Corrected claim and claim reconsideration requests submissions

Please review this guide to learn about corrected claims, claim reconsideration requests and submission options.

Corrected claims

Corrected claims[1] replace an original claim submission that had incorrect information. For example, you may submit a corrected claim if you need to correct the date of service or add a modifier. All lines from the original claim should be included even if they were correct in the first submission.

Claim reconsideration requests

A claim reconsideration request[2] is typically the quickest way to address any concern you have with how we processed your claim. We'll review whether a claim was paid correctly. This includes checking to see if your provider information and/or contract are set up incorrectly in our system, which could have resulted in the original claim being denied or reduced.

Submission options

You may submit your requests online or by mail. We recommend you submit your requests online using the UnitedHealthcare Provider Portal, which offers the following benefits:

- The overall turnaround time for the request may be reduced by eliminating mail time
- You'll receive immediate confirmation of receipt and a tracking number
- You'll be able to check the claim status online
- You can upload related documents, if needed

If you submit your requests by mail, each one must be accompanied by the form on page 4 of this guide.

Getting set up for online submissions

If you aren't registered, please go to **UHCprovider.com/access.**

To submit a single claim reconsideration or corrected claim, you can use the Claims tool on the UnitedHealthcare Provider Portal. Please refer to the **Claims Interactive Guide for instructions.**

To submit 20 or more claims with the same processing issue, you can use the Claim Research Project tool to submit them at the same time. For directions, please refer to the **Claims Research Project Guide.**

Web support

Refer to **UHCprovider.com/portal** or contact UnitedHealthcare Web Support at **providertechsupport@uhc.com.** Or call **866-842-3278,** option 1, Monday through Friday, 7 a.m. to 9 p.m. CT.

Paper submissions

The form on page 4 of this guide can be used for UnitedHealthcare commercial (including UnitedHealthcare Oxford), UnitedHealthcare® Medicare Advantage, UnitedHealthcare Community and State, and UnitedHealthcare West claims.

- Arizona and Indiana Community and State plans have their own forms that are located on **uhcprovider.com**
- Please submit a separate form for each claim (this guide should not be submitted with the form)
- No new claims can be submitted with the form
- Do not use the form for formal claims appeals or disputes. Continue to follow your standard process as found in your provider manual or agreement.

United Healthcare

Completing the form

On the paper form, you will select 1 of 8 reasons for the request. Information about the choices and requirements is below.

1. Denied 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 an out-of-network health care professional, the benefit plan decides the timely filing limits. These requests require one of the following attachments.

Requirements for electronic claims:

Submit an electronic data interchange (EDI) acceptance report (not a submission report). This must show that UnitedHealthcare or one of our affiliates received, accepted and/or acknowledged the claim submission within the timely filing period.

Requirements for paper claims:

Submit a screenshot from your software that shows the date the claim was submitted. Please verify the date is within the timely filing period. The screenshot must show the correct member name and correct date of service as well.

2. Closed or held 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, address and member ID number
- Provider name and address
- Claim reference number

3. Denied for coordination of benefits information

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 Health Care Claim Encounter – Professional (837p) and Institutional 837I guidelines.

Commercial coordination of benefits claim requirements

- **Primary payer paid amount –** Submit the primary paid amount for each service line from the electronic remittance advice (835) or provider remittance advice (PRA). Submit the paid amount on institutional claims at the claim level.
- **Adjustment group code –** Submit the other payer's claim adjustment group code. Common reasons for the other payer paying less than billed include: Deductible, coinsurance, copayment, contractual obligations and/or non-covered services.
- **Adjustment reason code –** Submit the other payer's claim adjustment reason code. Common reasons for the other payer paying less than billed include deductible, etc.
- **Adjustment amount –** Submit the other payer's monetary adjustment amount

Medicare primary coordination of benefits claim requirements

- **Adjustment group code –** Submit Medicare's claim adjustment group code from the 835 or PRA. 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, coinsurance, copayment, contractual obligations and/or non-covered services.
- **Adjustment reason code –** Submit Medicare's claim adjustment reason code from the 835 or PRA. 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, etc.
- **Adjustment amount –** Submit Medicare's monetary adjustment amount
- **Medicare paid amount –** Submit Medicare's claim level and line level paid amounts
- **Medicare approved amount –** Submit Medicare's claim level and line level allowed amounts
- **Patient responsibility amount –** Submit the monetary amount for which the patient is responsible from the 835 or the PRA
- **Medicare acceptance of assignment –** Indicate whether the provider accepts the Medicare assignment

Medicaid primary coordination of benefits claim requirements

Primary coordination of benefits claim requirements can be found in the **individual state's care provider manual** on **uhcprovider.com.**

4. Submission of a corrected claim

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

- Do not make handwritten corrections on the claim. Make the changes in your practice management system, so the corrections print on the amended claim.
- Send the entire corrected claim (even line items that were previously paid correctly). The corrected claim is compared to the original claim and all charges for that date of service. Any partially corrected claim will be denied.
- The provider and patient information must be on the claim
- List the specific changes made and rationale or other supporting information in the comments section of our request form

Physician claims: Enter 7 in electronic field 12A or box 22 of the paper CMS-1500 form.

Facility claims: UB Type of Bill should be used to identify the type of bill[3] submitted as follows:

- XX5 Late charges only
- XX7 Replacement of previous bill (corrected claim)
- XX8 Void/cancel previous claim

5. Rate applied incorrectly resulting in overpayment or underpayment

In-network providers: Please check your fee schedules online prior to submitting a claim reconsideration request for this reason. Indicate the contract amount expected by code or case rate, compared to the amount received, as well as other factors related to the overpayment or underpayment. If you disagree with the fee schedule your claim was paid by, contact **Network Management** in your state.

6. Resubmission of prior notification/prior authorization information

Please let us know if the service was performed on an emergency basis and notification was not possible. Or, 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.

7. Resubmission of a claim with bundled services

If a bundled claim appears to be paid incorrectly, please review your claim submission for appropriate codes and modifiers. If you need to add or change codes or modifiers, please submit a corrected claim instead of checking this option. Otherwise, include an explanation of why the bundling is incorrect.

8. Other

Provide any information that supports your request.

After completing the entire form, please mail it to:

UnitedHealthcare, including Community and State, and UnitedHealthcare West (commercial or Medicare). Send the form to either:

- The address on the provider remittance advice (PRA)/explanation of benefits (EOB)
- The claim address on the back of the member's ID card

Questions about the form?

Please call the number on the back of the member's health care ID card.

[1] A corrected claim must be submitted within the timely filing period for claims. A corrected claim is not a claim appeal and does not alter or toll the deadline for submitting an appeal on any given claim.
[2] A claim reconsideration request is not a claim appeal and does not alter or toll the deadline for submitting an appeal on any given claim. Claim reconsideration requests cannot be submitted for member plans used in Maryland.
[3] Please check your Administrative Guide and reimbursement policies to confirm types of bills allowable for reconsideration.

United Healthcare

Single claim reconsideration/corrected claim request form

This form is to be completed by physicians, hospitals or other health care professionals for claim reconsideration requests for our members.

Note:
- **Please submit a separate form for each claim**
- **No new claims should be submitted with this form**
- **Do not use this form for formal appeals or disputes. Continue to use your standard process.**

Please refer to the preceding guide for instructions and where to mail this form. You may want to verify the member's information using the website listed on the back of the member's health care ID card.

☐ Physician ☐ Hospital ☐ Other health care professional (lab, durable medical equipment (DME), etc.)

Member information	**Date form completed**		
Member ID	**Control/Claim #**	**Date of service**	**Billed amount**
Member last name	**First name**	**MI**	
Street address	**State**	**ZIP code**	
Patient last name	**First name**	**Middle initial**	

Physician/health care professional information

Tax identification number (TIN): _____ Phone number (with area code): _____

Email address: _____

Physician or other health care professional name (as listed on provider remittance advice (PRA)/explanation of benefits (EOB)

Last name First Middle initial

Street address City State ZIP code

Facility/group name _____ Contact person _____

Expected amount owed _____ Contact fax number (with area code) _____

Reason for request: (Information about the reasons and required documentation can be found in the Claims self-paced guide)

☐ 1. Previously denied or closed as "Exceeds Filing Time"
☐ 2. Previously denied or closed for "Additional Information"
☐ 3. Previously denied or closed for "Coordination of Benefits" information
☐ 4. Resubmission of a corrected claim
☐ 5. Previously processed, but rate applied incorrectly resulting in overpayment/underpayment (network providers, check your fee schedules)
6. Resubmission of "Prior Notification Information"
☐ 7. Resubmission of a claim with "Bundled" services
☐ 8. Other (explain below)

Please include what you expect from UnitedHealthcare to close this claim in your practice management system, including dollar amount if possible:

Comments

Required attachments

- Copy of PRA or EOB
- A CMS-1500 or UB-04 claim form is ONLY required for corrected claim submissions
- Other required attachments as listed in the guide

You may have additional rights under individual state laws. Please review the provider website, your provider administrative guide or your provider agreement/contract if you need more information.

United Healthcare