Claim appeals processes

Table 1: Claim reconsideration and formal appeals process

Use the information in the following chart to help resolve claim issues and disputes. We base these processes on state and federal regulatory requirements and your provider contract. If you're not a network health care professional with UnitedHealthcare, please refer to applicable appeals and grievances laws, regulations and state Medicaid contract requirements for appeal instructions. For questions on claims, billing and payments, please go to **UHCprovider.com.**

Appeal type	Appeal type information	Where to submit an appeal	Contact phone number	Time frame for filing appeals	UnitedHealthcare response time frame
Medical and behavioral care provider claim reconsideration	Request for a one-time review of an administrative denial. We'll handle the request as a formal appeal if you submit the Health Care Provider Application to Appeal a Claims Determination (HCAPPA) form.	**Download forms to mail at:** **UHCprovider.com** > Claims and Payments **Mail appeals to:** UnitedHealthcare Community Plan P.O. Box 5250 Kingston, NY 12402-5250 **Submit appeals online by signing in at:** **UHCprovider.com** > Claims > Claims Management **Or at:** **UHCprovider.com** > Claims > Claims tool	888-362-3368	**Medicaid** • File appeals for UnitedHealth Group errors (e.g., contract updates, provider participating/ non-participating status, etc.) within 18 months from the date of service or within 95 calendar days from the paid date of the last timely submission, whichever is later • File appeals for non-UnitedHealth Group errors within 95 calendar days from the provider remittance advice, explanation of benefits, or letter date **Fully Integrated Dual Eligible (FIDE)** • File appeals for inpatient requests that result in an increased diagnosis-related group payment within 60 calendar days from the date of service • File disputes of a medical review denial within 15 months from the last paid date • File all other claims within 365 days from the original provider remittance advice	Within 30 calendar days

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Appeal type	Appeal type information	Where to submit an appeal	Contact phone number	Time frame for filing appeals	UnitedHealthcare response time frame
Medical and behavioral care provider formal appeal	Appeal request for review of an administrative denial. Submit the request on the HCAPPA form. Requests not submitted on the HCAPPA form will be routed for reconsideration, if eligible.	**Download forms to mail at:** **UHCprovider.com/njcommunityplan** > Provider Forms and References > DOBI Health Care Provider Application to Appeal a Claims Determination **Medicaid** **Mail appeals to:** UnitedHealthcare Community Plan Attn: Appeals and Grievance P.O. Box 31364 Salt Lake City, UT 84131-0364 **FIDE** **Mail appeals to:** UnitedHealthcare Community Plan Attn: Appeals and Grievance P.O. Box 6103 Cypress, CA 90630-9998 **Submit appeals online by signing in at:** **UHCprovider.com** > Claims > Claims Management **Or at:** **UHCprovider.com** > Claims > Claims tool	888-362-3368	**Medicaid** Appeals must be received within 90 days of the determination date **FIDE** • Participating health care professionals must follow the timelines in their provider contract • Out-of-network health care professionals must file appeals within 60 calendar days of the determination date	**Medicaid** Within 30 business days **FIDE** • Participating health care professionals: Refer to the provider contract • Non-participating health care professionals: Within 60 calendar days

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Table 2: Utilization management claim appeals process for services based on medical necessity

Use the information in the following chart to help resolve claim issues and disputes through the utilization management appeal process. The member disputing the claim must provide written permission to request a utilization management appeal either on their own or by the health care professional on behalf of the member.

Appeal stage	Appeal stage information	Where to submit an appeal	Contact phone number	Time frame for filing appeals	Time frame for requesting continuation of benefits for existing services	Reviewer response time frame
Internal utilization management appeal	This first level of appeal is a formal internal review by objective health care professionals not involved in the original claim decision. The plan selects the health care professionals based on their expertise in the type of case. This option is for FamilyCare plan types A/ABP, B, C, D.	**Medicaid** **Mail appeals to:** UnitedHealthcare Community Plan Attn: Appeals and Grievances P.O. Box 31364 Salt Lake City, UT 84131-0364 **Fax appeals to:** Standard pre- and post-service appeals: 801-994-1082 Expedited pre-service and concurrent appeals: 801-994-1261 **Submit appeals online by signing in at:** **UHCprovider.com** > Prior Authorization and Notification Tool > UnitedHealthcare Community Plan (Medicaid) Pre-Service Appeals & Grievances **FIDE:** **Mail appeals to:** UnitedHealthcare Community Plan Attn: Appeals and Grievance P.O. Box 6103 Cypress, CA 90630-9998	888-362-3368	Within 60 days of the denial letter	**By the latest date in the following scenarios:** • On or before the last day of the current authorization • Within 10 calendar days of the initial denial notification letter	• Within 72 hours for urgent appeals • Within 30 days for standard appeals

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Appeal stage	Appeal stage information	Where to submit an appeal	Contact phone number	Time frame for filing appeals	Time frame for requesting continuation of benefits for existing services	Reviewer response time frame
External/IURO appeal	This external appeal is conducted by an Independent Utilization Review Organization (IURO). This option is for FamilyCare plan types A/ABP, B, C, D.	**Mail appeals to:** Maximus Federal – NJ IHCAP 3750 Monroe Ave., Suite 705 Pittsford, New York 14534 **Fax appeals to:** 585-425-5296 Submit appeals to the Maximus Federal Service portal at **https://njihcap.maximus.com/**	888-866-6205	Within 60 calendar days of the internal appeal notification letter	**By the latest date in the following scenarios:** • On or before the last day of the current authorization • Within 10 calendar days of the internal appeal notification letter	Within 45 calendar days from the IURO's decision to review the case
Medicaid Fair Hearing	You can appeal to the IURO before you request a Medicaid Fair Hearing and wait for the IURO's decision, or you can appeal to the IURO at the same time that you request a Medicaid Fair Hearing. This option is for FamilyCare plan types A/ABP only.	**Mail appeals to:** State of New Jersey Division of Medical Assistance and Health Services Fair Hearing Unit P.O. Box 712 Trenton, NJ 08625-0712 **Fax appeals to:** 609-588-2435	N/A	Within 120 calendar days of the internal appeal notification letter	**By the latest date in the following scenarios:** • On or before the last day of the current authorization • Within 10 calendar days of the internal appeal notification letter • Within 10 calendar days of the external IURO appeal notification letter	Within 90 calendar days of the Fair Hearing request

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