



Claim Reconsideration Requests Reference Guide

This reference tool provides instruction regarding the submission of a Claim Reconsideration Request form and details the supporting information required for a claim reconsideration or to correct claims, and explains those processes.

This cover sheet should not accompany the Claim Reconsideration request form you are submitting.

The Claim Reconsideration Request form can be downloaded at:

- UnitedHealthcareOnline.com > Claims>Claims Reconsiderations for **Commercial and Medicare**
- uhcwest.com>Library>Choose your state>Resource Center
- UHCCommunityPlan.com >Health Care Professionals >Choose Your State >Claim & Member Information>Claim Reconsideration for **Medicaid**

Where to send Claim Reconsideration Requests:

- **For UnitedHealthcare/UnitedHealthcare West**, if your request for a claim reconsideration is for a *commercial* or *Medicare* member, send Claim Reconsideration Requests to one of the following:
 - the address on the Explanation of Benefits (EOB) or the Provider Remittance Advice (PRA)
 - the claim address on the back of the member's ID card
- **For UnitedHealthcare Empire Plan**, send to:
P.O. Box 1600
Kingston, NY 12402-1600
- **For UnitedHealthcare Community Plan** for a claim reconsideration for a *Medicaid* member, go to:
 - UHCCommunityPlan.com>Health Care Professionals >Choose Your State >Claim & Member Information>Claim Reconsideration for Medicaid
 - For more information, refer to your Provider Manual or call your Provider Services Center.

Explanation of reasons for requesting a claim reconsideration:

1. Previously denied/closed as “Exceeds Timely Filing”

Timely Filing is the time limit for filing claims, which is specified in the network contract, a state mandate or a benefit plan. For a non-network provider, the benefit plan would decide the timely filing limits. When timely filing denials are upheld, it is usually due to incomplete or invalid documentation submitted with claim reconsideration requests.

Submission requirements for electronic claims:

- Submit an electronic data interchange (EDI) acceptance report. This must show that UnitedHealthcare or one of its affiliates received, accepted and/or acknowledged the claim submission.
- A submission report alone is not considered proof of timely filing for electronic claims. It must be accompanied by an acceptance report.
 - The acceptance report must indicate the claim was either “accepted,” “received” and/or “acknowledged” within the timely filing period.

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by UnitedHealthcare Insurance Company, United HealthCare Services, Inc. or their affiliates.

Submission requirements for paper claims:

- Submit a screen shot from your accounting software that shows the date the claim was submitted. The screen shot must show the:
 - Correct patient name
 - Correct date of service
 - Submission date of claim that is within the timely filing period

2. Previously denied/closed for “Additional Information”

Please attach a copy of all information requested and include the following information on the first page of the request:

- Patient name
- Patient's address
- Patient member ID number
- Provider name and address
- Reference number

Add the additional information requested. Examples include:

- Medical notes
- Anesthesia time units
- Current Procedural Technology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes (missing, illegible, or deleted)
- Date of service
- Description of service
- Diagnosis code where the primary code is missing, illegible or is the wrong number of digits
- Physician name
- Patient name
- Place of service (POS) code
- Provider's Tax Identification Number (TIN)
- Semi-private room rate
- Accident information

3. Previously denied/closed for Coordination of Benefits information

4.

Commercial Coordination of Benefits claim requirements

- **Primary Payer Paid Amount** – Submit the primary paid amount for each service line on the 835 Electronic Remittance Advice (835) or EOB. Submit the paid amount on institutional claims at the claim level.
- **Adjustment Group Code** – Submit the other payer claim adjustment group code found on the 835 or the EOB. Common reasons for the other payer paying less than billed include: deductible, co-insurance, copayment, contractual obligations and/or non-covered services.
- **Adjustment Reason Code** – Submit the other payer claim adjustment reason code on the 835 or the EOB. Common reasons for the other payer paying less than billed include: deductible, co-insurance, copayment, contractual obligations and/or non-covered services.
- **Adjustment Amount** – Submit the other payer adjustment monetary amount.

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- **Preference** – Submit professional claims at the line level as allowed by the primary payer. Submit institutional claims at the claims or line level. The service level and claim level should be balanced. UnitedHealthcare follows 837p Health Care Claim Encounter – Professional (837p) and 837i Health Care Claim Encounter - Institutional (837i) guidelines.

Medicare Primary Coordination of Benefits claim requirements

- **Adjustment Group Code** – Submit the other payer claim adjustment group code on the 835 or the EOB. At the claim level, do not enter any amounts included at the line level. Common reasons for the other payer paying less than billed include: deductible, co-insurance, copayment, contractual obligations and/or non-covered services.
- **Adjustment Reason Code** – Submit the other payer claim adjustment reason code on the 835 or the EOB. At the claim level, do not enter any amounts included at the line level. Common reasons for the other payer paying less than billed include: deductible, co-insurance, copayment, contractual obligations and/or non-covered services.
- **Adjustment Amount** – Submit the other payer adjustment amount.
- **Medicare Paid Amount** – Submit the other payer claim level and line level paid amounts when UnitedHealthcare is the secondary payer to Medicare.
- **Medicare Approved Amount** – Submit the other payer claim level and line level allowed amounts when UnitedHealthcare is the secondary payer to Medicare.
- **Patient Responsibility Amount** – Submit the monetary amount for which the patient is responsible from the 835 or the Medicare EOB.
- **Medicare Acceptance of Assignment** – Indicate whether the provider accepts the Medicare assignment.
- **Preference** - Submit professional claims at the line level if the primary payer provides the information, and submit institutional claims at either the line or claim level. The service level and claim level should be balanced. UnitedHealthcare follows 837p and 837i guidelines.

Medicaid Primary Coordination of Benefits Claims Requirements

Benefits are not coordinated for Medicaid

5. Resubmission of a corrected claim

Health Care Financing Administration (HCFA):

Consistent with Health Insurance Portability and Accountability Act (HIPAA) requirements, submit corrected claims in their entirety.

If a claim needs correction, please follow these guidelines:

- Make the necessary changes in your practice management system, so the corrections print on the amended claim.

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- Attach the corrected claim (even line items that were previously paid correctly). Any partially-corrected request will be denied. Enter the words, “Corrected Claim” in the comments field on the claim form. Your practice management system help desk or your software vendor can provide specific instructions on where to enter this information in your system. If you do not have this feature, stamp or write “Corrected Claim” on the CMS 1500 form. Changes must be made in your practice management system and then printed on the claim form. You may not write on the claim itself.
- The resubmitted claim is compared to the original claim and all charges for that date of service. The provider and patient must be present on the claim, or we will send a letter advising that all charges for that day are required for reconsideration.
- Complete the reconsideration form as instructed and mark the box on Line 4 for Corrected Claims. Continue to the Comments section and list the specific changes made and rationale or other supporting information.

UB04: UB Type of Bill should be used to identify the type of bill submitted as follows:

- XX5 Late Charges
- XX7 Corrected Claim
- XX8 Void/Cancel previous claim

6. Previously processed but rate applied incorrectly resulting in over/underpayment

Indicate the contract amount expected by code or case rate, compared to the amount received, as well as other factors related to the over or underpayment.

7. Resubmission of “Prior Notification/Prior Authorization Information”

Submit a prior authorization number and other documents that support your request. If you spoke to a customer service representative and were told that notification was not required, please submit the date, time and reference number of that call and the name of the representative handling the call. Please also advise if the service was performed on an emergency basis and therefore notification was not possible.

8. Resubmission of a bundled claim

Review your claim for appropriate code billing, including modifiers. If the claim needs to be corrected, please submit a corrected claim. If a bundled claim is not paid correctly, submit a detailed explanation including any pertinent information on why the bundling is incorrect.

9. Other

Provide any additional information that supports your request.

Additional information on the claims reconsideration process can be found via:

- **Provider Services Manual**