



# **Contract Year 2019 Medicare Advantage Private Fee-For-Service (PFFS) Plan**

Terms and Conditions of Payment

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# Terms and Conditions of Payment

## 1. Introduction

UnitedHealthcare® MedicareDirect is a Medicare Advantage Private Fee-For-Service (PFFS) plan offered by UnitedHealthcare Insurance Company (UHIC), a division of UnitedHealth Group. UnitedHealthcare MedicareDirect allows members to use any provider, such as a physician, health professional, hospital, or other Medicare provider in the United States that agrees to treat the member after having the opportunity to review these terms and conditions of payment, as long as the provider is eligible to provide health care services under Medicare Part A and Part B (also known as “Original Medicare”) or eligible to be paid by UnitedHealthcare MedicareDirect for benefits that are not covered under Original Medicare.

Centers for Medicare & Medicaid Services (CMS) regulations provide that if you have an opportunity to review these terms and conditions of payment and you treat a UnitedHealthcare MedicareDirect member, you will be “deemed” to have a contract with us. Section 2 explains how the deeming process works. The rest of this document contains the contract that the regulations allow us to deem to hold between you (the provider) and UnitedHealthcare MedicareDirect. Any provider in the United States that meets the deeming criteria in Section 2 becomes deemed to have a contract with UnitedHealthcare MedicareDirect for the services furnished to the member when the deeming conditions are met. **No prior authorization, prior notification, or referral is required as a condition of coverage when medically necessary, plan-covered services are furnished to a member.** However, a member or provider may request an advance organization determination before a service is provided in order to confirm that the service is medically necessary and will be covered by the plan. Advance organization determination is described in Section 7.

## 2. When a provider is deemed to accept UnitedHealthcare MedicareDirect’s terms and conditions of payment

A provider is deemed by law to have a contract with UnitedHealthcare MedicareDirect when all of the following four criteria are met:

- 1) The provider is aware, in advance of furnishing health care services, that the patient is a member of UnitedHealthcare MedicareDirect. All of our members receive a member ID card that includes the UnitedHealthcare MedicareDirect plan name that clearly identifies them as PFFS members. The provider may validate eligibility by calling our **Provider Customer Service Center at 877-842-3210, 7:00 a.m. – 7:00 p.m. Central Time, Monday through Friday.**
- 2) The provider either has a copy of, or has reasonable access to, our terms and conditions of payment (this document). The terms and conditions are available on our website at [UHCProvider.com/Plans](https://UHCProvider.com/Plans) > Choose your state > Medicare > UnitedHealthcare MedicareDirect (PFFS) > Deeming Kit. The terms and conditions may also be obtained by calling our **Provider Customer Service Center at 877-842-3210, 7:00 a.m. – 7:00 p.m. Central Time, Monday through Friday.**
- 3) The provider furnishes covered services to a UnitedHealthcare MedicareDirect member.
- 4) The provider agrees to submit the bill for covered services directly to UnitedHealthcare MedicareDirect.

If all of these conditions are met, the provider is deemed to have agreed to UnitedHealthcare MedicareDirect's terms and conditions of payment for that member specific to that visit. For example: If a UnitedHealthcare MedicareDirect member shows you an enrollment card identifying him/her as a member of UnitedHealthcare MedicareDirect and you provide services to that member, you will be considered a deemed provider specific to that visit. Therefore, it is your responsibility to obtain and review the terms and conditions of payment prior to providing services, except in the case of emergency services (see below).

**Note:** You, the provider, can decide whether or not to accept UnitedHealthcare MedicareDirect's terms and conditions of payment each time you see a UnitedHealthcare MedicareDirect member. A decision to treat one plan member does not obligate you to treat other UnitedHealthcare MedicareDirect members, nor does it obligate you to accept the same member for treatment at a subsequent visit.

**If you DO NOT wish to accept UnitedHealthcare MedicareDirect's terms and conditions of payment, then you should not furnish services to a UnitedHealthcare MedicareDirect member, except for emergency services. If you furnish non-emergency services, you will be subject to these terms and conditions whether you wish to agree to them or not.** Providers furnishing emergency services will be treated as non-contracting (i.e., non-deemed) providers and paid at the payment amounts they would have received under Original Medicare.

### 3. Provider qualifications and requirements

In order to be paid by UnitedHealthcare MedicareDirect for services provided to one of our members, you must:

- Have a National Provider Identifier in order to submit electronic transactions to UnitedHealthcare MedicareDirect, in accordance with HIPAA requirements.
- Be licensed or certified by the state and furnish services to a UnitedHealthcare MedicareDirect member within the scope of your licensure or certification.
- Provide only services that are covered by our plan and that are medically necessary by Medicare definitions.
- Meet applicable Medicare certification requirements (e.g., if you are an institutional provider such as a hospital or skilled nursing facility).
- Have not opted out of participation in the Medicare program under §1802(b) of the Social Security Act, unless providing emergency or urgently needed services.
- Not be on the HHS Office of Inspectors General excluded and sanctioned provider lists.
- Not be included on the CMS preclusion list.
- Not be a federal health care provider, such as a Veterans' Administration provider, except when providing emergency care.
- Comply with all applicable Medicare and other applicable federal health care program laws, regulations, and program instructions, including laws protecting patient privacy rights and HIPAA that apply to covered services furnished to members. **You understand that you are subject to laws applicable to persons or entities receiving federal funds, and must notify all subcontractors that they are also subject to these laws.**

- Agree to cooperate with UnitedHealthcare MedicareDirect to resolve any member grievance involving the provider within the time frame required under federal requirements.
- Agree to abide by our appeal and grievance procedures. To obtain a copy of our procedures, please call our **Provider Customer Service Center at 877-842-3210, 7:00 a.m. – 7:00 p.m. Central Time, Monday through Friday.**
- For providers who are hospitals, home health agencies, skilled nursing facilities, or comprehensive outpatient rehabilitation facilities, provide applicable beneficiary appeals notices (see Section 11 for specific requirements).
- Agree to collect from the member the share of cost as identified in the member's Evidence of Coverage. Balance billing is prohibited.
- Agree to accept the Terms and Conditions of payment outlined in this document and provide services to a UnitedHealthcare MedicareDirect member.
- Agree to bill UnitedHealthcare MedicareDirect directly for reimbursement.
- All eligible physicians, facilities and other health care professionals who render services to UnitedHealthcare MedicareDirect members must accept our payment plus the member's applicable cost sharing as payment in full.
- Physicians, hospitals and other health care professionals who render services to UnitedHealthcare MedicareDirect members must adhere to all industry standards, as well as state and federal requirements.

## 4. Payment to providers

### Plan payment

UnitedHealthcare MedicareDirect reimburses deemed providers the amount they would have received as participating or non-participating physicians, as applicable, under Original Medicare for Medicare-covered services minus any member required cost sharing, for all medically necessary services covered by Medicare.

We will process and pay clean claims within 30 calendar days of receipt. If a clean claim is not paid within the 30 calendar day time frame, then we will pay interest on the claim according to Medicare guidelines. Section 5 has more information on prompt payment rules. Payment to providers for which Medicare does not have a publicly published rate will be based on the estimated Medicare amount. For more detailed information about our payment methodology for all provider types, go to [UHCProvider.com/Plans](https://UHCProvider.com/Plans) > Choose your state > Medicare > UnitedHealthcare MedicareDirect (PFFS) > Deeming Kit and look for the Reimbursement Guide.

Services covered under UnitedHealthcare MedicareDirect that are not covered under Original Medicare, e.g., Annual Physical Exam, Routine Foot Care, and Routine Vision and Hearing exams, are reimbursed as described in these Service Categories in the Reimbursement Guide. Go to [UHCProvider.com/Plans](https://UHCProvider.com/Plans) > Choose your state > Medicare > UnitedHealthcare MedicareDirect (PFFS) > Deeming Kit.

For more detailed information about our payment methodology for all provider types, go to [UHCProvider.com/Plans](https://UHCProvider.com/Plans) > Choose your state > Medicare > UnitedHealthcare MedicareDirect (PFFS) > Deeming Kit and look for the Reimbursement Guide.

Deemed providers furnishing such services must accept the fee schedule amount, minus applicable member cost sharing, as payment in full.

### Member benefits and cost sharing

Payment of cost sharing amounts is the responsibility of the member. Providers should collect the applicable cost sharing from the member at the time of the service when possible. **You can only collect from the member the appropriate UnitedHealthcare MedicareDirect copayments or coinsurance amounts as described in these terms and conditions.** After collecting cost sharing from the member, the provider should bill UnitedHealthcare MedicareDirect for covered services. Section 5 provides instructions on how to submit claims to us. Please note, however, that **UnitedHealthcare MedicareDirect** may not hold members accountable for any cost-sharing (deductibles, copayments, coinsurance) for Medicare-covered preventive services that are subject to zero cost sharing.

If a member is a dual-eligible Medicare beneficiary (that is, the member is enrolled in our PFFS plan and a State Medicaid program), then the provider cannot collect any cost sharing for Medicare Part A and Part B services from the member at the time of service when the State is responsible for paying such amounts (nominal copayments authorized under the Medicaid State plan may be collected). Instead, the provider may only accept the MA plan payment (plus any Medicaid copayment amounts) as payment in full or bill the appropriate State source.

To obtain more information about covered benefits, plan payment rates, and member cost sharing amounts under UnitedHealthcare MedicareDirect, you may call our **Provider Customer Service Center at 877-842-3210, 7:00 a.m. – 7:00 p.m. Central Time, Monday through Friday.** Be sure to have the member's ID number when you call.

UnitedHealthcare MedicareDirect follows Medicare coverage decisions for Medicare-covered services. Services not covered by Medicare are not covered by UnitedHealthcare MedicareDirect, unless specified by the plan. Information on obtaining an advance coverage determination can be found in Section 7. UnitedHealthcare MedicareDirect does not require members or providers to obtain prior authorization, prior notification, or referrals from the plan as a condition of coverage. There are no prior authorization and prior notification rules for UnitedHealthcare MedicareDirect members.

**Note: Medicare supplemental policies, commonly referred to as Medigap plans, cannot cover cost sharing amounts for Medicare Advantage plans, including PFFS plans. All cost sharing is the member's responsibility.**

### Prohibition of balance billing of members

A provider may collect only applicable plan cost sharing amounts from UnitedHealthcare MedicareDirect members and may not otherwise charge or bill members. Balance billing is prohibited by providers who furnish plan-covered services to UnitedHealthcare MedicareDirect members.

## Hold harmless requirements

In no event, including, but not limited to, nonpayment by UnitedHealthcare MedicareDirect, insolvency of UnitedHealthcare MedicareDirect, and/or breach of these terms and conditions, shall a deemed provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a member or persons acting on their behalf for plan-covered services provided under these terms and conditions. This provision shall not prohibit the collection of any applicable coinsurance, copayments, or deductibles billed in accordance with the terms of the member's benefit plan.

If any payment amount is mistakenly or erroneously collected from a member, you must make a refund of that amount to the member.

## 5. Filing a claim for payment

- You must submit a claim to UnitedHealthcare MedicareDirect for Original Medicare covered services within the same time frame you would have to submit under Original Medicare, which is within one calendar year after the date of service.
- Failure to be timely with claim submissions may result in non-payment. Per 42 CFR 424.44, for services furnished on or after January 1, 2010, the claim must be filed no later than the close of the period ending 1 calendar year after the date of service.
- **Prompt Payment.** UnitedHealthcare MedicareDirect will process and pay clean claims within 30 calendar days of receipt. If a clean claim is not paid within the 30 calendar day time frame, UnitedHealthcare MedicareDirect will pay interest on the claim according to Medicare guidelines. A clean claim includes the minimum information necessary to adjudicate a claim, not to exceed the information required by Original Medicare. UnitedHealthcare MedicareDirect will process all non-clean claims and notify providers of the determination within 60 calendar days of receiving such claims.
- Submit claims using the standard CMS-1500, CMS-1450 (UB-04), or the appropriate electronic filing format.
- Use the same coding rules and billing guidelines as Original Medicare, including Medicare CPT Codes, HCPCS codes and defined modifiers. Bill diagnosis codes to the highest level of specificity.
- **Clean Claim.** A completed "clean" claim must include the following information:
  - Member name
  - UnitedHealthcare MedicareDirect identification number
  - Date(s) of service
  - Procedure/service/supply/NDC codes
  - Diagnosis code(s) to the highest level of specificity
  - Provider's billing name and address
  - Provider's tax identification number, UPIN or Social Security number
  - National Provider Identifier (NPI)
  - **Note: For more information on NPI, see "Your Medicare Provider Number" on page 10.**
  - Days/units of service
  - Place of service
  - Total dollar amount billed

- Other documentation may also be required depending on the type of provider and services billed on a specific claim.
- **Interim Rate Letters.** For facilities not paid under PPS methodology, UnitedHealthcare MedicareDirect must have an interim rate letter on file for any date(s) of service for which services were rendered to a member. Fax letters and updates to:

**Reimbursement Services Fax: 866-943-9811**

- **Coordination of Benefits.** All Medicare secondary payer rules apply. These rules can be found in the Medicare Secondary Payer Manual located at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019017.html?DLPage=1&DLSort=0&DLSortDir=ascending>  
Providers should identify primary coverage and provide information to UnitedHealthcare MedicareDirect at the time of billing.

### Where to submit a claim

- For **electronic claim submission**, UnitedHealthcare MedicareDirect accepts electronic transactions from multiple clearinghouses for our Private Fee-For-Service plan. We suggest that you contact your clearinghouse to determine their available connectivity to UnitedHealthcare. Submit all of your UnitedHealthcare MedicareDirect claims using the:

**UnitedHealthcare Payer ID — 87726**

To avoid processing delays, you must validate the appropriate UnitedHealthcare MedicareDirect Payer ID number with your clearinghouse or refer to your clearinghouse's Published Payer Lists. Using a clearinghouse may help ensure that EDI requirements outlined in the Health Insurance Portability and Accountability Act (HIPAA) are met. For more information on Electronic Payments and Statements, please call:

**866 UHC-FAST, Option 5**

For information to receive your remittance advice electronically (835ERA), please call:

**800-842-1109, Option 4**

- For **paper claim submission**, submit completed, hard copy CMS-1500, or CMS-1450 (UB-04), as of March 1, 2007, claims to:

**UnitedHealthcare MedicareDirect  
P.O. Box 31353  
Salt Lake City, UT 84131-0353**

If you have problems submitting claims to us or have any billing questions, contact our technical billing resource at our **Provider Customer Service Center** at **877-842-3210, 7:00 a.m. – 7:00 p.m. Central Time, Monday through Friday.**



## Resubmissions

Providers can find out why a claim was adjudicated as originally submitted in one of two ways. Either by checking its status at [www.UHCProvider.com](http://www.UHCProvider.com), or by Provider Remittance Advice (PRA) that accompanies each check payment for claims. The PRA also includes additional information or instructions related to denied claims included with the check payment. If you do not understand the information provided online or on the PRA, please contact our **Provider Customer Service Center** at **877-842-3210, 7:00 a.m. – 7:00 p.m. Central Time, Monday through Friday.**

There is a difference in resubmitting previous claims containing the same information versus resubmitting previous claims with new information. If information has not changed, simply resubmit a hard copy via mail or electronically:

### Submission of Paper Claims Submission of Electronic Claims

**UnitedHealthcare MedicareDirect UnitedHealthcare Payer ID – 87726  
P.O. Box 31353 Salt Lake City, UT 84131-0353**

If new information or further documentation has been added, a paper claim needs to be mailed and stamped with “Corrected Claim” or “Resubmission.” **Do not resubmit via EDI.**

In order to avoid any confusion between resubmissions and reconsiderations, resubmissions are those situations in which more information is needed to process a claim and make a determination. For example, additional information may be requested on a Provider Remittance Advice. Reconsiderations are filed by providers after a claim determination has been made and the provider disagrees with the payment decision. Reconsiderations are the first step in the provider dispute resolution process.

## Your Medicare Provider Number

Medicare Federal Regulations, and many state Medicaid agencies, require the use of the National Provider Identifier (NPI), on all electronic and paper claim submissions effective May 23, 2008.

A valid NPI is required for all covered claims. To avoid payment delays or denials, include a valid NPI on all UnitedHealthcare MedicareDirect claims submitted for processing.

In addition to the NPI, it is also important to continue to submit a Tax Identification Number (TIN). Please continue to submit complete claims to comply with clean claim billing requirements.

If you have not yet applied for and received your NPI, please do so immediately by visiting <https://nppes.cms.hhs.gov/NPPES/Welcome.do>

## 6. Maintaining medical records and allowing audits

Deemed providers shall maintain timely and accurate medical, financial and administrative records related to services they render to UnitedHealthcare MedicareDirect members. Unless a longer time period is required by applicable statutes or regulations, the provider shall maintain such records for at least 10 years from the date of service.

Deemed providers must provide UnitedHealthcare MedicareDirect, the Department of Health and Human Services, the Comptroller General, or their designees access to any books, contracts, medical records, patient care documentation, and other records maintained by the provider pertaining to services rendered to Medicare beneficiaries enrolled in a Medicare Advantage plan, consistent with federal and state privacy laws. Such records will primarily be used for CMS audits of risk adjustment data upon which CMS capitation payments to UnitedHealthcare MedicareDirect are based. Providers are required to furnish member medical records without charge when the medical records are required for government use.

UnitedHealthcare MedicareDirect may also request records for activities in the following situations: UnitedHealthcare MedicareDirect audits of risk adjustment data, determinations of whether services are covered under the plan, are reasonable and medically necessary, and whether the plan was billed correctly for the service; to investigate fraud and abuse; and in order to make advance coverage determinations. UnitedHealthcare MedicareDirect will not use these records for any purpose other than the intended use. Providers will not be reimbursed for furnishing the member medical records.

UnitedHealthcare MedicareDirect will not use medical record reviews to create artificial barriers that would delay payments to providers. Both mandatory and voluntary provision of medical records must be consistent with HIPAA privacy law requirements.

## 7. Getting an advance organization determination

Providers or plan enrollees may choose to obtain a written advance coverage determination (known as an organization determination) from us before a service is furnished to confirm whether the service will be covered by UnitedHealthcare MedicareDirect. To obtain an advance organization determination, call us at **866-822-0591**. UnitedHealthcare MedicareDirect will make a decision and notify you and the member within 14 calendar days of receiving the request, with a possible (up to) 14 calendar day extension either due to the member's request or UnitedHealthcare MedicareDirect justification that the delay is in the member's best interest. In cases where you believe that waiting for a decision under this time frame could place the member's life, health, or ability to regain maximum function in serious jeopardy, you can request an expedited determination. To obtain an expedited determination, call us at **866-822-0591**. We will notify you of our decision as expeditiously as the enrollee's health condition requires, but no later than 72 hours after receiving the request, unless we invoke a (up to) 14 calendar day extension either due to the member's request or UnitedHealthcare MedicareDirect's justification that the delay is in the member's best interest.

In the absence of an advance organization determination, UnitedHealthcare MedicareDirect can retroactively deny payment for a service furnished to a member if we determine that the service was not covered by our plan or was not medically necessary. However, providers have the right to dispute our decision by submitting a waiver of liability (promising to hold the member harmless regardless of the outcome), and exercising member appeal rights (see the Federal regulations at 42 CFR Part 422, subpart M, or Chapter 13 of the Medicare Managed Care Manual).

## 8. Provider payment dispute resolution process

If you believe that the payment amount you received for a service is less than the amount described in our terms and conditions of payment, you have the right to dispute the payment amount by following our dispute resolution process.

To file a payment dispute with UnitedHealthcare MedicareDirect, send a written dispute to:

**UnitedHealthcare MedicareDirect – Payment Disputes**  
**P.O. Box 30997**  
**Salt Lake City, UT 84130-0997**

A copy of our Provider Payment Dispute Resolution Form is available on our website at [UHCProvider.com/Plans](https://UHCProvider.com/Plans) > Choose your state > Medicare > UnitedHealthcare MedicareDirect (PFFS):

- Under “Tools & Resources,” click and download the appropriate form:
  - Medicare Advantage Non-Contracted Provider Claim Payment Dispute Request Form

Additionally, please provide appropriate documentation to support your payment dispute (e.g., a remittance advice from a Medicare carrier would be considered such documentation). Claims must be disputed within 120 calendar days from the date payment is initially received by the provider. Note that in cases where we re-adjudicate a claim (for instance, when we discover that we processed it incorrectly the first time), you have an additional 120 calendar days from the date you are notified of the re-adjudication in which to dispute the claim.

We will review your dispute and respond to you within 30 calendar days. If we agree with the reason for your payment dispute, we will pay you the additional amount you are requesting, including any interest that is due. We will inform you in writing if our decision is unfavorable and no additional amount is owed.

## 9. Member and provider appeals and grievances

UnitedHealthcare MedicareDirect members have the right to file appeals and grievances with UnitedHealthcare MedicareDirect when they have concerns or problems related to coverage or care. Members may appeal a decision made by UnitedHealthcare MedicareDirect to deny coverage or payment for a service or benefit that they believe should be covered or paid. Members should file a **grievance** for all other types of complaints not related to the provision or payment for health care.

A physician who is providing treatment may, upon notifying the member, appeal pre-service organization determination denials to the plan on behalf of the member. The physician may also appeal a post-service organization determination denial as a representative, or sign a waiver of liability (promising to hold the member harmless regardless of the outcome) and appeal the denial using the member appeal process. There must be potential member liability (e.g., an actual claim for services already rendered and denied in whole, as opposed to an advance organization determination or a partially paid claim), in order for a provider to appeal a post-service organization determination utilizing the member appeal process.

If you appeal on your own right, you agree to abide by the statutes, regulations, standards, and guidelines applicable to the Medicare PFFS Member appeals and grievance process.

A non-physician provider may appeal organization determinations on behalf of the member as a representative, or sign a waiver of liability (promising to hold the member harmless regardless of the outcome) and appeal post-service organization determinations (e.g., claims) using the member appeal process. As noted above, there must be potential member liability in order for a provider to appeal a post-service organization determination utilizing the member's appeal process.

If a provider appeals using the member appeal process, the provider agrees to abide by the statutes, regulations, standards and guidelines applicable to the Medicare PFFS Member appeal and grievance processes.

To learn more about the member appeals and grievance process, go to [UHC Medicare Solutions.com](http://UHC Medicare Solutions.com) > [Shop For a Plan](#) > [Resources](#) > [Medicare Advantage Plans](#) > [Get Plan Resources](#) > [Medicare Advantage Plan Information and Forms](#) > [Other Resources and Plan Information](#) > [Medicare Advantage \(no prescription drug coverage\) appeals and grievances](#). You can also call our **Provider Customer Service Center at 877-842-3210, 7:00 a.m. – 7:00 p.m. Central Time, Monday through Friday**, for more information on our member appeals and grievance policies and procedures.

## 10. Quality Improvement Organization (QIO) Complaint Process

If the member is concerned about the quality of care he or she has received, he or she can file a complaint with the local Quality Improvement Organization (QIO). The QIO is an entity paid by CMS to review medical necessity, access to care, appropriateness and quality of certain medical care and services provided to Medicare beneficiaries by practicing physicians and other health care professionals. The QIO review process is designed to identify and eliminate any improper practices.

## 11. Providing members with notice of their appeals rights — Requirements for Hospitals, SNFs, CORFs, and HHAs

**Hospitals** must notify Medicare beneficiaries, including Medicare Advantage beneficiaries enrolled in PFFS plans, who are hospital inpatients about their discharge appeal rights by complying with the requirements for providing the Important Message from Medicare (IM), including complying with the normal time frames for delivery. For copies of the notice and additional information regarding IM notice and delivery requirements, go to:

<http://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html>

Hospitals must also issue the Medicare Outpatient Observation Notice (MOON). The MOON is a standardized, written notice explaining that a Medicare beneficiary, including Medicare Advantage beneficiaries enrolled in PFFS plans, is receiving outpatient observation services, and is not an inpatient. The notice must include the reasons the individual is an outpatient receiving observation services and the implications of receiving such services. Hospitals and CAHs must deliver the notice no later than 36 hours after initiation of observation services. All hospitals and CAHs are required to start providing this statutorily required notification no later than March 8, 2017. For copies of the notice and the notice instructions, go to:

<http://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html>

**Skilled nursing facilities, home health agencies, and comprehensive outpatient rehabilitation facilities** must notify Medicare beneficiaries, including Medicare Advantage beneficiaries enrolled in PFFS plans, about their right to appeal a termination of services decision by complying with the requirements for providing the Notice of Medicare Non-Coverage (NOMNC), including complying with the normal time frames for delivery. For copies of the notice and the notice instructions, go to: <http://www.cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices.html>

As directed in the instructions, the NOMNC should contain UnitedHealthcare MedicareDirect contact information somewhere on the form (such as in the additional information section on page 2 of the NOMNC).

Hospitals, home health agencies, comprehensive outpatient rehabilitation facilities or skilled nursing facilities must provide members with a detailed explanation on behalf of the plan if a member notifies the Quality Improvement Organization (QIO) that the member wishes to appeal a decision regarding a hospital discharge (Detailed Notice of Discharge) or termination of home health agency, comprehensive outpatient rehabilitation facility or skilled nursing facility services (Detailed Explanation of Non-Coverage) within the time frames specified by law. For copies of the notices and the notice instructions, go to:

<http://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html> and  
<http://www.cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices.html>

## 12. If you need additional information or have questions

For inquiries related to member eligibility, benefits, copayments and claims status, you can register on our secured website for online access:

[www.UHCProvider.com](http://www.UHCProvider.com)

OR

Speak with one of our representatives by calling:

**877-842-3210**

**7:00 a.m. – 7:00 p.m. Central Time**

**Monday through Friday**

UnitedHealthcare MedicareDirect encourages providers to verify the member's eligibility each time he or she is seeking services.

### 13. Uncollectible Accounts (Bad Debt)

Providers must make reasonable and customary collection efforts before categorizing a patient account as uncollectible (bad debt). Charges for non-covered services are not eligible for bad debt reimbursement. No less than 120 days from the date the member received the first bill for the claim in question, and up to 12 months after that, providers may submit a request for reimbursement of the applicable portion of the bad debt. The bad debt submittal form, which can be downloaded from [UHCProvider.com/Plans](https://UHCProvider.com/Plans) > Choose your state > Medicare > UnitedHealthcare MedicareDirect (PFFS) > Tools & Resources > “UnitedHealthcare MedicareDirect (PFFS) Uncollectible Amounts (Bad Debt) Submittal Form”, must be completely filled out, listing only the amount of cost sharing for covered services assessed under the member’s UnitedHealthcare MedicareDirect benefit plan that could not be collected from the member, net of any partial amount(s) collected. Please note that documentation of billing and collection efforts may be requested during processing.

The bad debt submittal form should be mailed to:

**UnitedHealthcare MedicareDirect**  
**P.O. Box 31353**  
**Salt Lake City, UT 84131-0353**

A completed form will be processed within 30 days of receipt unless additional information or verification has been requested. If payment or a request for additional information has not been received within 30 days, providers may call our **Provider Customer Service Center at 877-842-3210, 7:00 a.m. – 7:00 p.m. Central Time, Monday through Friday.**

