UnitedHealthcare (UHC) Out of Network Claim Submission Instructions For Medical and Mental Health Claims

Clean and Unclean Claims

Because UnitedHealthcare processes claims according to state and federal requirements, a "*clean claim*" is defined as a complete claim or an itemized bill that does not require any additional information to process it. A clean claim includes at least all of the following*****:

- Patient name and UnitedHealthcare Member ID number
- UnitedHealthcare provider ID number
- Provider information, including federal tax ID number (FTIN)
- Date of service (DOS)
- Place of service
- Diagnosis code
- Procedure code
- Individual charge for each service
- Provider signature

*****More specific requirements are set forth below.

An "*unclean claim*" is defined as an incomplete claim, a claim that is missing any of the above information, or a claim that has been suspended in order to get more information from the provider. If you submit incomplete or inaccurate information, we may reject the claim, delay processing or make a payment determination (e.g., denial, reduced payment) that may be adjusted later when complete information is obtained.

UnitedHealthcare applies the appropriate state and federal guidelines to determine whether the claim is clean.

Anesthesia Claims

The following information must be included on anesthesia claims to ensure correct and timely payment:

- Total number of minutes
- Number of units (15 minutes = one unit)
- Actual start time and end time in the Remarks/Comments field

Ambulance Claims

UnitedHealthcare requires information on the point of pickup for ambulance services rendered to our members. Point of pickup refers to the complete address of the starting point of where the ambulance service began.

Coordination of Benefits — Commercial

When a patient's secondary coverage is UnitedHealthcare, you should bill the primary insurance company. When you receive the primary insurance company's explanation of benefits, submit it to us with the pertinent claim information. We will apply benefits as the secondary carrier, up to the limits of coverage under the member's plan.

Required Information for All Claims Submissions

Using the Correct Fields on the CMS-1500 Form

The following information is required for claim processing. If this information is not provided, the claim will be suspended, the submitter will be requested to submit the missing information, and payment will be withheld until the claim is resubmitted with the necessary information.

Information	CMS-1500 Line Number	Description
Patient name	2	Name of the patient receiving service
Member ID number	1a	The patient's UnitedHealthcare ID number
Date of service	24a	Date on which service was performed
Other insurance coverage	9a	Coverage in addition to UnitedHealthcare
Provider name/address	33	Name/address of treating physician or provider
Provider number	33	Treating provider's UnitedHealthcare ID number
Provider FTIN	25	Federal tax ID number
DIAGNOSIS OR NATURE OF ILLNESS OR INJURY DIAGNOSIS POINTER	21 (ICD Ind. & A-L) 24E	ICD-9 or ICD-10 (effective for DOS 10/1/15 and after) - CM code(s) for the primary and secondary diagnoses for which patient is being treated **Instructions:** Enter the applicable ICD indicator to identify which version of the ICD codes is being reported: 9 for ICD-9, 0 for ICD-10. Enter the codes to identify the patient's diagnosis and/or condition. List no more than 12 ICD-9 or ICD-10 diagnosis codes. Relate lines A-L to the lines of service in 24E by the letter of the line. Do not provide narrative description in this field. **Description:** The diagnosis or nature of illness or injury refers to the sign, symptom, complaint or condition of the patient relating to the service (s) on the claim.
Services/procedures	24D	Service(s) itemized by CPT-4 code and/or HCPCS code and modifiers, if applicable (i.e., per service or procedure)
Number of days and units	24G	Days or units of service as appropriate; must be whole numbers
Total charge	28	Sum of all itemized charges or fees
Certain conditions	10	If a visit is related to employment or accident
NPI number	17b	NPI number of the referring provider
Rendering provider	24J	NPI number of the rendering provider

Using the Correct Place Codes

To ensure timely and accurate payment of claims, UnitedHealthcare uses the place codes created by the Centers for Medicare and Medicaid Services (CMS) and mandated by the Health Insurance Portability and Accountability Act (HIPAA) for electronic transactions:

Code	Description
11	Office
12	Home
15	Mobile diagnostic unit
20	Urgent care facility
21	Inpatient hospital
22	Outpatient hospital
23	Emergency room hospital
24	Ambulatory surgical center
25	Birthing center
26	Military treatment facility
31	Skilled nursing facility
32	Nursing facility
33	Custodial care
34	Hospice
41	Ambulance — land
42	Ambulance — air or water
51	Inpatient psychiatric facility
52	Psychiatric facility partial hospitalization
53	Community mental health center
54	Intermediate care facility/mentally retarded
55	Residential substance abuse
56	Psychiatric residential treatment center
61	Comprehensive inpatient rehabilitation facility
62	Comprehensive outpatient rehabilitation facility
65	End stage renal disease facility
71	State or local public health clinic
72	Rural health clinic
81	Independent lab
99	Other unlisted facility

Required Information for Submission of Hospital/Facility Claims

Required Information	Description
Billing FTIN	Federal tax identification number of the organization requesting reimbursement
Facility ID/NPI Number	UnitedHealthcare -assigned provider identification number and NPI number of the facility requesting claim reimbursement, e.g., HO1234, ANC123
Billing Facility Name	Name of the organization requesting claim reimbursement
Billing Facility City, State, Zip Code	City, state and zip code of organization requesting claim reimbursement
Billing Address	Street address of the organization requesting claim reimbursement
Patient UnitedHealthcare ID number	UnitedHealthcare member identification number of person to whom services are being rendered (Do not use a space or an asterisk when entering the Member ID number, e.g., 17935801)
Patient Last Name	Last name of the patient
Patient First Name	First name of the patient
Patient Gender	Sex of the patient
Patient Date of Birth	Date of birth of the patient (Eight spaces are provided for the date of birth, e.g., 01011957 not 010157)
Revenue Code(s)	Code that identifies a specific accommodation, ancillary service or billing calculation
Diagnosis Code(s)	The ICD-CM code describing the principal diagnosis (i.e., the condition determined after study to be chiefly responsible for admitting the patient for care)
Date(s) of Service	Date(s) on which service was performed (“From-To” dates are accepted for inpatient charges only; outpatient charges must be entered line-by-line for each date-of-service)
Place Code(s) or Place of Service	Code(s) used to indicate the place where procedure was performed
Requested Amounts	Total billing amount requested by the provider
Required Information	**Description**
CPT/HCPC Code(s)	The charge or fee for the service itemized by each HCPC or CPT-4 code, (i.e., per service or procedure; inpatient charges do not require CPT codes; outpatient charges require CPT codes)

Units of Service	**As appropriate** - A quantitative measure of services rendered by revenue category to or for the pints of blood, renal patient to include items such as number of accommodation days, miles, pints of blood, renal dialysis treatments, etc.
Condition Code(s)	**As appropriate** - Code(s) used to identify relating conditions that may affect claim processing
Occurrence Code(s)	**As appropriate** - Hospital/Facility codes and associated dates defining a significant event relating to this bill that may affect claim processing
Occurrence Span Code(s)	**As appropriate** - Hospital/Facility codes and the related dates that identify an event that relates to the payment of the claim
Assignment of Benefits	**As appropriate** - Authorization for claim reimbursement to be made to billing provider
Coordination of Benefits	**As appropriate** - Coverage in addition to UnitedHealthcare
Statement Covers Date	The beginning and ending service dates of the period included on this claim
Covered Days	The number of days covered by the primary insurer, as qualified by that organization
Non-covered Days	Days of care not covered by the primary insurer
Coinsurance Days	The inpatient Medicare days occurring after the 60th day and before the 91st day, or inpatient skilled nursing facility swing bed days occurring after the 20th and before the 101st day in a single period of illness
Lifetime Reserve Days	Under Medicare, each beneficiary has a lifetime reserve of 60 of additional days of inpatient hospital services after using 90 days of inpatient hospital services during a period of illness
Patient Marital Status	The marital status of the patient at date of admission, outpatient service or start of care
Admission/Start of Care Date	The date the patient was admitted to the provider of inpatient care, outpatient service or start of care
Admission Hour	The hour during which the patient was admitted for inpatient or outpatient care
Admission Type	Hospital/Facility code indicating the priority of this admission
Admission Source	Hospital/Facility code indicating the source of this admission
Discharge Hour	Hour that the patient was discharged from inpatient care
Patient (discharge) Status	Hospital/Facility code indicating patient status as of the ending service date of the period covered on this bill, as reported in field 6 of the form
Medical/Health Record Number	The number assigned to the patient's medical/health record by the provider
Treatment Authorization Codes	A number, Hospital/Facility code, or other indicator that designates that the treatment covered by this bill has been authorized by UnitedHealthcare
Admitting Diagnosis Code	The ICD-9-CM or ICD-10 diagnosis code (effective for DOS 10/1/15 and after) provided at the time of admission, as stated by the physician
External Cause of Injury Code	The ICD-9-CM or ICD-10 code (effective for DOS 10/1/15 and after) for the external cause of an injury, poisoning or (E-code) adverse effect

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) X | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456789

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Smith, John A

3. PATIENT'S BIRTH DATE MM DD YY: 01 01 1985 SEX M X F

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Smith, John A

5. PATIENT'S ADDRESS (No., Street): 123 ABC Street

6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other

7. INSURED'S ADDRESS (No., Street): 123 ABC Street

CITY: Santa Rosa | STATE: CA

8. RESERVED FOR NUCC USE

CITY: Santa Rosa | STATE: CA

ZIP CODE: 95401 | TELEPHONE (Include Area Code): (999) 999-9999

ZIP CODE: 95401 | TELEPHONE (Include Area Code): (999) 999-9999

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES X NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES X NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES X NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES X NO *If yes*, complete items 9, 9a and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED Only if provider is to receive payment DATE 04/07/2016

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED Only if provider is to receive payment

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 04 07 2016 QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. J040 B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	12 07 15	12 07 15	11		99213		1	336.30	1		NPI	
2											NPI	
3											NPI	
4											NPI	
5											NPI	
6											NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 987654321 X

26. PATIENT'S ACCOUNT NO.: 109486997

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES X NO

28. TOTAL CHARGE: $ 336.30

29. AMOUNT PAID: $ 336.30

30. BALANCE DUE: $ 0 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED Office Stamp DATE

32. SERVICE FACILITY LOCATION INFORMATION

Doe's Family Center
987 XWY Street
Santa Rosa, CA 95401

a. 987654321 b.

33. BILLING PROVIDER INFO & PH # (999) 123-4567

John Doe
987 XWY Street
Santa Rosa, CA 95401

a. 987654321 b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM CMS-1500 (02-12)

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

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CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare#) MEDICAID ☐ (Medicaid#) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (ID#) FECA BLK LUNG ☐ (ID#) OTHER ☐ (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO ***If yes***, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.