UnitedHealthcare Community Plan Provider Remittance Advice (PRA) Overview

UnitedHealthcare®
Community Plan

In This Overview

UnitedHealthcare Community Plan

- Remittance Delivery Options
- Four Sections of the PRA
- Section One: Care Provider Information and Payment Summary
- Section Two: Patient Information
- Section Two: Claims Details
- Section Two: Amount Totals
- Section Four: Overpayment Information
- Electronic Data Interchange (EDI)
- Electronic PRA or EPRA

Proprietary information of UnitedHealth Group. Do not distribute or reproduce without express permission of UnitedHealth Group.

Remittance Delivery Options

UnitedHealthcare Community Plan

For All UnitedHealthcare Community Plan States

Care providers can choose to receive PRA in the mail or select one of our paperless options.

Paperless Options

Document Vault

- Access PDF files of PRA in Document Vault
- Turn off mail delivery in Paperless Delivery Options (you'll still receive checks in the mail)

Learn more at **UHCprovider.com/paperless**

EPS/Optum Pay with PDF files

- Access PDF files of PRA in EPS/Optum Pay
- Direct deposit or virtual card payments

EPS/Optum Pay with 835 files

- Receive 835 files through your clearinghouse or online
- Direct deposit or virtual card payments

Enrollment required. Learn more at **UHCprovider.com/eps**

835 Files with Paper Checks

- Receive 835 files through your clearinghouse.
- Checks will be mailed

Contact your clearinghouse to get started

Four Sections of the PRA

UnitedHealthcare Community Plan

Print and PDF PRA files contain up to four sections of information.

1

- Provider and Payee Information
- Summary of Payment Details

2

- Member and Claim Line Details
- Provider Totals
- Payee Totals

3

- State-Specific Provider Communications
- Appeal Rights

Four Sections of the PRA (cont.)

UnitedHealthcare Community Plan

4 Included if the care provider has outstanding or recovered overpayments

4

SUMMARY OF OVERPAYMENTS/ PAYMENTS RECOVERED										
									PRIOR BALANCE	$83.19
OVERPAYMENT CREATION DATE	PATIENT LAST NAME	PATIENT FIRST NAME	MEMBER ID	PATIENT ACCT NUMBER	CLAIM NUMBER	DATE(S) OF SERVICE	ORIGINAL OVERPAYMENT AMOUNT	PREVIOUSLY DEDUCTED	CURRENT RECOVERED	REMAINING AMOUNT
10/08/17						07/13/2017	$83.19	$0.00	$0.00	$83.19
THIS REPRESENTS PREVIOUS BENEFITS THAT WERE PAID IN ERROR								TOTAL DEDUCTIONS	$0.00	
									TOTAL OVERPAYMENT CARRIED FORWARD	$83.19

Proprietary information of UnitedHealth Group. Do not distribute or reproduce without express permission of UnitedHealth Group.

Section One: Care Provider and Payment Summary

UnitedHealthcare
Community Plan

Arizona Physicians IPA, Inc.
DBA UnitedHealthcare Community Plan
PO Box 7550
Phoenix AZ 85011-7550
PHONE: 1-800-293-3740
URL: UHCprovider.com

STD-PRA

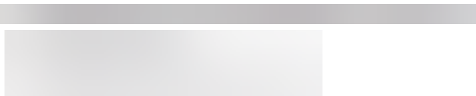
PROVIDER REMITTANCE ADVICE

Arizona

Provider/Payee Information

PAYMENT DATE:	01/17/19
PAYEE TAX NUMBER:	
PAYEE NPI:	
PAYEE ID:	
PAYEE NAME:	
PAYMENT NUMBER:	
PAYMENT AMOUNT:	$485.29
GRP ID:	
RA REFERENCE ID:	

DPS$$$PKG



This section summarizes the payment for all claims in this PRA

PROVIDER REMITTANCE AT A GLANCE

NET PAYABLE	$485.29
OVERPAYMENT AMOUNT	$79.20
RECOVERED AMOUNT	$79.20
NET PAID AMOUNT	$485.29

Proprietary information of UnitedHealth Group. Do not distribute or reproduce without express permission of UnitedHealth Group.

Section Two: Key Patient Information

PATIENT:

SUBSCRIBER ID:
MEMBER ID:
SERVICING PROV NPI:
COB PRIMARY INS: MEDICARE PART A & B
DRG:

SUBSCRIBER NAME:
INTEREST AMOUNT: $0.00
SERVICING PROV NM:
POLICY NUMBER:
DRG WEIGHT:

PROMPT PAY DISC: $0.00
PCP NUMBER:
COVERAGE DATE:
DRG AMOUNT:

CLAIM NUMBER:
REMIT DETAIL:
PCP NAME:

PATIENT ACCOUNT:
PRODUCT DESC.: AZ Complete Care w/QMB Copay Level 00
BILLING NPI:
CARRIER ID:

DATE(S) OF SERVICE	DESCRIPTION OF SERVICE	UNITS	BILLED AMT	DISALLOW AMT	ALLOWED AMT	DEDUCT AMT	COPAY/COINS AMT	COB PMT AMT	WITHHOLD AMT	PAID TO PROVIDER AMT	PATIENT RESP AMT	AUTH#	RMK CD	GRP CD/ RSN CD
03/16/20 - 03/20/20	billing code 0206 POS/ Bill Type 111	1	$5,413.00	-$6,106.72	$11,519.72			$11,519.72	$0.00	$0.00	$0.00			OA23, CO45
03/16/20 - 03/20/20	billing code 0250 POS/ Bill Type 111	324	$8,578.00	$8,578.00				$0.00	$0.00	$0.00	$0.00			
03/16/20 - 03/20/20	billing code 0255 POS/ Bill Type 111	224	$1,344.00	$1,344.00				$0.00	$0.00	$0.00	$0.00			
03/16/20 - 03/20/20	billing code 0272 POS/ Bill Type 111	3	$1,380.00	$1,380.00				$0.00	$0.00	$0.00	$0.00			

Field	Description
CLAIM NUMBER	A system generated number. The last two digits will change as the claim is adjusted (01,02, etc.)
MEMBER ID	The member's UnitedHealthcare ID number
PATIENT	Patient's first and last name
PATIENT ACCOUNT	The provider's account number for the patient, if it's submitted on the claim
PRODUCT DESC	The plan that the member was eligible for at the time services were rendered
SUBSCRIBER ID	The subscriber's ID number
SUBSCRIBER NAME	The name of the insured

There may be more than one patient and claim per page in the PRA.

Proprietary information of UnitedHealth Group. Do not distribute or reproduce without express permission of UnitedHealth Group.

Section Two: Additional Patient Information

UnitedHealthcare
Community Plan

Field	Description
BILLING NPI	The NPI of the billing provider
CARRIER ID	The ID number associated with the primary carrier insurance (if applicable)
COB PRIMARY INS	The primary insurance carrier (if applicable)
DRG	Diagnosis-related group (DRG) is a system to classify hospital cases into one of approximately 500 groups
DRG Weight	Each DRG has a payment weight assigned to it, based on the average resources used to treat Medicare patients in that DRG
DRG Amount	Reimbursable dollar amount representing the DRG rate and weight calculation
INTEREST AMOUNT	The interest amount applied to qualified claims (if applicable)
PCP NAME	The name of the member's primary care physician (PCP)
PCP NUMBER	ID number for the member's PCP
POLICY NUMBER	The primary insurance policy number (if applicable)
PROMPT PAY DISC	Arizona and Maryland: The prompt payment discount is applied if we pay the claim within a time frame specified in the state contract
REMIT DETAIL	Identifies the claim type as professional or institutional
SERVICING PROV NM	The name of the rendering provider
SERVICING PROV NPI	The rendering provider's National Provider Identification number (NPI)

Section Two: Key Claims Information

PATIENT:

SUBSCRIBER ID:	SUBSCRIBER NAME:		PROMPT PAY DISC:	$0.00	CLAIM NUMBER:		PATIENT ACCOUNT:
MEMBER ID:	INTEREST AMOUNT:	$0.00	PCP NUMBER:		REMIT DETAIL:	Institutional Claim	PRODUCT DESC.:
SERVICING PROV NPI:	SERVICING PROV NM:				PCP NAME:		
							BILLING NPI:
							CARRIER ID:

DATE(S) OF SERVICE	DESCRIPTION OF SERVICE	UNITS	BILLED AMT	DISALLOW AMT	CONSIDERED AMT	ALLOWED AMT	DEDUCT AMT	COPAY/COINS AMT	COB PMT AMT	WITHHOLD AMT	PAID TO PROVIDER AMT	PATIENT RESP AMT	AUTH#	RMK CD	GRP CD/ RSN CD
01/29/20 - 01/29/20	billing code 0258 NDC 00264180031 POS/ Bill Type 131	1	$49.00	$49.00	$0.00				$0.00	$0.00	$0.00	$0.00			CO97
01/29/20 - 01/29/20	billing code 78227 POS/ Bill Type 131	1	$3,144.00	$3,144.00	$4,137.00				$0.00	$0.00	$0.00	$0.00			OA94, CO45, CO197
01/29/20 - 01/29/20	billing code A9537 NDC 04556704552 POS/ Bill Type 131	1	$135.00	$135.00	$0.00				$0.00	$0.00	$0.00	$0.00			CO97
01/29/20 - 01/29/20	billing code J2805 NDC 00270055615 POS/ Bill Type 131	1	$809.00	$809.00	$0.00				$0.00	$0.00	$0.00	$0.00			CO97
CLAIM NUMBER: 20B256805200 SUBTOTAL:			$4,137.00	$4,137.00	$4,137.00				$0.00	$0.00	$0.00	$0.00			

Field	Definition
ALLOWED AMT	Amount allowed per UnitedHealthcare Community Plan agreement or non-participating rate
DISALLOW AMT	The amount that is not considered for payment.
GRP CD/RSN CD	Industry-standard, HIPAA-compliant reason code explaining each line's processing or denial reason
PAID TO PROVIDER AMT	Amount paid at the service-line level after any applicable discounts, penalties or member responsibilities were applied
PATIENT RESP AMT	The sum of the copayment, coinsurance and deductible
RMK CD	Industry-standard, HIPAA-compliant remark code explaining each line's processing or denial reason

Proprietary information of UnitedHealth Group. Do not distribute or reproduce without express permission of UnitedHealth Group.

Section Two: Additional Claims Information

UnitedHealthcare Community Plan

Field	Description
AUTH#	The prior authorization number used for processing the claim (if applicable)
BILLED AMT	The billed amount for each line item
COB PMT AMT	Allowed amount offset by primary carrier's payment amount
CONSIDERED AMT	Amount considered for payment if billed lines are bundled
COPAY/COINS AMT	The member's copayment or coinsurance responsibility based on the benefit package
DATE(S) OF SERVICE	Dates of service submitted on the claim
DEDUCT AMT	The deductible amount the member must pay before insurance payments begin
DESCRIPTION OF SERVICE	(1) Billing Code - A CPT® or HCPCS code and/or revenue code, may include modifiers (2) Place of Service or Bill Type billed on the claim. (3) Texas: Level of Service code identifies the level of payment for the skilled nursing facility determined by the state
UNITS	The number of units for each service/line item
WITHHOLD AMT	The amount withheld based on Medicare sequestration or other circumstances

CPT® is a registered trademark of the American Medical Association.

Proprietary information of UnitedHealth Group. Do not distribute or reproduce without express permission of UnitedHealth Group.

Section Two: Amount Totals

UnitedHealthcare Community Plan

- **Provider Totals Section –** A breakdown of payments to individual providers
- **Payee Totals Section -** A breakdown of payment to the payee

Field	Description
ALLOWED AMT	Sum of allowed amounts from the claims details
BILLED AMOUNT	Sum of billed amounts from the claims details
COB PMT AMT	Sum of coordination of benefits (COB) payments from the claims details
COPAY/COINS AMT	Sum of copay/coinsurance amounts from the claims details
DEDUCT AMT	Sum of deductible amounts from the claims details
DISALLOW AMT	Sum of disallowed amounts from the claims details
INTEREST AMOUNT	Sum of interest amounts from the claims details
PAID TO PROVIDER AMT	Sum of amounts paid to the provider from the claims details
PATIENT RESP AMT	Sum of patient responsibility amounts from the claims details
PAYEE ID	A United Healthcare assigned payee ID number
PROMPT PAY DISCOUNT	Sum of prompt pay discount amounts from the claims details
SERVICE PROVIDER ID	A United Healthcare assigned ID number
WITHHOLD AMT	Sum of withhold amounts from the claims details

Proprietary information of UnitedHealth Group. Do not distribute or reproduce without express permission of UnitedHealth Group.

PRA Section Four: Overpayment Information

UnitedHealthcare Community Plan

Field	Description
CLAIM NUMBER	A system generated number. The last two digits in the claim number will change if the claim is adjusted (01,02, etc.)
CURRENT RECOVERED	Amount deducted from the current payment cycle
DATE(S) OF SERVICE	Dates of service submitted on the claim
SUBSCRIBER NAME	The name of the insured
MEMBER NUMBER	The member’s ID number
ORIGINAL OVERPAYMENT AMOUNT	Amount of the overpayment
OVERPAYMENT CREATION DATE	Date of original PRA that contained the overpayment
PATIENT ACCT NUMBER	The provider’s account number if it’s submitted
PATIENT FIRST NAME	Patient’s first name
PREVIOUSLY DEDUCTED	Amount deducted from prior payment cycle(s)
PRIOR BALANCE	Total overpayment carried forward from the prior payment cycle
REMAINING AMOUNT	Remaining overpayment eligible for future payment cycle deductions
TOTAL DEDUCTIONS	Total amount of overpayment deductions from current payment cycle
TOTAL OVERPAYMENT CARRIED FORWARD	Remaining overpayment amount from current payment cycle. Carried forward and becomes prior balance on next payment cycle

Proprietary information of UnitedHealth Group. Do not distribute or reproduce without express permission of UnitedHealth Group.

Electronic Data Interchange (EDI) 835

UnitedHealthcare Community Plan

HIPAA-Compliant Transactions

- Machine readable files used by practice management systems for autoposting.

REF*6R*CCID-466857
AMT*B6*3.34
SVC*HC:90834*200*55.89**1**0
DTM*472*20170926
CAS*CO*45*144.11
REF*LU*M2
REF*6R*CCID-466858
AMT*B6*55.89
CLP*XP468912*1*125*0**MC*XXXXXXX*XX*X
NM1*QC*1*XXXXX*XXXXX*X***XX*XXXXXXXXXXX
NM1*82*1*XXXXX*XXX*X**XX*XX*XXXXX
202MOA***N95
DTM*232*20170822
DTM*233*20170822
SVC*HC:90832*125*0**1**0
DTM*472*20170822
CAS*CO*8*125
REF*LU*M1
REF*6R*CCID-466118
LQ*HE*N95
CLP*XP469068*1*125*0**MC*XXXXXXXX*XX*X
NM1*QC*1*XXXXX*XXXXX*X***XX*XXXXXXXXXXX
NM1*82*1*BATTA*ANA*L**MA*XX*1245314202
MOA***N95
DTM*232*20170830
DTM*233*20170830
SVC*HC:90832*125*0**1**0
DTM*472*20170830
CAS*CO*8*125

Proprietary information of UnitedHealth Group. Do not distribute or reproduce without express permission of UnitedHealth Group.

Electronic PRA (EPRA)

UnitedHealthcare Community Plan

EPRA - Contains two main sections of information

1

- Provider and Payee Information
- Member and Claim Line Details

2

- Remark Codes
- Total Paid to Provider

*PDF image of 835 data does not include the level of detail offered in the print remit.

1

Page 1 of 1

UnitedHealthcare

Electronic Payments and Statements

CONSULTANTS IN INFECTIOUS DISEASES
5670 54TH AVE
KENNETH CITY FL 33709

UnitedHealthcare of FL Dual
PO Box 7550
Phoenix AZ 850117550
Phone: (866) 842-4968
Payment Date: 04/03/2019
TIN:
NPI:
Payment Number:
Payment Amount:

Electronic Provider Remittance Advice

Account Number	Patient Name/ Patient ID			Subscriber ID/ Corrected ID		Rendering Provider		Claim #/Claim Type			Group Policy Number/Product Name
Date(s) of Service	Description of Service	Amount Charged	Claim / Service Adj	Prov Adj Discount	Amount Allowed	Deduct/ Coins/ Copay	Paid to Provider	Adj Reason Code	RMK Code	Patient Resp	
Account #	Patient Name / Patient ID			Subscriber ID		Rendering Provider		Claim #/Claim Type			FLSNPPQ1
01/05/2019 - 01/05/2019	HC:99232	$140.00	--	-$67.28	$74.20	--	$72.72	253, 45	N192	--	
01/06/2019 - 01/06/2019	HC:99232	$140.00	--	-$67.28	$74.20	--	$72.72	253, 45	N192	--	
01/07/2019 - 01/07/2019	HC:99232	$140.00	--	-$67.28	$74.20	--	$72.72	253, 45	N192	--	
01/08/2019 - 01/08/2019	HC:99232	$140.00	--	-$67.28	$74.20	--	$72.72	253, 45	N192	--	
Subtotal		$560.00	$0.00	-$269.12	$296.80	$0.00	$290.88			$0.00	

2

"--" indicates payer has not supplied this information.

Total Paid to Provider : $290.88

N192 - Patient is a Medicaid/Qualified Medicare Beneficiary.
45 - Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication.
253 - Sequestration - reduction in federal payment

Proprietary information of UnitedHealth Group. Do not distribute or reproduce without express permission of UnitedHealth Group.

Thank you.

PCA-1-20-00608-C&S-PRES_02262020

© 2020 United HealthCare Services, Inc.