UnitedHealthcare of California, Inc.
5701 Katella Ave. MS CA120-0500
Cypress, CA 90630-5006

This is a sample for illustrative purposes only. The actual Explanation of Denial a care provider receives may have different information depending on the claims processed.

Provider Name
Provider Address
City, State, Zip

Explanation of Denial

PROVIDER NAME

Patient: SMITH, JOHN Q
Employer Group: HCFAX99
Date of Service: 08/23/19 – 08/23/19

Claim No: 9999999-09-99
Plan Code: X99
PCN: H1234567890

Amount: 9890.00

Code	Date	Charge Amount	Adjustment Amount	CARC/RARC
CLAIM	08/23/19	0.00	0.00	
U0300 36415	08/23/19	43.00	43.00	16/N4
U0301 80051	08/23/19	81.00	81.00	16/N4
U0301 82247	08/23/19	71.00	71.00	16/N4
U0301 82565	08/32/19	87.00	87.00	16/N4
U0301 82947	08/23/19	50.00	50.00	16/N4
U0301 82962	08/23/19	49.00	49.00	16/N4
U0301 83605	08/23/19	280.00	280.00	16/N4
U0301 83690	08/23/19	200.00	200.00	16/N4
U0301 84075	08/23/19	63.00	63.00	16/N4
U0301 84450	08/23/19	79.00	79.00	16/N4
U0301 84460	08/23/19	76.00	76.00	16/N4
U0301	08/23/19	250.00	250.00	16/N4

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84484				
U0301	08/23/19	46.00	46.00	16/N4
84520				
U0305	08/23/19	180.00	180.00	16/N4
85025				
U0306	08/23/19	108.00	108.00	16/N4
87040				
U0307	08/23/19	90.00	90.00	16/N4
81001				
U0350	08/23/19	4500.00	4500.00	16/N4
74176				
U0450	08/23/19	3637.00	3437.00	16/N4
99284-25				
Total		9890.00	9890.00	
Total Payable			**0.00**	

Patient: DOE, JANE Q
Employer Group: HCFAY71B
Date of Service: 10/13/19-10/16/19

Claim No: 1111111-01-111
Plan Code: X3R11
PCN: H0123456789

Amount: 3500.00

Code	Date	Charge amount	Adjustment Amount	CARC/RARC
CLAIM	10/13/19	0.00	0.00	
U0651	10/13/19- 10/16/19-	3500.00	3500.00	252/M127
	Provider needs to submit all charges on a single claim.			
Total		3500.00	3500.00	
Total Payable			**0.00**	

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Claims Adjustment Reason Code (CARC)

16	Claim/service lacks information or has submission/billing error(s).
252	An attachment/other documentation is required to adjudicate this claim/service.

Remittance Advice Remark Code (RARC)

M127	Missing patient medical record for this service..
N4	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.

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Appeals Process for Non-Contracted Medicare Providers

Pursuant to federal regulations governing the Medicare Advantage program, non-contracted providers may request reconsideration (appeal) of a Medicare Advantage plan payment denial determination. To appeal a claim denial, submit a written request within 60 calendar days of the remittance notificate date and include at a minimum:

- A statement indicating factual or legal basis for appeal
- A signed Waiver of Liability form (you may obtain a copy on www.Uhconline.com)
- A copy of the original claim
- A copy of the remittance advice notice showing the claim denia
- Aqny additional information, clinical records or documentation

Mail the appeal request to:
UnitedHealthcare
P. O. Box 30764
Salt Lake City UT 84130-0764

Payment Dispute Process for Non-Contractd Medicare Providers

Pursuant to federal regulations governing the Medicare Advantage program, non-contracted providers may file a payment dispute for Medicare Advantage plan payment determination. A payment dispute may be filed when the provider disagrees with the amount paid, including issues related to bundling of services. To dispute a claim payment, submit a written request within 120 calendar days of the remittance notification date and include at a minimum:

- A statement indicating factual or legal basis for the dispute
- A copy of the original claim
- A copy of the remittance notice showing the claim payment
- Any additional information, clinical record or documentation to support the dispute

Mail the payment dispute to:
UnitedHealthcare
P. O. Box 30764
Salt Lake City UT 84130-0764

For additional information in the Non-contracted Appeal and Dispute Processes including a form that may be used to facilitate your request for appeal r dispute, please go to www.Uhconline.com

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