnitedHealthcare:

- **Chat support available**
  Have a question? Skip the phone and chat with a live service advocate when you sign in to the **UnitedHealthcare Provider Portal**.
  Available 7 a.m.–7 p.m. ET, Monday–Friday, chat support can help with claims, prior authorizations, credentialing and member benefits.
- **UHCprovider.com**
  This public website is available 24/7 and does not require registration to access. You'll find valuable resources, including administrative and plan-specific policies, protocols and guides, health plans by state, regulatory and practice updates, and quality programs.
- **UHCprovider.com/PAcommunityplan**
  The UnitedHealthcare Community Plan of Pennsylvania page has state-specific resources, guidance and rules.
- **Policies and protocols**
  UHCprovider.com/policies > **For Community Plans** library includes UnitedHealthcare Community Plan policies and protocols
- **Social media**
  Public websites that provide information about UnitedHealth Group, company updates and partnerships, investor relations, health insights and solutions, and other health care-related topics.
  - Facebook
  - Instagram
  - LinkedIn
  - YouTube
  - X (formerly Twitter)
- **Pennsylvania health plans**
  UHCprovider.com/PA is the fastest way to review all of the health plans UnitedHealthcare offers in Pennsylvania. To review plan information for another state, use the drop-down menu at **UHCprovider.com/plans**. Then choose a state and review the types of plans (commercial, Medicare Advantage, etc.) offered in that market.
- **UnitedHealthcare Community & State newsletter**
  Stay current on the latest insights, trends and resources related to Medicaid. **Sign up** to receive this twice-a-month newsletter.
- **UnitedHealthcare Provider Portal**
  This secure portal is accessible from **UHCprovider.com**. It allows you to access patient information such as eligibility and benefit information and digital ID cards. You can learn more about the portal in **Chapter 1** of this care provider manual or by visiting **UHCprovider.com/portal.**
  - You can also access **self-paced user guides** for many of the tools and tasks available in the portal.
- **UnitedHealthcare Network News**
  Bookmark **UHCprovider.com/networknews**. It's the home for updates across our commercial, Medicare Advantage and Community Plan (Medicaid) health plans.

- You'll find contractual and regulatory updates, process changes and reminders, program launches and resources to help manage your practice and care for patients.
- Get news related to your role, specialty, health plan and state. When you **subscribe** to Network News, you can update your preferences to select what news you receive.
- You'll get the latest news, policy and reimbursement updates we've posted on our news webpage. These email briefs include monthly notification of policy and protocol updates, including medical and reimbursement policy changes. They also include announcements of new programs and changes in administrative procedures. You can tailor your subscription to help ensure you only receive updates relevant to your state, specialty and point of care.

Care provider education and training

To help ensure you are reimbursed accurately and patients have access to the care they need, we have developed a full range of training resources, including interactive self-paced courses and quick reference guides along with registration for instructor-led sessions. Topics include the digital solutions available on the **UnitedHealthcare Provider Portal**, plan and product overviews, clinical tools and state-specific training.

View the training resources at **UHCprovider.com/training**. Content is updated frequently and organized by categories to make it easy to find what you need.

Email communication – required contact information

We must have a valid email address on file to send you required notifications and important information.

Submit your email address in one of the following ways:

1. Sign up for a **One Healthcare ID**, which also gives you access to the **UnitedHealthcare Provider Portal**.
2. **Subscribe** to Network News email briefs to receive regular email updates. Need to update your information? It takes just a few minutes to manage your **email address** and **content preferences**.
3. Already have a One Healthcare ID? To review or update your email, simply sign in to the **UnitedHealthcare Provider Portal**. Go to "Profile & Settings," then "Account Information" to manage your email.

Care provider office visits

Provider advocates regularly visit PCPs and specialist offices. Each advocate is assigned to a care provider group to deliver face-to-face support. We do this to create program awareness, promote compliance and problem resolution.

Care provider manual

UnitedHealthcare Community Plan publishes this manual online. It includes an overview of the program, a toll-free number for **Provider Services** at **1-800-600-9007** and a list of additional care provider resources. If you do not have internet access, request a hard copy of this manual by contacting Provider Services.

Appendix

Appendix A: Consent for provider to file a grievance for member

CONSENT FOR PROVIDER TO FILE A GRIEVANCE FOR MEMBER

Provider Name:	Provider Plan ID Number:
Provider Address:	
Description of Specific Service or Item for which I agree the Provider Can File a Grievance:	Name and Address of UnitedHealthcare Community Plan Where Complaint Will Be Filed: UnitedHealthcare Community Plan Grievance and Complaint Department PO Box 31364 Salt Lake City UT 84131-0364
Member:	Member Date of Birth:
Member ID No.:	
Member Mailing Address:	
Member Daytime Telephone Number:	Member Evening Telephone Number:

I, (Member name), agree that (Provider name), can file a grievance for me with UnitedHealthcare Community Plan of PA ("UnitedHealthcare") about the service or item described above.

By signing this consent form, I understand the following:

1. I or my representative may not file a complaint about the service or item listed in this consent form unless I or my representative takes back my consent in writing. I have the right to take back my consent at any time during the complaint process by telling UnitedHealthcare Community Plan of PA ("UnitedHealthcare") and (Provider name) in writing that I do not want (Provider name) to continue the grievance process for me.

2. My consent to have the Provider file the grievance for me will automatically no longer be in effect if the Provider does not file a grievance or does not continue with the grievance through the end of the grievance review process.

3. I or my representative has read, or has been read, this consent form, and have had it explained to me until I understand it. I or my representative understands the information in this consent form.

Signature of Member or Representative

Witness Signature Date

Print Witness Name Date

If the Member is unable to sign this Consent Form because the Member is legally incompetent:

Name of Person Signing on Behalf of Member

Address of Person Signing on Behalf of Member

Relationship of Person Signing to Member

Appendix B: Form — Authorization to appoint a personal representative

Authorization to Appoint a Personal Representative

A personal representative is a person authorized to represent you through the complaint and grievance process.

Instructions: Please complete and sign this form to appoint a personal representative. A separate form is required for each member. Return in the self-addressed, stamped envelope. AmeriChoice of UnitedHealthcare of., will provide your appointed personal representative the same rights to your protected health information (PHI) that is provided to you.

Member Information: (individual whose information will be released)

Name (Last, First, MI) _____

Identification Number _____

Social Security Number _____ Date of Birth _____

Telephone Number _____

Street Address _____

AUTHORIZATION:

I hereby authorize the request and release of my PHI, held by AmeriChoice, to UnitedHealthcare, representative. By appointing the person named on this form as my personal representative, I understand that I am authorizing UnitedHealthcare to give this person access to my PHI and medical records and the right to talk to UnitedHealthcare about my account.

I understand that my authorization will remain in effect of the length of time specified below.

I have had full opportunity to read and consider the contents of this authorization. I understand that by signing this form, I am confirming my authorization for the request and release of my PHI, as described in this form.

I _____ appoint _____ to be my personal
(Member) (Personal Representative) representative.

Time Period for Representation: From: ___/___/___ To: ___/___/___

NOTE: If no time period is provided, this request will remain in effect until the member or his/her legal representative notifies UnitedHealthcare, in writing, requesting a change.

YOUR RIGHT TO REVOKE: You may revoke this authorization, at any time, by giving written notice to AmeriChoice. (UnitedHealthcare. this authorization will not affect any action we took prior to receiving your written notification. Please contact AmeriChoice fo UnitedHealthcare information if you desire to cancel this authorization.

Personal Representative Information: (required for privacy verification purposes)

Name (Last, First, MI) _____

Social Security Number (last 4 digits) _____ Date of Birth _____

Telephone Number _____

Address _____

Relationship to Member _____

IMPORTANT: Guardians, court-appointed representatives or other responsible parties must send a copy of legal documents. If you have questions or need help, call Member Services at the number listed on the back of the member card.

Signature of Member/Requestor: _____ Date: _____

Printed Name: _____

Appendix C: Medical assistance transportation program phone numbers

Medical Assistance Transportation Program (MATP) provides non-emergency transportation to and from qualified MA-enrolled medical providers and pharmacies of a member's choice who are generally available and used by other residents of their community. This service is provided at no cost to the member. The MATP in the county where the member lives will determine their need for the program and provide the right type of transportation for the member. Transportation services are typically provided in the following ways:

- Where public transportation such as buses, subways or trains are available, MATP provides tokens or passes or repays a member for the public transportation fare if they live within ¼ mile of a fixed route service stop.
- If the member or someone else has a car that they can use to get to appointments, MATP may pay the member an amount per mile plus parking and tolls with valid receipts.
- Where public transportation is not available or is not right for the member, MATP provides rides in paratransit vehicles, which include vans, vans with lifts, or taxis. Usually, the vehicle will have more than 1 rider with different pick-up and drop-off times and locations.

If a member needs transportation to a medical appointment or to the pharmacy, they should contact the local MATP to get more information and to register for services. A complete list of county MATP contact information can be found here: https://matp.pa.gov/CountyContact.aspx., or please see below for a complete list of county MATP contact information.

MATP will confirm with UnitedHealthcare Community Plan or the member's doctor's office that the medical appointment for which the member needs transportation for is a covered service. UnitedHealthcare Community Plan works with MATP to help arrange transportation. Members can also call Member Services for more information at **1-800-414-9025**, TTY **711**.

Transportation is available for Medical Assistance (MA) members to use for medical appointments.

Non-emergency medical transportation services are provided through the Medical Assistance – Transportation Program.

Medical Assistance Transportation program

Each county has a program to help with transportation. If the member needs transportation to their appointments, have them call the phone number for their county.

County	Telephone number	Toll-free number
Adams	1-717-846-7433	1-800-632-9063
Allegheny	412-350-4476	1-888-547-6287
Armstrong	1-724-548-3408	1-800-468-7771
Beaver	1-724-375-2895	1-800-262-0343
Bedford	1-814-623-9129	1-800-323-9997
Berks	1-610-921-2361	1-800-383-2278
Blair	1-814-946-1235	1-800-458-5552
Bradford	1-570-888-7330	1-800-242-3484

County	Telephone number	Toll-free number
Bucks	1-215-794-5554	1-888-795-0740
Butler	1-724-431-3663	1-866-638-0598
Cambria	1-814-535-4630	1-888-647-4814
Cameron	1-866-282-4968	1-866-282-4968
Carbon	1-610-253-8333	1-800-990-4287
Centre	1-814-355-6807	1-814-355-6807
Chester	484-696-3854	1-877-873-8415
Clarion	1-814-226-7012	1-800-672-7116
Clearfield	1-814-765-1551	1-800-822-2610
Clinton	1-570-323-7575	1-800-222-2468
Columbia	1-717-846-7433	1-800-632-9063
Crawford	1-814-333-7090	1-800-210-6226
Cumberland	1-717-846-7433	1-800-632-9063
Dauphin	1-717-232-7009	1-800-309-8905
Delaware	1-610-490-3960	1-610-490-3960
Elk	1-866-282-4968	1-866-282-4968
Erie	1-814-456-2299	1-800-323-5579
Fayette	1-724-628-7433	1-800-321-7433
Forest	1-814-927-8266	1-800-222-1706
Franklin	1-717-846-7433	1-800-632-9063
Fulton	1-717-485-6767	1-888-329-2376
Greene	1-724-627-6778	1-877-360-7433
Huntingdon	1-814-641-6408	1-800-817-3383
Indiana	1-724-801-8857	1-724-801-8857
Jefferson	1-814-938-3302	1-800-648-3381
Juniata	1-717-242-2277	1-800-348-2277
Lackawanna	1-570-963-6482	1-570-963-6482
Lancaster	1-717-291-1243	1-800-892-1122
Lawrence	1-724-652-5588	1-888-252-5104

County	Telephone number	Toll-free number
Lebanon	1-717-273-9328	1-717-273-9328
Lehigh	1-610-253-8333	1-888-253-8333
Luzerne	1-570-288-8420	1-800-679-4135
Lycoming	1-570-323-7575	1-800-222-2468
McKean	1-866-282-4968	1-866-282-4968
Mercer	1-724-662-6222	1-800-570-6222
Mifflin	1-717-242-2277	1-800-348-2277
Monroe	1-570-839-8210	1-888-955-6282
Montgomery	1-215-542-7433	1-215-542-7433
Montour	1-717-846-7433	1-800-632-7433
Northampton	1-610-253-8333	1-888-253-8333
Northumberland	1-717-846-7433	1-800-632-9063
Perry	1-717-846-7433	1-800-632-9063
Philadelphia	1-877-835-7412	1-877-835-7412
Pike	1-570-296-3408	1-866-681-4947
Potter	1-814-544-7315	1-800-800-2560
Schuylkill	1-570-628-1425	1-866-656-0700
Snyder	1-717-846-7433	1-800-632-9063
Somerset	1-814-701-3691	1-800-452-0241
Sullivan	1-570-888-7330	1-800-242-3484
Susquehanna	1-570-278-6140	1-866-278-9332
Tioga	1-570-888-7330	1-800-242-3484
Union	1-717-846-7433	1-800-632-9063
Venango	1-814-432-9767	1-877-836-4699
Warren	1-814-723-1874	1-877-723-9456
Washington	1-724-223-8747	1-800-331-5058
Wayne	1-570-253-4280	1-800-662-0780
Westmoreland	1-724-832-2706	1-800-242-2706
Wyoming	1-570-278-6140	1-866-278-9332
York	1-717-846-7433	1-800-632-9063

Appendix D: Medical record charting standards

- All pages of the record must contain patient identification (name and identifying number)
- The record must contain biographical/personal data, such as age, date of birth, sex, race/ethnicity, and marital status/social supports as well as a notation of cultural/linguistic needs
- Each entry must have provider name, initials, or other identification (even for solo practitioner sites)
- Each entry must be dated and signed
- The record must be legible, as judged by the auditor (illegibility of records may result in the need for provider assistance in completing the audit)
- The record must contain a completed, up-to-date, problem list and a list of all prescribed medications
- Allergies and adverse reactions to medications must be prominently displayed for patients of all ages. Document even if no allergies exist.
- The record must contain an appropriate and organized medical history and physical exam
- Preventive services/risk screenings must be appropriately used and documented
- Pediatric charting must contain a completed immunization record and BMI charting
- Adolescents should be screened for and counseled on depression, substance abuse, tobacco use, sexual activity, exercise and nutrition
- The record must document smoking habits and history of alcohol and substance use: negative histories also must be noted. If the history is positive for any of these habits, document advice to quit.
- Lab and other studies must be signed and documented
- Notes must be appropriate in presenting a problem or complaint
- Working diagnosis(es) must be documented and must be consistent with findings
- Plans of action/treatment must be consistent with diagnosis(es)
- Episodes of emergency care, hospitalizations and discharge summaries must be documented, including follow-up care, such as home health visits, physical therapy reports, etc.
- Each encounter must include documentation of clinical findings and evaluation, as well as a follow-up plan, such as date for return visit
- Each encounter must present evidence that unresolved problems from previous visits have been addressed
- Consultations documented in the record must be appropriate given patient characteristics, history, and presenting problems
- The record must document appropriate coordination of care between the PCP and authorized specialty care provider.
- Consultant summaries, lab reports, imaging study reports, operative procedures, and tissue excisions must be noted in the chart or otherwise reflect care provider's review
- Care must be medically appropriate
- The record must document efforts to educate patients, including lifestyle counseling, and disease specific education.
- Records should reflect the patient's advance directives
- Providers are to maintain an organized medical record keeping system and standards for the availability of medical records and medical record retention
- Providers are to maintain the confidentiality of all medical records in accordance with any applicable statutes and regulations
- All medical records are to be stored securely. Only authorized personnel are to have access to the records and all staff should receive periodic training on maintaining confidentiality of member information.

Appendix E: Civil rights

UnitedHealthcare Community Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex gender, gender identity or expression, or sexual orientation.

UnitedHealthcare Community Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex gender, gender identity or expression, or sexual orientation.

UnitedHealthcare Community Plan provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

UnitedHealthcare Community Plan provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact UnitedHealthcare Community Plan at **800-414-9025, TTY/PA RELAY 711.**

If you believe that UnitedHealthcare Community Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex gender, gender identity or expression, or sexual orientation, you can file a complaint with:

UnitedHealthcare Community Plan
P.O. Box 31364
Salt Lake City, UT 84131-0364
800-414-9025, TTY/PA RELAY 711

The Bureau of Equal Opportunity
Room 223, Health and Welfare Building
P.O. Box 2675
Harrisburg, PA 17105-2675
Phone: **717-787-1127, TTY/PA Relay 711**
Fax: **717-772-4366**, or
Email: **RA-PWBEOAO@pa.gov**

You can file a complaint in person or by mail, fax, or email. If you need help filing a complaint, UnitedHealthcare Community Plan and the Bureau of Equal Opportunity are available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **ocrportal.hhs.gov**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, D.C. 20201
800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at **hhs.gov**.

Appendix F: Language assistance service

1-800-414-9025, TTY 711

English: ATTENTION: Translation and other language assistance services are available at no cost to you. If you need help, please call the number above.

Spanish: ATENCIÓN: La traducción y los servicios de asistencia de otros idiomas se encuentran disponibles sin costo alguno para usted. Si necesita ayuda, llame al número que se indica arriba.

Russian: ВНИМАНИЕ! Услуги перевода, а также другие услуги языковой поддержки предоставляются бесплатно. Если вам требуется помощь, пожалуйста, позвоните по указанному выше номеру.

Chinese (Simplified): 请注意：您可以免费获得翻译和其他语言帮助服务。如果您需要帮助，请拨打上述电话号码。

Vietnamese: CHÚ Ý: Dịch vụ dịch thuật và hỗ trợ ngôn ngữ khác được cung cấp cho quý vị miễn phí. Nếu quý vị cần trợ giúp, vui lòng gọi số ở trên.

Arabic: تنبيه: تتوفر خدمات الترجمة وخدمات المساعدة اللغوية الأخرى لك مجانًا. إذا كنت بحاجة إلى المساعدة، يُرجى الاتصال بالرقم أعلاه.

Nepali: ध्यान दिनुहोस्: तपाईंका लाग िअनुवाद र अन्य भाषा सहायता सेवाहरू नि :शुल्क उपलब्ध छन्। यदि तपाईंलाई मद्दत चाहि न्छ भने कृपया माथ किो नम्बर फोन गर्नि नुनुहोस्।

Korean: 참고: 번역 및 기타 언어 지원 서비스를 무료로 제공해 드립니다. 도움이 필요하시면 위에 명시된 번호로 전화해 주십시오.

Cambodian: សម្គាល់៖ ប្រតិបត្តិការ និងសេវាជំនួយភាសាផ្សេងទៀត គឺអាចរកបានដោយឥតគិតថ្លៃចំពោះរូបអ្នក។ ប្រសិនបើអ្នកត្រូវការជំនួយ សូមហៅទូរសព្ទទៅលេខខាងលើ។

French: ATTENTION : la traduction et d'autres services d'assistance linguistique sont disponibles sans frais pour vous. Si vous avez besoin d'aide, veuillez appeler le numéro ci-dessus.

Burmese: သတိမူရန်- သင့်အတွက် အခကြေးငွေ ကုန်ကျမှု မရှိဘဲ ဘာသာပြန်ဆိုခြင်းနှင့် အခြားသော ဘာသာစကား အကူအညီ ဝန်ဆောင်မှုများကို ရယူနိုင်ပါသည်။ အကူအညီလိုအပ်ပါက အထက်ပါဖုန်း နံပါတ်ကို ခေါ်ဆိုပါ။

Haitian Creole: ATANSYON: Gen tradiksyon ak lòt sèvis èd pou lang ki disponib gratis pou ou. Si w bezwen èd, tanpri rele nimewo ki mansyone anwo a.

Portuguese (Brazil): ATENÇÃO: Serviços de tradução e outros serviços de assistência linguística estão disponíveis sem nenhum custo para você. Se precisar de ajuda, ligue para o número acima.

Bengali: মনোযোগ দিন: অনুবাদ এবং অন্যান্য ভাষা সহায়তা পরিষেবাগুলি আপনার জন্য বিনা খরচে পাওয়া যায়। আপনার সাহায্যের প্রয়োজন হলে অনুগ্রহ করে উপরের নম্বরে কল করুন।

Albanian: VINI RE: Shërbimet e përkthimit dhe të tjera të ndihmës me gjuhën janë në dispozicion pa asnjë kosto për ju. Nëse keni nevojë për ndihmë, ju lutemi telefonojinni numrit më sipër.

Gujarati: ધ્યાન આપો: ભાષાન્તર અને અન્ય ભાષા સહાય સેવાઓ તમારા માટે કોઈપણ ખર્ચ વિના ઉપલબ્ધ છે. જો તમને મદદની જરૂર હોય, તો કૃપા કરીને ઉપરના નંબર પર કૉલ કરો.

Appendix G: Complaints, grievances and fair hearing (from member handbook)

Section 8 – Complaints, grievances, and Fair Hearings

Complaints, grievances, and Fair Hearings

If a provider or UnitedHealthcare Community Plan does something that you are unhappy about or do not agree with, you can tell UnitedHealthcare Community Plan or the Department of Human Services what you are unhappy about or that you disagree with what the provider or UnitedHealthcare Community Plan has done. This section describes what you can do and what will happen.

Complaints

What is a complaint?

A Complaint is when you tell UnitedHealthcare Community Plan you are unhappy with UnitedHealthcare Community Plan or your provider or do not agree with a decision by UnitedHealthcare Community Plan.

Some things you may complain about:

- You are unhappy with the care you are getting
- You cannot get the service or item you want because it is not a covered service or item
- You have not gotten services that UnitedHealthcare Community Plan has approved
- You were denied a request to disagree with a decision that you have to pay your provider

First level complaint

What should I do if I have a complaint?

To file a first level Complaint:

- Call UnitedHealthcare Community Plan at **1-800-414-9025**, TTY/PA Relay **711** and tell UnitedHealthcare Community Plan your Complaint, or
- Write down your Complaint and send it to UnitedHealthcare Community Plan using one of the below methods
- If you received a notice from UnitedHealthcare Community Plan telling you UnitedHealthcare Community Plan's decision and the notice included a Complaint/Grievance Request Form, fill out the form and send it to UnitedHealthcare Community Plan using one of the below methods:

UnitedHealthcare Community Plan's address and fax number for Complaints:

By mail: UnitedHealthcare Community Plan of Pennsylvania
P.O. Box 31364
Salt Lake City, UT 84131-0364

By fax: 1-877-886-8120

By secure email:* **PA_CSA_GA_INTAKE@uhc.com**

* Because emails are not secure unless encrypted by the sender, you should not include personal identifying information such as your date of birth or personal medical information unless you encrypt the email. Your provider can file a Complaint for you if you give the provider your consent in writing to do so.

When should I file a first level complaint?

Some Complaints have a time limit on filing. You must file a Complaint **within 60 days of getting a notice** telling you that:

- UnitedHealthcare Community Plan has decided that you cannot get a service or item you want because it is not a covered service or item
- UnitedHealthcare Community Plan will not pay a provider for a service or item you got
- UnitedHealthcare Community Plan did not tell you its decision about a Complaint or Grievance you told UnitedHealthcare Community Plan about within thirty (30) calendar days from when UnitedHealthcare Community Plan got your Complaint or Grievance
- UnitedHealthcare Community Plan has denied your request to disagree with UnitedHealthcare Community Plan's decision that you have to pay your provider

Section 8 — Complaints, grievances, and Fair Hearings

You must file a Complaint **within 60 days of the date you should have gotten a service or item** if you did not get a service or item. The time by which you should have received a service or item is listed below:

New member appointment for your first examination:	We will make an appointment for you:
Members with HIV/AIDS	with PCP or specialist no later than 7 days after you become a member in UnitedHealthcare Community Plan unless you are already being treated by a PCP or specialist.
Members who receive Supplemental Security Income (SSI)	with PCP or specialist no later than 45 days after you become a member in UnitedHealthcare Community Plan, unless you are already being treated by a PCP or specialist.
Members under the age of 21	with PCP for an EPSDT exam no later than 45 days after you become a member in UnitedHealthcare Community Plan, unless you are already being treated by a PCP or specialist.
All other members	with PCP no later than 3 weeks after you become a member in UnitedHealthcare Community Plan.
Members who are pregnant:	**We will make an appointment for you:**
Pregnant women in their first trimester	with OB/GYN provider within 10 business days of UnitedHealthcare Community Plan learning you are pregnant.
Pregnant women in their second trimester	with OB/GYN provider within 5 business days of UnitedHealthcare Community Plan learning you are pregnant.
Pregnant women in their third trimester	with OB/GYN provider within 4 business days of UnitedHealthcare Community Plan learning you are pregnant.
Pregnant women with high-risk pregnancies	with OB/GYN provider within 24 hours of UnitedHealthcare Community Plan learning you are pregnant.

Appointment with:	An appointment must be scheduled:
PCP	
Urgent medical condition	within 24 hours
Routine appointment	within 10 business days
Health assessment/general physical examination	within 3 weeks
Specialists (when referred by PCP)	
Urgent medical condition	within 24 hours of referral
Routine appointment with one of the following specialists: • Otolaryngology • Dermatology • Pediatric Endocrinology • Pediatric General Surgery • Pediatric Infectious Disease • Pediatric Neurology • Pediatric Pulmonology • Pediatric Rheumatology • Dentist • Orthopedic Surgery • Pediatric Allergy and Immunology • Pediatric Gastroenterology • Pediatric Hematology • Pediatric Nephrology • Pediatric Oncology • Pediatric Rehab Medicine • Pediatric Urology • Pediatric Dentistry	within 15 business days of referral
Routine appointment with all other specialists	within 10 business days of referral

You may file all other Complaints at any time.

Section 8 — Complaints, grievances, and Fair Hearings

What happens after I file a first level complaint?

After you file your Complaint, you will get a letter from UnitedHealthcare Community Plan telling you that UnitedHealthcare Community Plan has received your Complaint, and about the First Level Complaint review process.

You may ask UnitedHealthcare Community Plan to see any information UnitedHealthcare Community Plan has about the issue you filed your Complaint about at no cost to you. You may also send information that you have about your Complaint to UnitedHealthcare Community Plan.

You may attend the Complaint review if you want to attend it. UnitedHealthcare Community Plan will tell you the location, date, and time of the Complaint review at least 10 days before the day of the Complaint review. You may appear at the Complaint review in person, by phone, or by videoconference, if available. If you decide that you do not want to attend the Complaint review, it will not affect the decision.

A committee of 1 or more UnitedHealthcare Community Plan staff who were not involved in and do not work for someone who was involved in the issue you filed your Complaint about will meet to make a decision about your Complaint. If the Complaint is about a clinical issue, a licensed doctor or licensed dentist will be on the committee. UnitedHealthcare Community Plan will mail you a notice within thirty (30) calendar days from the date you filed your First Level Complaint to tell you the decision on your First Level Complaint. The notice will also tell you what you can do if you do not like the decision.

If you need more information about help during the Complaint process, see page 110.

What to do to continue getting services:

If you have been getting the services or items that are being reduced, changed or denied and you file a Complaint verbally, or that is faxed, postmarked, or received by UnitedHealthcare Community Plan within 15 days of the date on the notice telling you that the services or items you have been receiving are not covered services or items for you, the services or items will continue until a decision is made.

What if I do not like UnitedHealthcare Community Plan's decision?

You may ask for an external Complaint review, a Fair Hearing, or an external Complaint review and a Fair Hearing if the Complaint is about one of the following:

- UnitedHealthcare Community Plan's decision that you cannot get a service or item you want because it is not a covered service or item
- UnitedHealthcare Community Plan's decision to not pay a provider for a service or item you got
- UnitedHealthcare Community Plan's failure to decide a Complaint you told UnitedHealthcare Community Plan about within 30 days of receipt from when UnitedHealthcare Community Plan got your Complaint
- You did not get a service or item within the time by which you should have received it
- UnitedHealthcare Community Plan's decision to deny your request to disagree with UnitedHealthcare Community Plan's decision that you have to pay your provider

You must ask for an external Complaint review **within 15 days of the date you got the First Level Complaint decision notice**.

You must ask for a Fair Hearing **within 120 days from the mail date on the notice** telling you the Complaint decision.

For all other Complaints, you may file a Second Level Complaint **within 45 days of the date you got the Complaint decision notice**.

For information about Fair Hearings, see page 111.

For information about external Complaint review, see page 101.

If you need more information about help during the Complaint process, see page 110.

Section 8 — Complaints, grievances, and Fair Hearings

Second level complaint

What should I do if I want to file a second level complaint?

To file a Second Level Complaint:

- Call UnitedHealthcare Community Plan at **1-800-414-9025**, TTY/PA Relay **711** and tell UnitedHealthcare Community Plan your Second Level Complaint, or
- Write down your Second Level Complaint and send it to UnitedHealthcare Community Plan using one of the below methods, or
- Fill out the Complaint Request Form included in your Complaint decision notice and send it to UnitedHealthcare Community Plan using one of the below methods, or

UnitedHealthcare Community Plan's address and fax number for Second Level Complaints:

By mail: UnitedHealthcare Community Plan of Pennsylvania
P.O. Box 31364
Salt Lake City, UT 84131-0364

By fax: 1-877-886-8120

By secure email:* **PA_CSA_GA_INTAKE@uhc.com**

* Because emails are not secure unless encrypted by the sender, you should not include personal identifying information such as your date of birth or personal medical information unless you encrypt the email.

What happens after I file a second level complaint?

After you file your Second Level Complaint, you will get a letter from UnitedHealthcare Community Plan telling you that UnitedHealthcare Community Plan has received your Complaint, and about the Second Level Complaint review process.

You may ask UnitedHealthcare Community Plan to see any information UnitedHealthcare Community Plan has about the issue you filed your Complaint about at no cost to you. You may also send information that you have about your Complaint to UnitedHealthcare Community Plan.

You may attend the Complaint review if you want to attend it. UnitedHealthcare Community Plan will tell you the location, date, and time of the Complaint review at least 15 days before the Complaint review. You may appear at the Complaint review in person, by phone, or by videoconference, if available. If you decide that you do not want to attend the Complaint review, it will not affect the decision.

A committee of 3 or more people, including at least 1 person who does not work for UnitedHealthcare Community Plan, will meet to decide your Second Level Complaint. The UnitedHealthcare Community Plan staff on the committee will not have been involved in and will not have worked for someone who was involved in the issue you filed your Complaint about. If the Complaint is about a clinical issue, a licensed physician or licensed dentist will be on the committee. UnitedHealthcare Community Plan will mail you a notice within 45 days from the date your Second Level Complaint was recieved to tell you the decision on your Second Level Complaint. The letter will also tell you what you can do if you do not like the decision.

If you need more information about help during the Complaint process, see page 110.

What if I do not like UnitedHealthcare Community Plan's decision on my second level complaint?

You may ask for an external review from the Pennsylvania Insurance Department's Bureau of Managed Care.

You must ask for an external review **within 15 days of the date you got the Second Level Complaint decision notice**.

External complaint review

How do I ask for an external complaint review?

Send your written request for an external review of your Complaint to the following:

Pennsylvania Insurance Department
Bureau of Consumer Services
Room 1209, Strawberry Square
Harrisburg, Pennsylvania 17120

Telephone number: 1-877-881-6388

Fax: 717-787-8585

You can also go to the "File a Complaint Page at: **https://www.Insurance.pa.gov/Consumers/**.

If you need help filing your request for external review, call the Bureau of Consumer Services at 1-877-881-6388.

If you ask, the Bureau of Consumer Services will help you put your Complaint in writing.

Section 8 — Complaints, grievances, and Fair Hearings

What happens after I ask for an external complaint review?

The Insurance Department will get your file from UnitedHealthcare Community Plan. You may also send them any other information that may help with the external review of your Complaint.

You may be represented by an attorney or another person such as your representative during the external review.

A decision letter will be sent to you after the decision is made. This letter will tell you all the reason(s) for the decision and what you can do if you do not like the decision.

What to do to continue getting services:

If you have been getting the services or items that are being reduced, changed or denied and your request for an external Complaint review is postmarked or received by the Pennsylvania Insurance Department within 15 days of the date on the notice telling you UnitedHealthcare's First Level Complaint decision that you cannot get service or items you have been receiving because they are not covered services or items for you for the service or items to continue until a decision is made. If you will be asking for both an external Complaint review and a Fair Hearing, you much request both the external Complaint review and the Fair Hearing within 15 days of the date on the notice telling you UnitedHealthcare's First Level Complaint decision. If you want to request a Fair Hearing until after receiving a decision on your external Complaint, service will not continue.

Grievances

What is a grievance?

When UnitedHealthcare Community Plan denies, decreases, or approves a service or item different than the service or item you requested because it is not medically necessary, you will get a notice telling you UnitedHealthcare Community Plan's decision.

A Grievance is when you tell UnitedHealthcare Community Plan you disagree with UnitedHealthcare Community Plan's decision.

What should I do if I have a grievance?

To file a Grievance:

- Call UnitedHealthcare Community Plan at **1-800-414-9025**, TTY/PA Relay **711** and tell UnitedHealthcare Community Plan your Grievance, or
- Write down your Grievance and send it to UnitedHealthcare Community Plan using one of the below methods, or
- Fill out the Complaint/Grievance Request Form included in the denial notice you got from UnitedHealthcare Community Plan and send it to UnitedHealthcare Community Plan using one of the below methods:

  UnitedHealthcare Community Plan's address and fax number for Grievances:

  By mail: UnitedHealthcare Community Plan of Pennsylvania
  P.O. Box 31364
  Salt Lake City, UT 84131-0364

  By fax: 1-877-886-8120

  By secure email:* **PA_CSA_GA_INTAKE@uhc.com**

  * Because emails are not secure unless encrypted by the sender, you should not include personal identifying information such as your date of birth or personal medical information unless you encrypt the email.

Your provider can file a Grievance for you if you give the provider your consent in writing to do so. If your provider files a Grievance for you, you cannot file a separate Grievance on your own.

Section 8 — Complaints, grievances, and Fair Hearings

When should I file a grievance?

You must file a Grievance **within 60 days from the date you get the notice** telling you about the denial, decrease, or approval of a different service or item for you.

What happens after I file a grievance?

After you file your Grievance, you will get a letter from UnitedHealthcare Community Plan telling you that UnitedHealthcare Community Plan has received your Grievance, and about the Grievance review process.

You may ask UnitedHealthcare Community Plan to see any information that UnitedHealthcare Community Plan used to make the decision you filed your Grievance about at no cost to you. You may also send information that you have about your Grievance to UnitedHealthcare Community Plan.

You may attend the Grievance review if you want to attend it. UnitedHealthcare Community Plan will tell you the location, date, and time of the Grievance review at least 10 days before the day of the Grievance review. You may appear at the Grievance review in person, by phone, or by videoconference, if available. If you decide that you do not want to attend the Grievance review, it will not affect the decision.

A committee of 3 or more people, including a licensed doctor or licensed dentist, will meet to decide your Grievance. The UnitedHealthcare Community Plan staff on the committee will not have been involved in and will not have worked for someone who was involved in the issue you filed your Grievance about. UnitedHealthcare Community Plan will mail you a notice 30 days from the date your Grievance was received to tell you the decision on your Grievance. The notice will also tell you what you can do if you do not like the decision.

If you need more information about help during the Grievance process, see page 110.

What to do to continue getting services:

If you have been getting services or items that are being reduced, changed, or denied and you file a Grievance faxed, postmarked, or received by UnitedHealthcare Community Plan within 15 days of the date on the notice telling you that the services or items you have been receiving are being reduced, changed, or denied, the services or items will continue until a decision is made.

What if I do not like UnitedHealthcare Community Plan's decision?

You may ask for an external Grievance review or a Fair Hearing or you may ask for both an external Grievance review and a Fair Hearing. An external Grievance review is a review by a doctor who does not work for UnitedHealthcare Community Plan.

You must ask for an external Grievance review **within 15 days of the date you got the Grievance decision notice**.

You must ask for a Fair Hearing from the Department of Human Services **within 120 days from the date on the notice** telling you the Grievance decision.

For information about Fair Hearings, see page 111.

For information about external Grievance review, see page 106.

If you need more information about help during the Grievance process, see page 110.

External grievance review

How do I ask for external grievance review?

To ask for an external Grievance review:

- Call UnitedHealthcare Community Plan at **1-800-414-9025**, TTY/PA Relay **711** and tell UnitedHealthcare Community Plan your Grievance, or
- Write down your Grievance and send it to UnitedHealthcare Community Plan using one of the below methods:

  By mail: UnitedHealthcare Community Plan of Pennsylvania
  P.O. Box 31364
  Salt Lake City, UT 84131-0364

  By fax: 1-877-886-8120

  By secure email:* **PA_CSA_GA_INTAKE@uhc.com**

  * Because emails are not secure unless encrypted by the sender, you should not include personal identifying information such as your date of birth or personal medical information unless you encrypt the email.

UnitedHealthcare Community Plan will send your request for external Grievance review to the Insurance Department.

What happens after I ask for an external grievance review?

UnitedHealthcare will notify you of the external Grievance reviewer's name, address, email address, fax number, and phone number. You will also be given information about the external Grievance review process.

UnitedHealthcare Community Plan will send your Grievance file to the reviewer. You may provide additional information that may help with the external review of your Grievance to the reviewer within 20 days of being notified of the request for an external Grievance review reviewer's name.

You will receive a decision letter within 60 days of the date you asked for an external Grievance review. This letter will tell you all the reason(s) for the decision and what you can do if you do not like the decision.

What to do to continue getting services:

If you have been getting the services or items that are being reduced, changed, or denied and you ask for an external Grievance review verbally or in a written request that is postmarked or received by the Pennsylvania Insurance Department within 15 days of the date on the notice telling you UnitedHealthcare Community Plan's Grievance decision, the services or items will continue until a decision is made.

If you will be asking for both an external Grievance review and a Fair Hearing, you must request both the external Grievance review and the Fair Hearing within 15 days of the date on the notice telling you UnitedHealthcare's Grievance decision. If you wait to request a Fair Hearing until after receiving a decision on your external Grievance, services will not continue.

Expedited complaints and grievances

What can I do if my health is at immediate risk?

If your doctor or dentist believes that waiting 30 days to get a decision about your 1st Level Complaint or Grievance, or 45 days to get a decision about your 2nd Level Complaint could harm your health, you or your doctor or dentist may ask that your Complaint or Grievance be decided more quickly. For your Complaint or Grievance to be decided more quickly:

- You must ask UnitedHealthcare Community Plan for an early decision by calling UnitedHealthcare Community Plan at **1-800-414-9025**, TTY/PA Relay **711**, faxing a letter or the Complaint/Grievance Request Form to 801-994-1261, or sending an email to **pa_csa_ga_intake@uhc.com**
- Your doctor or dentist should fax a signed letter to 801-994-1261 within 72 hours of your request for an early decision that explains why UnitedHealthcare Community Plan taking 30 or 45 days to tell you the decision about your Complaint or Grievance could harm your health

If UnitedHealthcare Community Plan does not receive a letter from your doctor or dentist and the information provided does not show that taking the usual amount of time to decide your Complaint or Grievance could harm your health, UnitedHealthcare Community Plan will decide your Complaint or Grievance in the usual timeframe of 30 days from when UnitedHealthcare Community Plan first got your Complaint or Grievance.

Section 8 — Complaints, grievances, and Fair Hearings

Expedited complaint and expedited external complaint

Your expedited Complaint will be reviewed by a committee that includes a licensed doctor or licensed dentist. If the Complaint is about dental services, the expedited Complaint review committee will include a dentist. Members of the committee will not have been involved in and will not have worked for someone who was involved in the issue you filed your Complaint about.

You may attend the expedited Complaint review if you want to attend it. You can attend the Complaint review in person, but may have to appear by phone or by videoconference because UnitedHealthcare Community Plan has a short amount of time to decide an expedited Complaint. If you decide that you do not want to attend the Complaint review, it will not affect the decision.

UnitedHealthcare Community Plan will tell you the decision about your Complaint within 48 hours of when UnitedHealthcare Community Plan gets your doctor's or dentist's letter explaining why the usual timeframe for deciding your Complaint will harm your health or within 72 hours from when UnitedHealthcare Community Plan gets your request for an early decision, whichever is sooner, unless you ask UnitedHealthcare Community Plan to take more time to decide your Complaint. You can ask UnitedHealthcare Community Plan to take up to 14 more days to decide your Complaint. You will also get a notice telling you the reason(s) for the decision and how to ask for expedited external Complaint review, if you do not like the decision.

If you did not like the expedited Complaint decision, you may ask for an expedited external Complaint review from the Pennsylvania Insurance Department within 2 business days from the date you get the expedited Complaint decision notice. To ask for expedited external review of a Complaint:

- Call UnitedHealthcare Community Plan at **1-800-414-9025**, TTY/PA Relay **711** and tell UnitedHealthcare Community Plan your Complaint, or
- Send an email to UnitedHealthcare Community Plan at **pa_csa_ga_intake@uhc.com**, or
- Write down your Complaint and send it to UnitedHealthcare Community Plan by mail or fax:

  UnitedHealthcare Community Plan of Pennsylvania
  P.O. Box 31364
  Salt Lake City, UT 84131-0364

  801-994-1261

UnitedHealthcare Community Plan will send your request for expedited review to the Pennsylvania Insurance Department within 24 hours of receiving it.

Expedited grievance and expedited external grievance

A committee of 3 or more people, including a licensed doctor or licensed dentist, will meet to decide your Grievance. If the Grievance is about dental services, the expedited Grievance review committee will include a dentist. The UnitedHealthcare Community Plan staff on the committee will not have been involved in and will not have worked for someone who was involved in the issue you filed your Grievance about.

You may attend the expedited Grievance review if you want to attend it. You can attend the Grievance review in person, but may have to appear by phone or by videoconference because UnitedHealthcare Community Plan has a short amount of time to decide the expedited Grievance. If you decide that you do not want to attend the Grievance review, it will not affect our decision.

UnitedHealthcare Community Plan will tell you the decision about your Grievance within 48 hours of when UnitedHealthcare Community Plan gets your doctor's or dentist's letter explaining why the usual timeframe for deciding your Grievance will harm your health or within 72 hours from when UnitedHealthcare Community Plan gets your request for an early decision, whichever is sooner, unless you ask UnitedHealthcare Community Plan to take more time to decide your Grievance. You can ask UnitedHealthcare Community Plan to take up to 14 more days to decide your Grievance. You will also get a notice telling you the reason(s) for the decision and what to do if you do not like the decision.

If you do not like the expedited Grievance decision, you may ask for an expedited external Grievance review or an expedited Fair Hearing by the Department of Human Services or both an expedited external Grievance review and an expedited Fair Hearing. An expedited external Grievance review is a review by a doctor who does not work for UnitedHealthcare.

You must ask for expedited external Grievance review **within 2 business days from the date you get the expedited Grievance decision notice**. To ask for expedited external review of a Grievance:

- Call UnitedHealthcare Community Plan at **1-800-414-9025**, TTY/PA Relay **711** and tell UnitedHealthcare Community Plan your Grievance, or
- Send an email to UnitedHealthcare Community Plan at **pa_csa_ga_intake@uhc.com**, or
- Write down your Grievance and send it to UnitedHealthcare Community Plan by mail or fax:

  UnitedHealthcare Community Plan of Pennsylvania
  P.O. Box 31364
  Salt Lake City, UT 84131-0364

  801-994-1261

UnitedHealthcare Community Plan will send your request to the Pennsylvania Insurance Department within 24 hours after receiving it.

You must ask for a Fair Hearing **within 120 days from the date on the notice** telling you the expedited Grievance decision.

Section 8 — Complaints, grievances, and Fair Hearings

What kind of help can I have with the complaint and grievance processes?

If you need help filing your Complaint or Grievance, a staff member of UnitedHealthcare Community Plan will help you. This person can also represent you during the Complaint or Grievance process. You do not have to pay for the help of a staff member. This staff member will not have been involved in any decision about your Complaint or Grievance.

You may also have a family member, friend, lawyer or other person help you file your Complaint or Grievance. This person can also help you if you decide you want to appear at the Complaint or Grievance review.

At any time during the Complaint or Grievance process, you can have someone you know represent you or act for you. If you decide to have someone represent or act for you, tell UnitedHealthcare Community Plan, in writing, the name of that person and how UnitedHealthcare Community Plan can reach him or her.

You or the person you choose to represent you may ask UnitedHealthcare Community Plan to see any information UnitedHealthcare Community Plan has about the issue you filed your Complaint or Grievance about at no cost to you.

You may call UnitedHealthcare Community Plan's toll-free telephone number at **1-800-414-9025**, TTY/PA Relay **711** if you need help or have questions about Complaints and Grievances, you can contact your local legal aid office at 1-800-322-7572 or call the Pennsylvania Health Law Project at 1-800-274-3258.

Persons whose primary language is not English

If you ask for language services, UnitedHealthcare Community Plan will provide the services at no cost to you.

Persons with disabilities

UnitedHealthcare Community Plan will provide persons with disabilities with the following help in presenting Complaints or Grievances at no cost, if needed. This help includes:

- Providing sign language interpreters
- Providing information submitted by UnitedHealthcare Community Plan at the Complaint or Grievance review in an alternative format. The alternative format version will be given to you before the review; and
- Providing someone to help copy and present information.

Department of Human Services Fair Hearings

In some cases, you can ask the Department of Human Services to hold a hearing because you are unhappy about or do not agree with something UnitedHealthcare Community Plan did or did not do. These hearings are called "Fair Hearings." You can ask for a Fair Hearing after UnitedHealthcare Community Plan decides your First Level Complaint or decides your Grievance.

What can I request a Fair Hearing about and by when do I have to ask for a Fair Hearing?

Your request for a Fair Hearing must be postmarked, faxed, or submitted via email* **within 120 days from the date on the notice** telling you UnitedHealthcare Community Plan's decision on your First Level Complaint or Grievance about the following:

- The denial of a service or item you want because it is not a covered service or item
- The denial of payment to a provider for a service or item you received and the provider can bill you for the service or item
- UnitedHealthcare Community Plan's failure to decide a First Level Complaint or Grievance you told UnitedHealthcare Community Plan about within 30 days from when UnitedHealthcare Community Plan got your Complaint or Grievance
- The denial of your request to disagree with UnitedHealthcare Community Plan's decision that you have to pay your provider
- The denial of a service or item, decrease of a service or item, or approval of a service or item different from the service or item you requested because it was not medically necessary
- You're not getting a service or item within the time by which you should have received a service or item

You can also request a Fair Hearing within 120 days from the date on the notice telling you that UnitedHealthcare Community Plan failed to decide a First Level Complaint or Grievance you told UnitedHealthcare Community Plan about within 30 days from when UnitedHealthcare Community Plan got your Complaint or Grievance.

* Because emails are not secure unless encrypted by the sender, you should not include personal identifying information such as your date of birth or personal medical information unless you encrypt the email.

Section 8 — Complaints, grievances, and Fair Hearings

How do I ask for a Fair Hearing?

Your request for a Fair Hearing must be in writing. You can either fill out and sign the Fair Hearing Request Form included in the Complaint or the Grievance decision notice or write and sign a letter or email.

If you write a letter or email, it needs to include the following information:

- Your (the member's) name and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have the Fair Hearing in person or by telephone;
- The reason(s) you are asking for a Fair Hearing; and
- A copy of any letter you received about the issue you are asking for a Fair Hearing about.

* Because emails are not secure unless encrypted by the sender, you should not include personal identifying information such as your date of birth or personal medical information unless you encrypt the email. You may send a request for a Fair Hearing through email and provide your personal identifying information in a letter mailed to the above address.

You must send your request for a Fair Hearing to the following address:

Department of Human Services
Office of Medical Assistance Programs – HealthChoices Program
Complaint, Grievance and Fair Hearings
P.O. Box 2675
Harrisburg, PA 17105-2675

Fax: 1-717-772-6328

Email: **RA-PWCGFHteam@pa.gov**

What happens after I ask for a Fair Hearing?

You will get a letter from the Department of Human Services' Bureau of Hearings and Appeals telling you where the hearing will be held and the date and time for the hearing. You will receive this letter at least 10 days before the date of the hearing.

You may come to where the Fair Hearing will be held or be included by phone. A family member, friend, lawyer or other person may help you during the Fair Hearing. You **MUST** participate in the Fair Hearing.

UnitedHealthcare Community Plan will also go to your Fair Hearing to explain why UnitedHealthcare Community Plan made the decision or explain what happened.

You may ask UnitedHealthcare Community Plan to give you any records, reports and other information about the issue you requested your Fair Hearing about at no cost to you.

When will the Fair Hearing be decided?

The Fair Hearing will be decided within 90 days from when you filed your Complaint or Grievance with UnitedHealthcare Community Plan, not including the number of days between the date on the written notice of the UnitedHealthcare Community Plan's First Level Complaint decision or Grievance decision and the date you asked for a Fair Hearing.

If you requested a Fair Hearing because UnitedHealthcare Community Plan did not tell you its decision about a Complaint or Grievance you told UnitedHealthcare Community Plan about within 30 days from when UnitedHealthcare Community Plan got your Complaint or Grievance, your Fair Hearing will be decided within 90 days from when you filed your Complaint or Grievance with UnitedHealthcare Community Plan, not including the number of days between the date on the notice telling you that UnitedHealthcare Community Plan failed to timely decide your Complaint or Grievance and the date you asked for a Fair Hearing.

The Department of Human Services will send you the decision in writing and tell you what to do if you do not like the decision.

If your Fair Hearing is not decided within 90 days from the date the Department of Human Services receives your request, you may be able to get your services until your Fair Hearing is decided. You can call the Department of Human Services at 1-800-798-2339 to ask for your services.

What to do to continue getting services:

If you have been getting the services or items that are being reduced, changed or denied and you ask for a Fair Hearing and your request is postmarked or received by the Department of Human Services within 15 days of the date on the notice telling you UnitedHealthcare Community Plan's First Level Complaint or Grievance decision, the services or items will continue until a decision is made.

Section 8 — Complaints, grievances, and Fair Hearings

Expedited Fair Hearing

What can I do if my health is at immediate risk?

If your doctor or dentist believes that waiting the usual timeframe for deciding a Fair Hearing could harm your health, you may ask that the Fair Hearing take place more quickly. This is called an expedited Fair Hearing. You can ask for an early decision by calling the Department at 1-800-798-2339 or by faxing a letter or the Fair Hearing Request Form to 717-772-6328, or submitting a written request electronically via email* to **RA-PWCGFHteam@pa.gov**. Your doctor or dentist must fax a signed letter to 717-772-6328 explaining why taking the usual amount of time to decide your Fair Hearing could harm your health. If your doctor or dentist does not send a letter, your doctor or dentist must testify at the Fair Hearing to explain why taking the usual amount of time to decide your Fair Hearing could harm your health.

The Bureau of Hearings and Appeals will schedule a telephone hearing and will tell you its decision within 3 business days after you asked for a Fair Hearing.

If your doctor does not send a written statement and does not testify at the Fair Hearing, the Fair Hearing decision will not be expedited. Another hearing will be scheduled, and the Fair Hearing will be decided using the usual timeframe for deciding a Fair Hearing.

* Because emails are not secure unless encrypted by the sender, you should not include personal identifying information such as your date of birth or personal medical information unless you encrypt the email.

You may call UnitedHealthcare Community Plan's toll-free telephone number at **1-800-414-9025**, TTY/PA Relay **711** if you need help or have questions about Fair Hearings, you can contact your local legal aid office at 1-800-322-7572 or call the Pennsylvania Health Law Project at 1-800-274-3258.

County Assistance Office contact information

County Assistance Office contact information		
County	**Assistance Office address**	**Telephone/Fax numbers**
Adams	Adams County Assistance Office 225 South Franklin Street P.O. Box 4446 Gettysburg, PA 17325-4446 Office Hours: 8:30 AM to 5 PM	Toll-Free: 1-800-638-6816 Phone: 717-334-6241 Fax: 717-334-4104
Allegheny	Allegheny County Assistance Office Headquarters Piatt Place 301 5th Avenue, Suite 470 Pittsburgh, PA 15222 Office Hours: 7:30 AM to 5 PM	Phone: 412-565-2146 Fax: 412-565-3660
	Low Income Home Energy Assistance Program (LIHEAP) 5947 Penn Avenue, 4th Floor Pittsburgh, PA 15206 *** The entrance is at Kirkwood Street and North Highland Avenue.** Office Hours: 7:30 AM to 5 PM	Phone: 412-562-0330 Fax: 412-565-0107
	Alle-Kiski District 909 Industrial Blvd New Kensington, PA 15068-0132 Office Hours: 7:30 AM to 5 PM	Toll-Free: 1-800-622-3527 Phone: 724-339-6800 Fax: 724-339-6850
	Institution-Related Eligibility District (IRED) 301 5th Avenue, Suite 420 Pittsburgh, PA 15222 Office Hours: 7:30 AM to 5 PM	Phone: 412-565-5604 Fax: 412-565-5074

Section 8 — County Assistance Office contact Information

County Assistance Office contact information		
County	**Assistance Office address**	**Telephone/Fax numbers**
Allegheny (continued)	Liberty District 332 5th Avenue, Suite 300 Pittsburgh, PA 15222 Office Hours: 7:30 AM to 5 PM	Phone: 412-565-2652 Fax: 412-565-5088
	Three Rivers District Warner Center 332 Fifth Avenue, 2nd Floor Pittsburgh, PA 15222 Office Hours: 7:30 AM to 5 PM	Phone: 412-565-7755 Fax: 412-565-5198 or 5075
	Southeast District 220 Sixth Street McKeesport, PA 15132-2720 Office Hours: 7:30 AM to 5 PM	Phone: 412-664-6800 or 6801 Fax: 412-664-5218
	Southern District 332 Fifth Avenue, Suite 230 Pittsburgh, PA 15222 Office Hours: 7:30 AM to 5 PM	Phone: 412-565-2232 Fax: 412-770-3686 or 412-565-5713
	Greater Pittsburgh East District 5947 Penn Avenue Pittsburgh, PA 15206-3844 Office Hours: 7:30 AM to 5 PM	Phone: 412-645-7400 or 7401 Fax: 412-365-2821
Armstrong	Armstrong County Assistance Office 1280 North Water Street Kittanning, PA 16201-0898 Office Hours: 7:30 AM to 5 PM	Toll-Free: 1-800-424-5235 Phone: 724-543-1651 LIHEAP: 724-543-6076 or 800-543-5105 Fax: 724-548-0274
Beaver	Beaver County Assistance Office 171 Virginia Avenue P. O. Box 349 Rochester, PA 15074-0349 Office Hours: 7 AM to 5 PM	Toll-Free: 1-800-653-3129 Phone: 724-773-7300 LIHEAP: 724-773-7495 Fax: 724-773-7859

Section 8 — County Assistance Office contact Information

County Assistance Office contact information		
County	**Assistance Office address**	**Telephone/Fax numbers**
Bedford	Bedford County Assistance Office 150 North Street Bedford, PA 15522-1040 Office Hours: 8 AM to 5 PM	Toll-Free: 1-800-542-8584 Phone: 814-623-6127 LIHEAP: 814-624-4072 Fax: 814-623-7310
Berks	Berks County Assistance Office Reading State Office Building 625 Cherry Street Reading, PA 19602-1188 Office Hours: 8 AM to 5 PM	Toll-Free: 1-866-215-3912 Phone: 610-736-4211 LIHEAP: 610-736-4228 or 866-215-3911 Fax: 610-736-4004
Blair	Blair County Assistance Office 1100 Green Avenue Altoona, PA 16601-3440 Office Hours: 7:30 AM to 5 PM	Toll-Free: 1-866-812-3341 LIHEAP: 814-946-7365 Fax: 814-941-6813
Bradford	Bradford County Assistance Office 1 Elizabeth Street, Suite 4 P.O. Box 398 Towanda, PA 18848-0398 Office Hours: 8 AM to 5 PM	Toll-Free: 1-800-542-3938 Phone: 570-265-9186 Fax: 570-265-3061
Bucks	Bucks County Assistance Office 1214 Veterans Highway Bristol, PA 19007-2593 Office Hours: 8 AM to 5 PM	Phone: 215-781-3300 Toll-Free: 1-800-362-1291 LIHEAP: 215-781-3393 or 1-800-616-6481 Fax: 215-781-3438
Butler	Butler County Assistance Office 108 Woody Dr. Butler, PA 16001-5692 Office Hours: 7:30 AM to 5 PM	Toll-Free: 1-866-256-0093 Phone: 724-284-8844 Fax: 724-284-8833
Cambria	Cambria County Assistance Office 625 Main Street Johnstown, PA 15901-1678 Office Hours: 7 AM to 5 PM	Toll-Free: 1-877-315-0389 Phone: 814-533-2491 LIHEAP: 814-533-2253 Fax: 814-533-2214

Section 8 — County Assistance Office contact Information

County Assistance Office contact information		
County	**Assistance Office address**	**Telephone/Fax numbers**
Cameron	Cameron County Assistance Office 411 Chestnut Street P.O. Box 71 Emporium, PA 15834-0071 Office Hours: 8:30 AM to 5 PM	Toll-Free: 1-877-855-1824 Phone: 814-486-3757 LIHEAP: 814-486-1206 Fax: 814-486-1379
Carbon	Carbon County Assistance Office 101 Lehigh Drive Lehighton, PA 18235 Office Hours: 7:30 AM to 5 PM	Toll-Free: 1-800-314-0963 Phone: 610-577-9020 LIHEAP: (cash) 610-577-9073 LIHEAP: (crisis) 866-410-2093 Fax: 610-577-9043
Centre	Centre County Assistance Office 2580 Park Center Boulevard State College, PA 16801-3005 Office Hours: 8 AM to 5 PM	Toll-Free: 1-800-355-6024 Phone: 814-863-6571 LIHEAP: 814-861-1955 Fax: 814-689-1356
Chester	Chester County Assistance Office 100 James Buchanan Drive Thorndale, PA 19372-1132 Office Hours: 8 AM to 5 PM	Toll-Free: 1-888-814-4698 Phone: 610-466-1000 LIHEAP: 610-466-1042 Fax: 610-466-1130
Clarion	Clarion County Assistance Office 71 Lincoln Drive Clarion, PA 16214-3861 Office Hours: 8 AM to 5 PM	Toll-Free: 1-800-253-3488 Phone: 814-226-1700 LIHEAP: 814-226-1780 Fax: 814-226-1794
Clearfield	Clearfield County Assistance Office 1025 Leonard Street Clearfield, PA 16830 Office Hours: 7:30 AM to 5 PM	Toll-Free: 1-800-521-9218 Phone: 814-765-7591 LIHEAP: 814-765-0684 or 800-862-8941 Fax: 814-765-0802
Clinton	Clinton County Assistance Office 300 Bellefonte Avenue, Suite 101 Lock Haven, PA 17745-1929 Office Hours: 7:30 AM to 5 PM	Toll-Free: 1-800-820-4159 Phone: 570-748-2971 LIHEAP: 570-893-4409 Fax: 570-893-2973

Section 8 — County Assistance Office contact Information

County Assistance Office contact information		
County	**Assistance Office address**	**Telephone/Fax numbers**
Columbia	Columbia County Assistance Office 27 East Seventh Street P.O. Box 628 Bloomsburg, PA 17815-0628 Office Hours: 8 AM to 5 PM	Toll-Free: 1-877-211-1322 Phone: 570-387-4200 LIHEAP: 570-387-4232 Fax: 570-387-4708
Crawford	Crawford County Assistance Office 1084 Water Street P.O. Box 1187 Meadville, PA 16335-7187 Office Hours: 7:30 AM to 5 PM	Toll-Free:1-800-527-7861 Phone: 814-333-3400 LIHEAP: 814-333-3400 Fax: 814-333-3527
Cumberland	Cumberland County Assistance Office 33 Westminster Drive Carlisle, PA 17013-0599 Office Hours: 7:45 AM to 5 PM	Toll-Free: 1-800-269-0173 Phone: 717-240-2700 Fax: 717-240-2781
Dauphin	Dauphin County Assistance Office 2432 N. 7th Street P.O. Box 5959 Harrisburg, PA 17110-0959 Office Hours: 8 AM to 5 PM	Toll-Free: 1-800-788-5616 Phone: 717-787-2324 LIHEAP: 717-265-8919 Fax: 717-772-4703
Delaware	Delaware County Assistance Office Headquarters 701 Crosby Street, Suite A Chester, PA 19013-6099 Office Hours: 8 AM to 5 PM	Phone: 610-447-5500 LIHEAP: 610-447-3099 Fax: 610-447-5399
	Crosby District 701 Crosby Street, Suite A Chester, PA 19013-6099 Office Hours: 8 AM to 5 PM	Phone: 610-447-5500 LIHEAP: 610-447-3099 Fax: 610-447-5399
	Darby District 845 Main Street Darby, PA 19023 Office Hours: 8 AM to 5 PM	Phone: 610-461-3800 Fax: 610-461-3900

Section 8 — County Assistance Office contact Information

County Assistance Office contact information		
County	**Assistance Office address**	**Telephone/Fax numbers**
Elk	Elk County Assistance Office 145 Race Street P.O. Box F Ridgway, PA 15853-0327 Office Hours: 8:30 AM to 5 PM	Toll-Free: 1-800-847-0257 Phone: 814-776-1101 LIHEAP: 814-772-5215 or 814-776-1101 Fax: 814-772-7007
Erie	Erie County Assistance Office 1316 Holland Street P.O. Box 958 Erie, PA 16512-0958 Office Hours: 7:30 AM to 5 PM	Toll-Free: 1-800-635-1014 Phone: 814-461-2000 LIHEAP: 814-461-2002 Fax: 814-461-2294
Fayette	Fayette County Assistance Office 41 West Church Street Uniontown, PA 15401-3418 Office Hours: 7:30 AM to 5 PM	Toll-Free: 1-877-832-7545 Phone: 724-439-7015 LIHEAP: 724-439-7125 Fax: 724-439-7002
Forest	Forest County Assistance Office 106 Sherman Street Tionesta, PA 16353 Office Hours: 7:30 AM to 5 PM	Toll-Free: 1-800-876-0645 Phone: 814-755-3552 Fax: 814-755-3420
Franklin	Franklin County Assistance Office 620 Norland Avenue Chambersburg, PA 17201-4205 Office Hours: 8 AM to 5 PM	Toll-Free: 1-877-289-9177 Phone: 717-264-6121 LIHEAP: 717-262-6579 Fax: 717-264-4801
Fulton	Fulton County Assistance Office 539 Fulton Drive McConnellsburg, PA 17233 Office Hours: 8 AM to 5 PM	Toll-Free: 1-800-222-8563 Phone: 717-485-3151 Fax: 717-485-3713
Greene	Greene County Assistance Office 108 Greene Plaza, Suite 1 Waynesburg, PA 15370-0950 Office Hours: 8 AM to 5 PM	Toll-Free: 1-888-410-5658 Phone: 724- 627-8171 Fax: 724-627-8096

Section 8 — County Assistance Office contact Information

County Assistance Office contact information		
County	**Assistance Office address**	**Telephone/Fax numbers**
Huntingdon	Huntingdon County Assistance Office 7591 Lake Raystown Shopping Center Huntingdon, PA 16652-0398 Office Hours: 8 AM to 5 PM	Toll-Free: 1-800-237-7674 Phone: 814-643-1170 LIHEAP: 814-643-4098 Fax: 814-643-5441
Indiana	Indiana County Assistance Office 2750 West Pike Road Indiana, PA 15701 Office Hours: 7 AM to 5 PM	Toll-Free: 1-800-742-0679 Phone: 724-357-2900 LIHEAP: 724-357-2918 Fax: 724-357-2951
Jefferson	Jefferson County Assistance Office 100 Prushnok Drive P.O. Box 720 Punxsutawney, PA 15767-0720 Office Hours: 8:30 AM to 5 PM	Toll-Free: 1-800-242-8214 Phone: 814-938-2990 LIHEAP: 814-938-1329 Fax: 814-938-3842
Juniata	Juniata County Assistance Office 100 Meadow Lane P.O. Box 65 Mifflintown, PA 17059-9983 Office Hours: 8:30 AM to 5 PM	Toll-Free: 1-800-586-4282 Phone: 717-436-2158 Fax: 717-436-5402
Lackawanna	Lackawanna County Assistance Office 200 Scranton State Office Building 100 Lackawanna Avenue Scranton, PA 18503-1972 Office Hours: 7:30 AM to 5 PM	Toll-Free: 1-877-431-1887 Phone: 570-963-4525 LIHEAP: 570-963-4842 Fax: 570-963-4843
Lancaster	Lancaster County Assistance Office 832 Manor Street P.O. Box 4967 Lancaster, PA 17604-4967 Office Hours: 8 AM to 5 PM	Phone: 717-299-7411 LIHEAP: (cash) 717-299-7543 LIHEAP: (crisis) 717-299-7543 Fax: 717-299-7565

Section 8 — County Assistance Office contact Information

County Assistance Office contact information		
County	**Assistance Office address**	**Telephone/Fax numbers**
Lawrence	Lawrence County Assistance Office 108 Cascade Galleria New Castle, PA 16101-3900 Office Hours: 7:30 AM to 5 PM	Toll-Free: 1-800-847-4522 Phone: 724-656-3000 LIHEAP: 724-656-3021 Fax: 724-656-3076
Lebanon	Lebanon County Assistance Office 625 South Eighth Street Lebanon, PA 17042-6762 Office Hours: 8 AM to 5 PM	Toll-Free: 1-800-229-3926 Phone: 717-270-3600 LIHEAP: 717-273-1641 Fax: 717-228-2589
Lehigh	Lehigh County Assistance Office 555 Union Blvd., Suite 3 Allentown, PA 18109-3389 Office Hours: 7:30 AM to 5 PM	Toll-Free: 1-877-223-5956 Phone: 610-821-6509 Fax: 610-821-6705
Luzerne	Luzerne County Assistance Office Wilkes-Barre District 205 South Washington Street Wilkes-Barre, PA 18711-3298 Office Hours: 7:30 AM to 5 PM	Toll-Free: 1-866-220-9320 Phone: 570-826-2100 LIHEAP: 570-826-2041 LIHEAP: (crisis): 570-826-0510 Fax: 570-826-2178
	Hazleton District Center Plaza Building 10 West Chestnut Street Hazleton, PA 18201-6409 Office Hours: 7:30 AM to 5 PM	Phone: 570-459-3800 LIHEAP: 570-459-3834 Fax: 570-459-3931
Lycoming	Lycoming County Assistance Office 400 Little League Boulevard P.O. Box 127 Williamsport, PA 17703-0127 Office Hours: 7:30 AM to 5 PM	Toll-Free: 1-877-867-4014 Phone: 570-327-3300 LIHEAP: 570-327-3497 Fax: 570-321-6501
McKean	McKean County Assistance Office 68 Chestnut Street, Suite B Braford, PA 16701-0016 Office Hours: 7:30 AM to 5 PM	Toll-Free: 1-800-822-1108 Phone: 814-362-4671 Fax: 814-362-4959

Section 8 — County Assistance Office contact Information

County Assistance Office contact information		
County	**Assistance Office address**	**Telephone/Fax numbers**
Mercer	Mercer County Assistance Office 2236 Highland Road Hermitage, PA 16148-2896 Office Hours: 7:30 AM to 5 PM	Toll-Free: 1-800-747-8405 Phone: 724-983-5000 LIHEAP: 724-983-5022 Fax: 724-983-5706
Mifflin	Mifflin County Assistance Office 1125 Riverside Drive Lewistown, PA 17044-1942 Office Hours: 7:30 AM to 5 PM	Toll-Free: 1-800-382-5253 Phone: 717-248-6746 LIHEAP: 717-242-6095 Fax: 717-242-6099
Monroe	Monroe County Assistance Office 1972 W. Main Street, Suite 101 Stroudsburg, PA 18360-0232 Office Hours: 7:30 AM to 5 PM	Toll-Free: 1-877-905-1495 Phone: 570-424-3030 LIHEAP: 570-424-3517 Fax: 570-424-3915
Montgomery	Montgomery County Assistance Office Norristown District 1931 New Hope Street Norristown, PA 19401-3191 Office Hours: 8 AM to 5 PM	Toll-Free: 1-877-398-5571 Phone: 610-270-3500 LIHEAP: 610-272-1752 Fax: 610-270-1678
	Pottstown District 24 Robinson Street Pottstown, PA 19464-5584 Office Hours: 8 AM to 5 PM	Toll-Free: 1-800-641-3940 Phone: 610-327-4280 LIHEAP: 610-272-1752 Fax: 610-327-4350
Montour	Montour County Assistance Office 497 Church Street Danville, PA 17821-2217 Office Hours: 8 AM to 5 PM	Toll-Free: 1-866-596-5944 Phone: 570-275-7430 LIHEAP: 1-866-410-2093 Fax: 570-275-7433
Northampton	Northampton County Assistance Office 201 Larry Holmes Drive P.O. Box 10 Easton, PA 18044-0010 Office Hours: 7:30 AM to 5 PM	Toll-Free: 1-800-349-5122 Phone: 610-250-1700 LIHEAP: 610-250-1785/6 Fax: 610-250-1839

Section 8 — County Assistance Office contact Information

County Assistance Office contact information		
County	**Assistance Office address**	**Telephone/Fax numbers**
Northumberland	Northumberland County Assistance Office 320 Chestnut Street Sunbury, PA 17801 Office Hours: 8 AM to 5 PM	Toll-Free: 1-800-368-8390 Phone: 570-988-5900 LIHEAP: 570-988-5996 or 800-332-8583 Fax: 570-988-5918
Perry	Perry County Assistance Office 100 Centre Drive P.O. Box 280 New Bloomfield, PA 17068-0280 Office Hours: 8:30 AM to 5 PM	Toll-Free: 1-800-991-1929 Phone: 717-582-2127 LIHEAP: 717-582-5038 Fax: 717-582-4187
Philadelphia	Philadelphia County Assistance Office Headquarters 801 Market Street Philadelphia, PA 19107 Office Hours: 8 AM to 5 PM	Phone: 215-560-7226 LIHEAP: 215-560-1583 Fax: 215-560-3214
	Low Income Home Energy Assistance Program (LIHEAP) 1348 W. Sedgley Ave. Philadelphia, PA 19132-2498 Office Hours: 8 AM to 5 PM	LIHEAP Phone: 215-560-1583 LIHEAP Fax: 215-560-2260
	Boulevard District 4109 Frankford Avenue Philadelphia, PA 19124-4508 Office Hours: 8 AM to 5 PM	Phone: 215-560-6500 Fax: 215-560-2087
	Chelten District 301 East Chelten Avenue, 1st Floor Philadelphia, PA 19144-5751 Office Hours: 8 AM to 5 PM	Phone: 215-560-5200 Fax: 215-560-5251
	Delancey District 5740 Market Street 2nd Floor Philadelphia, PA 19139-3204 Office Hours: 8 AM to 5 PM	Phone: 215-560-3700 Fax: 215-560-2907

Section 8 — County Assistance Office contact Information

County Assistance Office contact information		
County	**Assistance Office address**	**Telephone/Fax numbers**
Philadelphia (continued)	Elmwood District 5740 Market Street 1st Floor Philadelphia, PA 19139-3204 Office Hours: 8 AM to 5 PM	Phone: 215-560-3800 Fax: 215-560-2065
	Glendale District 5201 Old York Road Philadelphia, PA 19141-9943 Office Hours: 8 AM to 5 PM	Phone: 215-560-4600 Fax: 215-456-5103
	Liberty District 219 East Lehigh Avenue Philadelphia, PA 19125-1099 Office Hours: 8 AM to 5 PM	Phone: 215-560-4000 Fax: 215-560-4065
	Long Term and Independent Services District 5070 Parkside Avenue Philadelphia, PA 19131 Office Hours: 8 AM to 5 PM	Phone: 215-560-5500 Fax: 215-560-1495
	Ridge/Tioga District 1350 West Sedgley Avenue Philadelphia, PA 19132-2498 Office Hours: 8 AM to 5 PM	Phone: 215-560-4900 Fax: 215-560-4938
	Somerset District 2701 N. Broad Street, 2nd Floor Philadelphia, PA 19132-2743 Office Hours: 8 AM to 5 PM	Phone: 215-560-5400 Fax: 215-560-5403
	South District 1163 S. Broad Street Philadelphia, PA 19147 Office Hours: 8 AM to 5 PM	Phone: 215-560-4400 Fax: 215-218-4650
	Unity District 4111 Frankford Avenue Philadelphia, PA 19124 Office Hours: 8 AM to 5 PM	Phone: 215-560-6400 Fax: 215-560-2067

Section 8 — County Assistance Office contact Information

County Assistance Office contact information		
County	**Assistance Office address**	**Telephone/Fax numbers**
Philadelphia (continued)	West District 5070 Parkside Avenue Philadelphia, PA 19131-4747 Office Hours: 8 AM to 5 PM	Phone: 215-560-6100 Fax: 215-560-2053
Pike	Pike County Assistance Office Milford Professional Park Suite 101 10 Buist Road Milford, PA 18337 Office Hours: 8:30 AM to 5 PM	Toll-Free: 1-866-267-9181 Phone: 570-296-6114 LIHEAP: 570-296-6114 Fax: 570-296-4183
Potter	Potter County Assistance Office 269 Route 6 West, Room 1 Coudersport, PA 16915-8465 Office Hours: 8:30 AM to 5 PM	Toll-Free: 1-800-446-9896 Phone: 814-274-4900 Fax: 814-274-3635
Schuylkill	Schuylkill County Assistance Office 2640 Woodglen Road P.O. Box 1100 Pottsville, PA 17901-1100 Office Hours: 8:30 AM to 5 PM	Toll-Free: 1-877-306-5439 Phone: 570-621-3000 LIHEAP: 570-621-3072 Fax: 570-624-3334
Snyder	Snyder County Assistance Office 83 Maple Lane Selinsgrove, PA 17870-1302 Office Hours: 7:30 AM to 5 PM	Toll-Free: 1-866-713-8584 Phone: 570-374-8126 LIHEAP: 570-372-1721 Fax: 570-374-6347
Somerset	Somerset County Assistance Office 164 Stayrook Street Somerset, PA 15501 Office Hours: 7:45 AM to 5 PM	Toll-Free: 1-800-248-1607 Phone: 814-443-3681 LIHEAP: 814-443-3683 Fax: 814-445-4352
Sullivan	Sullivan County Assistance Office 918 Main Street, Suite 2 P.O. Box 355 Laporte, PA 18626-0355 Office Hours: 8:30 AM to 5 PM	Toll-Free: 1-877-265-1681 Phone: 570-946-7174 LIHEAP: 570-946-7174 Fax: 570-946-7189

Section 8 — County Assistance Office contact Information

County Assistance Office contact information		
County	**Assistance Office address**	**Telephone/Fax numbers**
Susquehanna	Susquehanna County Assistance Office 111 Spruce Street P.O. Box 128 Montrose, PA 18801-0128 Office Hours: 8 AM to 5 PM	Toll-Free: 1-888-753-6328 Phone: 570-278-3891 LIHEAP: 1-866-410-2093 Fax: 570-278-9508
Tioga	Tioga County Assistance Office 11809 Route 6 Wellsboro, PA 16901-6764 Office Hours: 8 AM to 5 PM	Toll-Free: 1-800-525-6842 Phone: 570-724-4051 LIHEAP: 570-724-4051 Fax: 570-724-5612
Union	Union County Assistance Office Suite 300 1610 Industrial Boulevard Lewisburg, PA 17837-1292 Office Hours: 8:30 AM to 5 PM	Toll-Free: 1-877-628-2003 Phone: 570-524-2201 LIHEAP: 570-522-5274 Fax: 570-524-2361
Venango	Venango County Assistance Office 530 13th Street Franklin, PA 16323-0391 Office Hours: 7:30 AM to 5 PM	Toll-Free: 1-877-409-2421 Phone: 814-437-4341/4342 LIHEAP: 814-437-4354 Fax: 814-437-4441
Warren	Warren County Assistance Office 210 North Drive, Suite A N. Warren, PA 16365 Office Hours: 8 AM to 5 PM	Toll-Free: 1-800-403-4043 Phone: 814-723-6330 LIHEAP: 814-726-2540 Fax: 814-726-1565
Washington	Washington County Assistance Office 167 North Main Street Washington, PA 15301-4354 Office Hours: 7:30 AM to 5 PM	Toll-Free: 1-800-835-9720 Phone: 724-223-4300 LIHEAP: 724-223-5246 Fax: 724-223-4675
	Valley District 595 Galiffa Drive P.O. Box 592 Donora, PA 15033-0592 Office Hours: 7:30 AM to 5 PM	Toll-Free: 1-800-392-6932 Phone: 724-379-1500 LIHEAP: 724-379-1549 Fax: 724-379-1572

Section 8 — County Assistance Office contact Information

County Assistance Office contact information		
County	**Assistance Office address**	**Telephone/Fax numbers**
Wayne	Wayne County Assistance Office 107 8th Street, 2nd Floor P.O. Box 229 Honesdale, PA 18431-0229 Office Hours: 8:30 AM to 5 PM	Toll-Free: 1-877-879-5267 Phone: 570-253-7100 LIHEAP: 570-253-7118 Fax: 570-253-7374
Westmoreland	Westmoreland County Assistance Office – Main Office 587 Sells Lane Greensburg, PA 15601-4493 Office Hours: 7 AM to 5 PM	Toll-Free: 1-800-905-5413 Phone: 724-832-5200 LIHEAP: 724-832-5524 Fax: 724-832-5202
	Donora/Valley District 595 Galiffa Drive P.O. Box 592 Donora, PA 15033-0592 Office Hours: 7 AM to 5 PM	Toll-Free: 1-800-238-9094 Phone: 724-379-1500 LIHEAP: 724-832-5524 Fax: 724-379-1572
	Alle-Kiski District 909 Industrial Boulevard New Kensington, PA 15068-0132 Office Hours: 7 AM to 5 PM	Toll-Free: 1-800-622-3527 Phone: 724-339-6800 LIHEAP: 724-832-5524 Fax: 724-339-6850
Wyoming	Wyoming County Assistance Office 608 Hunter Highway, Suite 6 P.O. Box 490 Tunkhannock, PA 18657-0490 Office Hours: 8 AM to 5 PM	Toll-Free: 1-877-699-3312 Phone: 570-836-5171 LIHEAP: 570-836-5171 Fax: 570-996-4141
York	York County Assistance Office 130 N. Duke Street P.O. Box 15041 York, PA 17405-7041 Office Hours: 8 AM to 5 PM	Phone: 717-771-1100 Toll-Free: 800-991-0929 LIHEAP: 1-800-991-0929 Fax: 717-771-1261