Disputing Claims Payments

When and how to submit a claim reconsideration or appeal

You have options to dispute a claim denial when necessary for services denied in whole or in part that were provided to our members in the following Texas programs: Medicaid, Children's Health Insurance Program (CHIP) and UnitedHealthcare Connected® (Medicare-Medicaid Plan). We're highlighting when and how you can submit a claim reconsideration or an appeal.

Claim Reconsiderations

You can submit a claim reconsideration request when you believe a claim was paid incorrectly. Claim reconsiderations need to be submitted within 120 days from the disposition date of the claim. Examples for when a claims reconsideration can be submitted include:

- Your payment is different than what you expected
- Claim was denied due to untimely filing, but you have proof of timely filing
- Claim was denied for no authorization, but you have an authorization number or medical necessity documentation
- Coordination of Benefits (COB) support documentation may be necessary for showing billing to another insurance company as primary when member is covered by more than one insurance
- No payment or denial received within 31 days of a claim submission for providers of long-term services and supports (LTSS)

How to Submit a Claim Reconsideration

The easiest way to submit a claim reconsideration is online. A paper option is also available. Supporting documentation helps us in reconsidering your claim payment.

- **Online:** You can electronically submit a claim reconsideration online using the claimsLink tool on Link. Go to **UHCprovider.com**, click on the Link button in the top right corner and sign in, then select Claim Reconsideration from the Claims & Payments dropdown menu.
- **Mail:** You can also mail a claim reconsideration. Go to **UHCprovider.com**, click on the Link button in the top right corner and sign in, then select Claim Reconsideration from the Claims & Payments drop down menu and download Claim Reconsideration Form - UnitedHealthcare Community Plan.

If you do not agree with the claim reconsideration decision, you can request another claim reconsideration within 120 days of the most recent decision. You have the right to request further considerations, all within 120 days of the most recent decision up to 12 months from the date of service. A 120-day filing deadline that falls on a weekend or a holiday is extended to the next business day.

How to Submit an Appeal

You also have the right to appeal any claims payment that you feel was not paid in whole or in part to your expectations. An appeal is a one-time opportunity. Only one appeal is allowed per claim disposition.

An appeal needs to be submitted no later than 12 months from the date of service. Claim reconsiderations are a normal first step to trying to resolve a claim dispute.

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UnitedHealthcare® Community Plan

An Appeal to UnitedHealthcare Community Plan

After the first claim reconsideration, or at any point within the 12 months from the date of service, you can request an appeal. The decision of the appeal is final. The documentation you include depends on the reason for the request. Learn more at TMPH.com > providers > Medicaid Provider Manual.

Supporting documentation may include:

- Proof of prior authorization, such as a copy of prior authorization or an authorization number
- Medical necessity, such as a signed physician or physician-supervised primary care provider order
- Claim correction, such as a rebilled claim to include a missing modifier which may have been necessary for payment, for example.

Mail to:
UnitedHealthcare Community Plan
Attn: Complaint and Appeals Dept.
P.O. Box 31364
Salt Lake City, UT 84131-0364

An Appeal to the Texas Health and Human Services Commission

If the claim appeal is related to the recovery of funds paid in error due to a member in retrospect being ineligible for Medicaid or CHIP, you can appeal to Texas Health and Human Services (HHS). Send the following:

- A letter indicating that the appeal is related to a managed care disenrollment/recoupment and that you are requesting an exception request
- The Explanation of Benefits (EOB) showing the original payment
- The EOB showing the recoupment and/or the plan's letter requesting recoupment

All paper claims must include both the valid National Provider Identifier (NPI) number and Texas Provider Identifier (TPI) number with any necessary prior authorization number.

Mail to:

Texas Health and Human Services Commission
HHS Claims Administrator Contract Management
Mail Code-91X
P.O. Box 204077
Austin, Texas 78720-4077

We're Here to Help

If you have questions, please contact your Provider or Physician Advocate or call Provider Services at **888-887-9003**, 8 a.m. – 6 p.m. Central Time, Monday – Friday.

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UnitedHealthcare® Community Plan