



Partnering for Better Care: Behavioral Health Success with UnitedHealthcare

2026 IHCP Works Annual Seminar

Presented by Paulette Means, Provider Relations Advocate for Northern Indiana

United
Healthcare

Purpose and Objectives

- **Reduce Administrative Friction**

- The session outlines clear steps and best practices to simplify enrollment, authorization, attestation, and claims for providers.

- **Emphasize Collaboration**

- Collaboration among providers, advocates, and health organizations improves member experience and health outcomes.

- **Coordinate Care Effectively**

- Coordination of care is essential for members with complex behavioral needs across multiple providers and systems.

- **Empower Providers**

- Providing practical knowledge and support enables providers to focus on delivering compassionate, effective care.





Agenda

- Why Behavioral Health Matters
- Network Participation and Enrollment
- Attestation and Directory Accuracy
- Prior Authorization
- Claims and Payment Success
- Coordination of Care
- Behavioral Health Contacts



Why Behavioral Health Matters

Behavioral Health Is Whole-Person Health



Mental health affects physical health



Early intervention improves outcomes



Providers are the cornerstone of access



Collaboration drives success



The Behavioral Health Member Journey

Member Need

Finds Provider

Authorization

Receives Care

Claims

Coordinated Care

Improved
Outcomes



Challenges Members Face



Finding
participating
providers



Accessing timely
treatment



Understanding
benefits



Navigating
transitions of
care



Managing
behavioral and
physical
conditions





Network Participation and Enrollment

Why Network Participation Matters

Provider Benefits:

- Access to members
- Streamlined referrals
- Claims support
- Educational resources

Member Benefits:

Greater access
Continuity of care
Better outcomes



Optum Behavioral Health Provider Types

- Board Certified Behavior Analyst (B.C.B.A.)
- Clinical Nurse Specialist (C.N.S.)
- CSR – Prescriptive Authority (CSR-Pres Auth)
- Doctor of Osteopathic Medicine (D.O.)
- Health Service Provider in Psychology (H.S.P.P.)
- Licensed Clinical Addiction Counselor (L.C.A.C.)
- Licensed Clinical Social Worker (L.C.S.W.)
- Licensed Marriage and Family Therapist (L.M.F.T.)
- Licensed Mental Health Counselor (L.M.H.C.)



Optum Behavioral Health Provider Types (cont.)

- Medical Doctor (M.D.)
- Nurse Practitioner (N.P.)
- Physician Assistant (P.A.)
- Registered nurse (R.N.)
- Advanced Practice Nurse (A.P.N.)
- Community Mental Health Centers (CMHC)
- Rural Health Clinics (RHC)
- Federally Qualified Health Centers (FQHC)
- Substance Use Disorder Agencies (SUD)
- Inpatient Facilities
- OTP (Opioid Treatment Program)



Provider Enrollment – Individual Providers

- UnitedHealthcare Community Plan of Indiana Homepage
- Bulletins and Newsletters | UnitedHealthcare Community Plan of Indiana
- Care Provider Manuals
- Claims and Payments | UnitedHealthcare Community Plan of Indiana
- Eligibility and Benefits
-  **How to Join the UnitedHealthcare network | Indiana**
- Pharmacy Resources and Physician Administered Drugs | UnitedHealthcare Community Plan of Indiana
- Policies and Clinical Guidelines | UnitedHealthcare Community Plan of Indiana
- Prior Authorization and Notification | UnitedHealthcare Community Plan of Indiana
- Provider Forms and References | UnitedHealthcare Community Plan of Indiana

UnitedHealthcare Community Plan of Indiana Homepage

Last update: May 14, 2025

We know you don't have time to spare, so we put all the UnitedHealthcare Community Plan resources you need in one place. Use the navigation on the left to quickly find what you're looking for. Be sure to check back frequently for updates.

Indiana PathWays for Aging continuity of care period

UnitedHealthcare (UHC) Pathways will honor existing A&D waiver service authorizations for up to 90 days from the date of enrollment. Members currently receiving A&D waiver services can continue receiving those same services under the UHC Pathways program. Please continue to provide services as we work to send authorization notices to you for those you serve. If you have any questions, please email IN_providerservices@uhc.com.

Prior Authorization and Notification Resources
[Learn more](#)

Current Policies and Clinical Guidelines
[Learn more](#)

Provider Administrative Manual and Guides
[Learn more](#)



Provider Enrollment – Individual Providers

(cont.)

- If you click on [UnitedHealthcare Community Plan of Indiana Homepage | UHCprovider.com](#), it will take you to the page that was mentioned on slide 12.



Join the Network– Individual Providers (cont.)

To begin the process	This section applies to behavioral health practitioners, ABA providers and facilities. If you work in this specialty area, the process to join our network begins with Optum Behavioral Health. They handle credentialing and contracting on behalf of UnitedHealthcare. To start the network participation request process, go to Optum's Join Our Network page and click on the button associated with your provider type (e.g., Individual Clinician, Agency, Facility, Autism/ABA). • Please complete all fields and submit all applicable information • Make sure all CAQH information is current and attested • Ensure all requested documents are current and accurate • Review the Optum Provider Express Onboarding Process for additional details You must also be enrolled with Indiana Health Coverage Programs (IHCP). If you haven't already done so, complete your provider enrollment. A complete request to join the Optum Behavioral Health network must include: • Active Medicaid ID obtained through IHCP • Current CAQH application, with access granted to UnitedHealthcare • National provider identification (NPI) number • W-9 • Phone & fax number • Email address • Physical address, including suite number if applicable • ZIP code + 4

Here's what happens next	Optum Behavioral Health will quickly review your application. Within 5 business days, they'll notify you by mail or email if your request is complete or if they need additional information from you (see the list above outlining what must be included for a request to be considered complete).
How to check the status of a network participation request	If you have questions about the status of an Optum Behavioral Health request for network participation, call 877-614-0484. Please provide your One Healthcare ID for clinicians or your Provider Reference Number for agencies or facilities (provided at time of submission of your request for network participation) to facilitate checking status of your request. For individual practitioners, you can also use your One Healthcare ID to check status throughout the network participation request process using the Initial Credentialing Toolbar on the Provider Express website.
Questions?	If you have questions, call Optum Behavioral Health Solutions at 877-614-0484.



Enrollment Options

Autism/ABA/BCBA Providers

Optum is recruiting Board Certified Behavior Analysts (BCBA) in solo private practice and qualified agencies that provide intensive ABA services in the treatment of ASD, for our Autism/ABA provider network.

[Click here to join](#)

Individually-Credentialed Clinicians

To apply as an individual, you must be a solo clinician or practicing within a group that does not currently have a group agreement with Optum.

[Click here to join](#)

Facility or Hospital-Based

To apply for Facility or Hospital-Based, your facility must offer MH or SUD Inpatient, Residential, Partial Hospitalization or Intensive Outpatient Levels of Care.

[Click here to join](#)

Group with Individually Credentialed Providers

To apply for group with individual credentialing, you must be part of a group that has a group agreement with Optum.

[Click here to join](#)

Group with Agency Credentialed Providers

To apply for Agency credentialing, your group must be designated as a Community Mental Health Center (CMHC), Federally Qualified Health Center (FQHC), Rural Health Center (RHC), Opioid Treatment Program (OTP), and/or other Federally or State licensed or certified entity (license or certification is at the organizational level).

[Click here to join](#)

Learn more about our Specialty Network Requests

[Express Access](#)

[virtual visits](#)



Individual Providers

- Individually Contracted Clinicians: To apply as an individual, you must be a solo clinician or practicing within a group that does not currently have a group agreement with Optum.

Individually Credentialed Clinicians

Individually Credentialed Clinicians

CAQH Participation is required in the majority of the states to join our network. If your state requires it, you will be required to enter your CAQH ID # on the credentialing application. To participate in CAQH, please contact: www.CAQH.org

- Credentialing Plans
 - [Optum](#) 
 - [California Behavioral Health](#) 

Improve the Speed of Processing - Tips for Applying to the Network

We recently conducted an audit of credentialing application issues. Here's an at-a-glance view of the most common issues that will slow down or lead to the cancellation of the credentialing of your application to join our network.

Category	Issues	Requirement
CAQH	• Your CAQH profile status is incomplete or expired • Your group information including but not limited to primary and practice locations listed on your UBH Network Participation form does not match what you have listed on your CAQH profile • We do not have authorization to access your CAQH application (log into the CAQH ProView Provider portal, go to the user account setting menu and review the Authorization section to update your preferences to authorize United Behavioral Health/US Behavioral Health Plan) • Information in your completed CAQH profile needs to be updated (Examples include Practice Information, Credentialing Contact information, License and Professional Liability Insurance effective and expiration dates)	The information on CAQH must match the information you provide on the Optum NPRF form.
Attached Documents	• Attaching the wrong document • Not signing the W-9 form or providing an incorrect Tax ID number or EIN • Current Professional Liability Insurance Certificate	Providing all the correct and completed documents is required.
Document Return	Slow response time to requested information. • Individual Contracts • Disclosure of Ownership documents	Missing documents are sent out via DocuSign. Sign and return as quickly as possible.

Continue

After clicking the Continue button you will be prompted to register or login to Provider Express. Once you are logged in to Provider Express, please use the Join Our Network feature in the menu to proceed to the credentialing application.

For help with this process: [Registering a Provider Access and Starting the Online Optum Credentialing Application](#)  



Agency Enrollment

- Group with Agency Credentialed Providers: To apply for Agency credentialing, your group must be designated as a CMHC, FQHC, RHC, OTP, and/or other federally or state licensed or certified entity (license or certification is at the organizational level).
- Group with agency credentialed providers
-

[Optum - Provider Express Home](#) > [Our Network](#) > Group with agency credentialed providers

Group with agency credentialed providers



In order to apply for Agency credentialing, your group must be designated as a Community Mental Health Center (CMHC), Federally Qualified Health Center (FQHC), Rural Health Center (RHC), Opioid Treatment Program (OTP), and/or other Federally or State licensed or certified entity (license or certification is at the organizational level).

Your organization must have the minimum Liability insurance of \$1 million/ \$3 Million for both General Liability and Professional Liability.

If you meet these requirements, [click here to complete the Agency application](#).

For questions or help – contact Network Management at (877) 614-0484

If your Agency only provides ABA services, click here to complete the [Autism/ABA/BCBA](#) application.

Please note that the following documents will be required (as applicable):

- A current state license or certificate for all services and locations where you offer services
- Optum accepts the below accreditations. If you are not accredited, a site audit will be required before the credentialing process will be complete
 - Accreditation Association for Ambulatory Health Care (AAAH)
 - Accreditation Commission for Health Care, Inc. (ACHC)
 - Commission on Accreditation of Rehabilitation Facilities (CARF)
 - Community Health Accreditation Program (CHAP)
 - Center for Improvement in Healthcare Quality (CIHQ)
 - Det Norske Veritas National Integrated Accreditation for Healthcare Organizations (DNV NIAHO)
 - Healthcare Facilities Accreditation Program (HFAP)
 - Joint Commission (TJC)
 - Council on Accreditation (COA)
- Medicaid and/or Medicare certification letters with applicable registration numbers
- Current Professional and General Liability insurance certificates showing limits, policy number(s) and expiration date(s)
- W9 form
- Current Staff roster including license, taxonomy and NPI
- For Opioid Treatment Programs (OTP), copies of the prescribers' DEA licenses are required



Facility Or Hospital Enrollment

- Facility or hospital-based groups: For facility or hospital-based enrollments, your facility must offer Mental Health Inpatient, Residential, Partial Hospitalization or Intensive Outpatient levels of care.

Facility or Hospital-Based Enrollment

[Optum - Provider Express Home](#) > [Our Network](#) > Facility or Hospital Based

Facility or Hospital-Based Providers



Facility or Hospital-Based Providers

- Do you offer licensed/certified Mental Health and/or Substance Use Disorder (SUD) inpatient and/or lower level of care services (i.e., Inpatient, Detox, Residential, Partial Hospitalization (PHP), and Intensive Outpatient (IOP) programs)?
- Do you have minimum professional liability coverage of \$5 million/\$5 million for acute inpatient services, and minimum professional and comprehensive liability coverage of \$1 million/\$3 million for non-acute inpatient services (unless state requirements vary)?

If meet above requirements, please click on the Facility Application link below to complete and select all applicable Level(s) of Care you provide.

IMPORTANT: For covered facility-based services billed with Revenue Code or Revenue Code + HCPC or CPT code on a UB-04 form, please complete the Facility Application. For covered facility-based services billed with single HCPC code or HCPC code + CPT code on a CMS 1500 form, please confirm the appropriate application to complete before completing the Facility Application.

[Facility Application](#) 

For questions or help – contact Network Management at (877) 614-0484

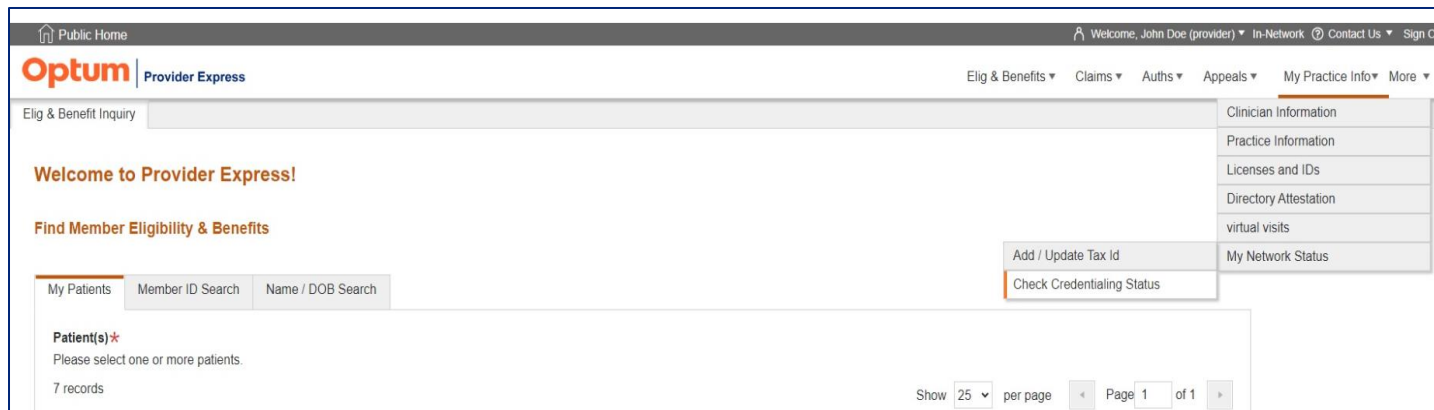
Please note following documents will be required (As Applicable):

- Current State License(s)/ Certificate(s) for all behavioral health services you provide, i.e. psychiatric, substance abuse, residential, intensive outpatient, etc. A18 – include all documentation for multiple facility locations.
- Accreditation status (i.e. The Joint Commission, CARF, COA, etc.)
- ASAM CARF Level of Care Certification, if applicable
- Medicare or Medicaid certification letter with Medicare number (REQUIRED if applying for participation in Medicaid or Medicare networks)
- Program Description-including any specialty program descriptions and hours per day/ days per week
- Copy of completed Ownership & Disclosure Form (REQUIRED if applying for participation in Medicaid networks)
- Copy of completed Ownership & Disclosure Form (REQUIRED if applying for participation in Medicaid networks)
- Current Professional and General Liability insurance certificates showing limits, policy number(s) and expiration date(s). If self - insured, attach a copy of an independently audited financial statement which shows retention of the required amounts.



Checking Status – Practitioner Initial Credentialing

Using the **Initial Credentialing Status Toolbar**, you can easily track the status of your online submission as it moves along the approval process. Log in to the secure transactions area of Provider Express, hover over *My Practice Info > My Network Status >* click on *Check Initial Credentialing Status*.



Agency or group practice, or facility – Contact Network Management at 877-614-0484, Monday – Friday, 7am – 7pm CT.



Practitioner Credentialing Tips

- Ensure your Council for Affordable Quality Healthcare (CAQH) is accurate and up to date
- Missing documents from Optum can be submitted via DocuSign. Sign and return as quickly as possible
- Check the status of your application with the Credentialing Status Toolbar that is available at [Indiana – Provider Express](#)

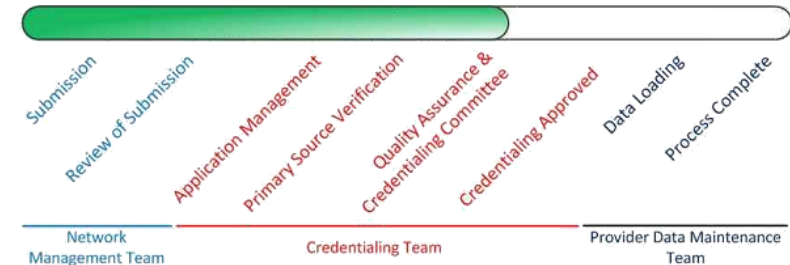
Provider Credentialing Status Toolbar

Great news! You can now easily track the status of your online submission as it moves along the approval process using the new [Credentialing Status Toolbar](#). Following up on valuable feedback we've heard from providers just like you, we've created an online tool that lets you see at-a-glance where you are in the credentialing process.



Network Participation Request Form

Your application is currently under review with our Credentialing Department's Quality Assurance Team. This review ensures that all regulatory and NCOA standards have been met. Should the file not meet standards, it may be sent back to the Processing Team to address.



You may now close this window and check back at later date for the current status of your request. If you need further assistance, please contact the Optum Provider Line at (877) 614-0484.





Attestation and Directory Accuracy

Why Attestation Matters for Behavioral Health Providers and Members

Regulatory Attestation Requirement

- Health plans must verify provider directory info every 90 calendar days to comply with regulations.

Benefits for Members

- Accurate directories reduce confusion and help members find in-network behavioral health providers easily.

Provider Visibility and Compliance

- Attestation enhances provider visibility, supports compliance, and highlights specialty services.

Streamlined Re-credentialing

- Maintains consistency across directories and CAQH profiles, enabling efficient re-credentialing.





Prior Authorization

Understanding Behavioral Health Authorization Requirements

Prior Authorization Purpose

- Prior authorization ensures behavioral health services are clinically appropriate and covered by benefits before delivery.

Services Requiring Authorization

- Inpatient admissions, residential treatment, partial hospitalization, and intensive outpatient programs usually require prior authorization.

Accessing Authorization Info

- Providers use member benefit info, ID card contact, or [Optum Provider Express](#) to verify authorization requirements and guidelines.

Escalation and Timely Care

- If no timely authorization response, providers escalate through established pathways to avoid treatment delays.



Determine Behavioral Health Service Prior Authorization Requirement

- Most outpatient behavioral health services do NOT require an authorization
- Call the number on the back of the member's card or call 877-610-9785 Monday through Friday from 8:00am to 8:00pm Eastern Standard Time to determine if authorization is required

- Or -

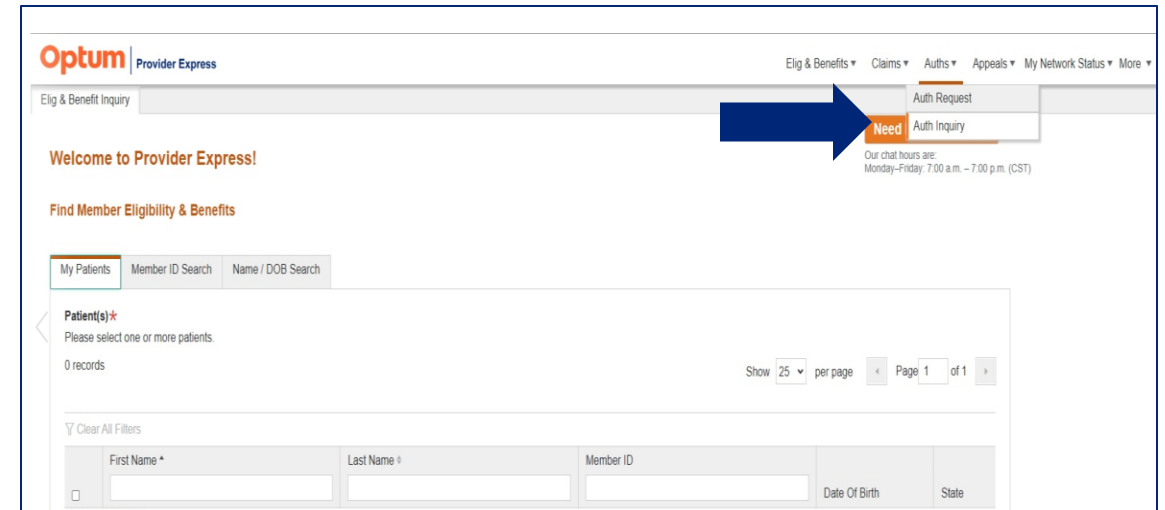
- [Provider Express – Indiana Medicaid](#)

The screenshot shows the Optum Provider Express website. At the top, there's a navigation bar with links: Home, Our Network, Clinical Resources, Admin Resources, Video Channel, Training, About Us, and Contact Us. Below this is a breadcrumb trail: Optum - Provider Express Home > Our Network > State-Specific Provider Information > Welcome Indiana. The main heading is "Welcome Indiana Behavioral Health Providers". Underneath is "Indiana Medicaid Network Participation" with a link to "Indiana PathWays for Aging and Hoosier Care Connect Medicaid Tips". A list of resources is shown with expandable icons (downward arrows): "How to submit an Optum participation request", "Credentialing requirements", "Individual Clinician requirements", "Individual clinician step-by-step guides", "Agency requirements", and "Facility requirements". A large blue arrow points from the "Individual Clinician requirements" link to a sidebar menu. The sidebar menu has sections: "Provider Communications and General Resources", "Prior Authorization and Appeals" (which is expanded), "Claims", and "Contacts". The "Prior Authorization and Appeals" section contains text about submitting a Universal PA form and a list of links: "Universal Prior Authorization Form", "Substance Use Disorder (SUD) Universal Prior Authorization Form", "IHCP SUD Admission Assessment Form", "IHCP SUD Reassessment Form", "Psych-Neuropsych Prior Authorization Request Form", and "United Healthcare Community Plan of Indiana Hoosier Care Connect Behavioral Health Prior Authorization List". At the bottom of this section is a link for appeals information: "uhcprovider.com/Indiana".

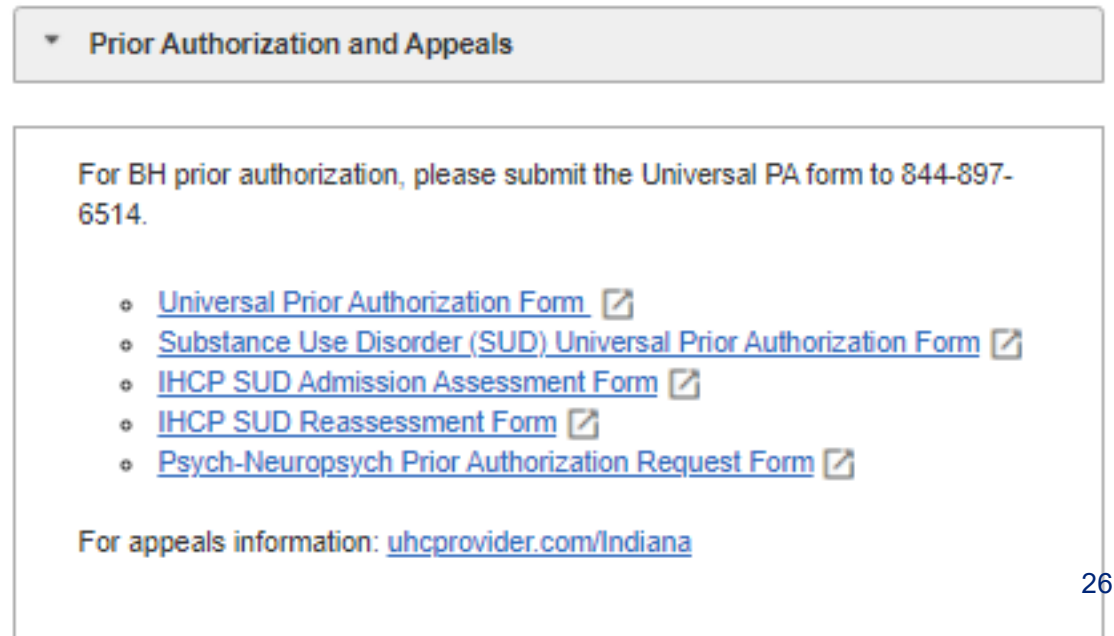


Request Behavioral Health Prior Authorization

- Initiate phone authorization process by calling the number on the back of the member's ID card
- Securely log in to Provider Express and select “Auth Request” from the “Auths” dropdown box
 - To check on status, select “Auth Inquiry”
- Use paper [IHCP Universal Prior Authorization Form](#) from [Provider Express - Indiana Medicaid](#) and click “Prior Authorizations and Appeals”
 - Fax 844-897-6514



The screenshot shows the Optum Provider Express website. The top navigation bar includes links for Elig & Benefits, Claims, Auths, Appeals, My Network Status, and More. The Auths dropdown menu is open, showing options for Auth Request and Auth Inquiry. A blue arrow points to the Auth Request option. Below the navigation bar, there is a search bar with tabs for My Patients, Member ID Search, and Name / DOB Search. The main content area displays a welcome message and a search results table with columns for First Name, Last Name, Member ID, Date Of Birth, and State. The table currently shows 0 records.



The screenshot shows the Prior Authorizations and Appeals section of the Optum Provider Express website. It contains the following text:

For BH prior authorization, please submit the Universal PA form to 844-897-6514.

- [Universal Prior Authorization Form](#)
- [Substance Use Disorder \(SUD\) Universal Prior Authorization Form](#)
- [IHCP SUD Admission Assessment Form](#)
- [IHCP SUD Reassessment Form](#)
- [Psych-Neuropsych Prior Authorization Request Form](#)

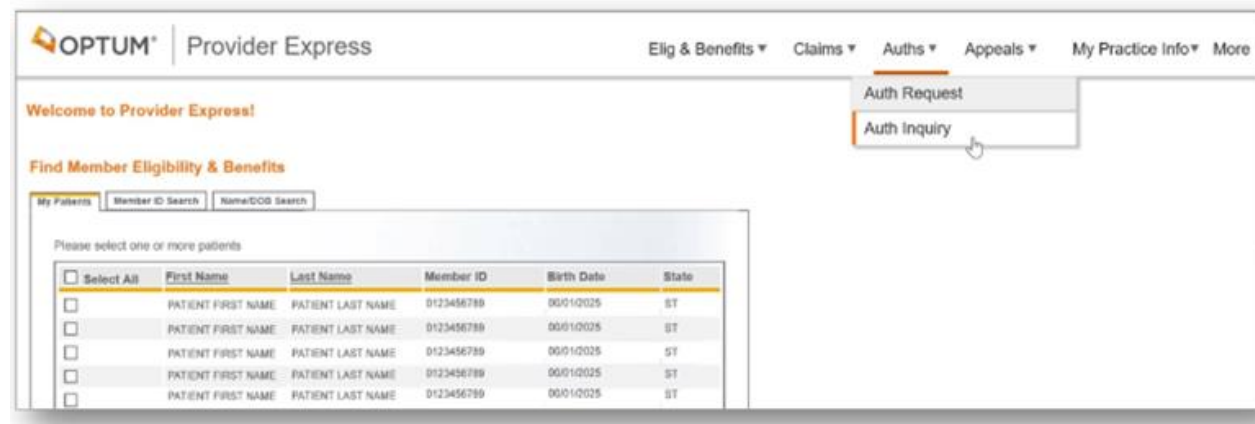
For appeals information: uhcprovider.com/Indiana



Escalate To A Provider Advocate

If provider submits a prior authorization request and does not receive a response within the required turnaround time, do the following:

1. Check the Provider Express portal



2. Call the number on the back of the member's ID card or call 877-610-9785 Monday through Friday from 8:00am to 8:00pm EST.
3. If 1 and 2 do not provide a response, please reach out via email to your Optum Behavioral Health Advocate at ohbs.centralregion@optum.com.



Appeal An Authorization Decision

In the event an authorization is denied, and an appeal is necessary, make sure to include the following information with the appeal:

- Member name
- Member date of birth
- Member ID
- PA request
- Denial letter
- Any additional supporting documentation

Send to:

National Appeals Team

Attn: Appeals Department/Retrospective Review

P.O. Box 30512

Salt Lake City, UT 84130-0512

Fax: 855-312-1470

Phone: 866-556-8166 (8 a.m. to 8 p.m. EST, Monday through Friday)





Claims and Payment Success

Best Practices for Behavioral Health Claims Submission

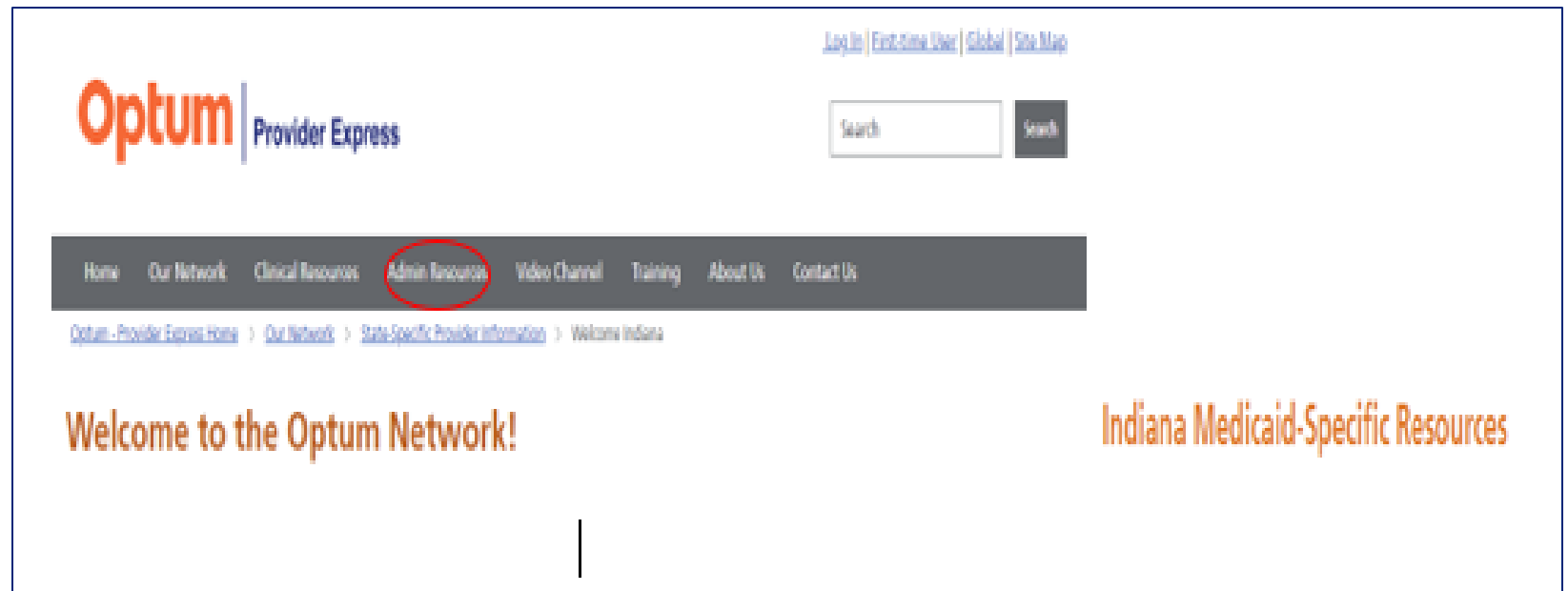
- Use correct claims forms like *CMS-1500* for professional and *UB-04* for institutional services with all fields completed accurately
- **Timely Filing**
 - Standard Timely Filing for Participating Providers and Non-Contracted Providers – *90 calendar days* from the date of service (DOS)
 - Secondary Claims Timely Filing – *90 calendar days* from date of Primary Explanation of benefits (EOB) for In-Network Providers and Out-of-Network providers from the Primary EOB date
- For electronic submission:
Payer ID 87726
- Claims Mailing Address:
 - UnitedHealthcare Community Plan
P.O. BOX 5240
Kingston, NY 12402
- Claim Submission Tool for Medical Professional claims (*CMS-1500*) on our UnitedHealthcare Provider Portal
- Behavioral Health Professional claims (*CMS-1500*) on our Provider Express Portal



Claim Submission

Claim tips can be found by clicking Admin Resources on the [Provider Express](#) – Indiana page

- Claims problem resolution
- Claim submission hints
- Outpatient claims
- Training



Claim Submission Tips

- All clinicians should submit a valid International Classification of Diseases, 10th Revision (ICD-10-CM) Mental Health/Substance Abuse primary diagnosis codes and encourages you to list all secondary codes as clinically appropriate
- Annually update Coordination of Benefits by calling United Behavioral Health at 877-610-9785 (8 a.m. to 8 p.m. Eastern, Monday through Friday)
- Verify that claims are submitted with the Place of Service code that matches the level of care provided (i.e., office (POS 11) and outpatient hospital setting (POS 22))



Claim Submission Tips (cont.)

- For Observation claims – Outpatient Place of Service code should be used whenever observation bed level of care lasts less than 24 hours and results in a discharge to a less restrictive level of care
- Verify the claim is sent to the correct mail address OR Payer ID 87726, if submitting electronically
- If you have claim issues, call Claims Customer Service at 800-888-2998 to reach Optum Behavioral Health (8 a.m. to 8 p.m. EST, Monday through Friday)
- Ensure that appeals are sent to the Care Advocate Center that issued the Adverse Benefit Determination
- Update provider demographic information online through the Provider Express portal – “My Practice Info”



Training Items

Provider Resources

- ❖ Training Courses
- ❖ Helpful Resources
- ❖ Webinars
- ❖ Toolkits

[Log In](#) | [Global](#) | [Site Map](#)

Search

Search

[Home](#) [Our Network](#) [Clinical Resources](#) [Admin Resources](#) [Training](#) [About Us](#) [Contact Us](#)

[Optum - Provider Express Home](#) > Training



Provider Training

Flexible training that fits the way you learn

Working in the Provider Express secure portal

The Provider Express secure portal gives you access to patient information and is where you'll complete most practice-specific administrative tasks. The secure portal is available to network and out-of-network clinicians and group practices.



Check back often for newly added courses

Working with Optum

Emotional Wellbeing Solutions / EAP



Model of Care DSNP



Claim Problem Resolution

Typically, there are 2 types of claim issues:

1. The claim was submitted with incorrect/inaccurate information
2. The claim was processed incorrectly

To resolve type 1:

- Submit corrected claims electronically through [Provider Express – Indiana](#)
- Complete a new *CMS-1500* claim form and write “CORRECTED CLAIM” across the top and submit with the correct claim information and mail to the address on the statement

To resolve type 2:

- Log in to Provider Express and look up the claim via Claim Inquiry transaction and file a Claim Adjustment Request
- Contact a claims representative via Provider Express’ Live Chat:
 - Locate the claim from the claim detail page, then click “Have questions about claim status?” to access Claims Live Chat
 - Call the Customer Service number on the back of the member’s card or on the EOB/Provider Remittance Advice



Submit A Claim Reconsideration

Securely log in to Provider Express

- Claim Inquiry
- Search for claim
- Click “Enter” under claim adjustment

Providers have 90 calendar days from the original EOB date to submit a Claim Reconsideration

Optum | Provider Express

Elig & Benefits | Claims | Auths | Appeals | My Network Status | More

Claim Entry | Claim Inquiry | My Submitted Claims | My Submitted Adjustments

Claim Inquiry

★ Indicates required field

My Patients | Member ID Search | Name / DOB Search

Member ID ★ | First Name ★

Dates of Service ⓘ

- ☐ Month / Year
- ☐ Date Range
- ☐ Previous 12 Months
- ☐ Previous 24 months

Search

Optum | Provider Express

Elig & Benefits | Claims | Auths | Appeals | My Practice Info | More

Claim Entry | Claim Inquiry | My Submitted Claims | My Submitted Adjustments

Claim Summary

Claims between 01/29/2023 to 07/28/2023

1 record

Show 10 per page | Page 1 of 1

Clear All Filters | Export (CSV)

Claim Number ⓘ	Member Name *	Dates of Service ⓘ	Claim Status ⓘ All	Claim Amount ⓘ	Paid Amount ⓘ	Provider/Practice Name ⓘ	Appeals ⓘ	Adjustment Request
123456789	John Doe	07/11/2023-07/11/2023	Finalized	\$125.00	\$125.00	Provider, Jane	☐	Enter

New Inquiry



Submit A Claim Reconsideration (cont.)

- Select a reason from the dropdown
- Select “Review”
- Review details and add necessary comments on next screen
- Select “Submit”
- Once submitted, document the “Confirmation Number” and “Issue ID”

The screenshot shows the 'Claim Adjustment' screen in the Optum Provider Express system. At the top, there's a navigation bar with 'Optum | Provider Express' and links for 'Elig & Benefits', 'Claims', 'Auths', 'Appeals', 'My Practice Info', and 'More'. Below this is a sub-navigation bar with 'Claim Entry', 'Claim Inquiry', 'My Submitted Claims', and 'My Submitted Adjustments'. The main heading is 'Claim Adjustment' with a 'Return to Claim Summary' link. The patient information section shows 'John Doe' as the member, '98765432-00' as the Member ID, and 'Provider, Jane' as the provider. A table displays claim details: Claim Number 123456789, Date(s) of Service 07/11/2023-07/11/2023, Date Paid 07/18/2023, Claim Amount \$125.00, Copay Amount \$10.00, Disallowed Amount \$50.00, and Paid Amount \$65.00. Below the table, there's a 'Reason' dropdown menu with options: 'Select', 'Corrected Claim', 'New or Updated Information', 'Change in Patient Eligibility', 'Claim Over/ Under Paid', 'Incorrect Member Liability', and 'Paid to Incorrect Provider'. The 'Comments' field contains the text: 'Claim processed against member deductible, which was met on 6/10/2023. Please reprocess and pay.' and shows '250 characters remaining'. At the bottom, there are 'Submit' and 'Cancel' buttons.

Claim Number	Date(s) of Service	Date Paid
123456789	07/11/2023-07/11/2023	07/18/2023

Claim Amount	Copay Amount	Disallowed Amount	Paid Amount
\$125.00	\$10.00	\$50.00	\$65.00

Reason

Select

- Corrected Claim
- New or Updated Information
- Change in Patient Eligibility
- Claim Over/ Under Paid
- Incorrect Member Liability
- Paid to Incorrect Provider

Comments

Claim processed against member deductible, which was met on 6/10/2023. Please reprocess and pay.

250 characters remaining

Submit Cancel

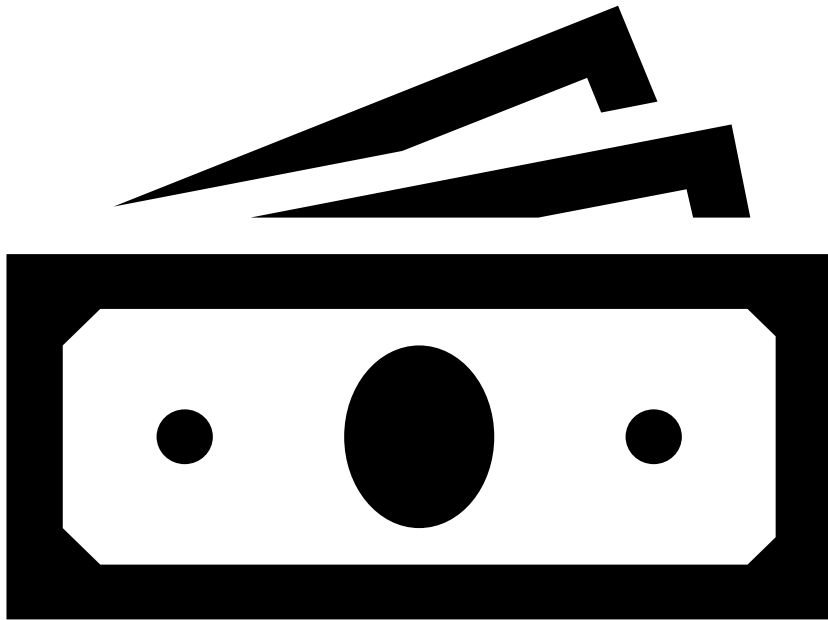


Covered Services

- The IHCP reimbursement is available for RHCs and FQHCs for service provided by practitioners (i.e.. Physician, Nurse Practitioner, Clinical Psychologist). Reimbursement is also available for services incident to services that would be covered if furnished by a physician or as an incident to a physician's services.
- Ambulatory service included in the Medicaid state plan is considered a covered FQHC service if the FQHC offers that service. FQHC services are defined the same as the services provided by RHCs
- IHCP reimburses for services to homebound individuals only in the case of FQHCs and RHCs located in areas with shortages of home health agencies, as determined by Indiana Family and Social Services Administration (FSSA)
- Prior authorization requirements follow that of all behavioral health IHCP providers



General Billing Guideline Reminders



UnitedHealthcare (UHC) Community Plan of Indiana follows the **IHCP Claim Submission and Processing** Provider Reference Module.

For Professional claims – In field 33, please enter the service location name and address (including zip code+4) as listed on the provider enrollment profile for the billing provider. The service location address is the actual physical location where a service was rendered.

The address should match the service location, not the legal (home office), pay-to, or mail-to address) on file for the billing provider. This address may be different from the provider's mail-to, pay-to, or legal addresses on file with the IHCP.

The UHC claim processing system compares data from the claim fields to the billing provider's IHCP Provider Profile to make a 1-to-1 match for reimbursement purposes. If the data elements are not in the correct field or do not match the provider's enrollment profile, the claim will deny.



Next Step In The Dispute Process

If you continue to disagree with the outcome of your claim after the Advocate team has escalated, your next step is to file a formal dispute.

- Must be submitted within 60 calendar days from the failed reconsideration

- Mail to:

UnitedHealthcare Community Plan of Indiana

Attn: Appeals and Grievances Unit

P.O. Box 31364

Salt Lake City, UT 84131-0364

- Submit within Claims on our UnitedHealthcare Provider Portal ([Claims, billing and payments | UHCprovider.com](#))



What If I Still Disagree?

If you still disagree with the outcome of your formal dispute, you may file a Formal Provider Grievance

- Must be submitted within 120 calendar days from the failed dispute (Must include additional or new information)
- Submit electronically within Claims on the UnitedHealthcare Provider Portal ([Claims, billing and payments | UHCprovider.com](https://UHCprovider.com))
- Mail to:

UnitedHealthcare Community Plan of Indiana
Attn: Appeals and Grievances Unit
P.O. Box 31364
Salt Lake City, UT 84131-0364





Coordination of Care

Coordination of Care (COC)

- UHC requires contracted behavioral health practitioners and providers to communicate relevant treatment information and coordinate treatment with other behavioral health practitioners and providers, Primary Medical Providers (PMPs), and other appropriate medical practitioners involved in a member's care
- Coordination of Care establishes collaborative, credible relationships



Benefits of Coordination of Care

Importance of Care Coordination

- Coordinated care improves treatment for members with complex behavioral health and co-occurring conditions.

Initiating Coordination at Intake

- Providers gather care team information and explain coordination benefits during member intake sessions.

Documentation and Consent

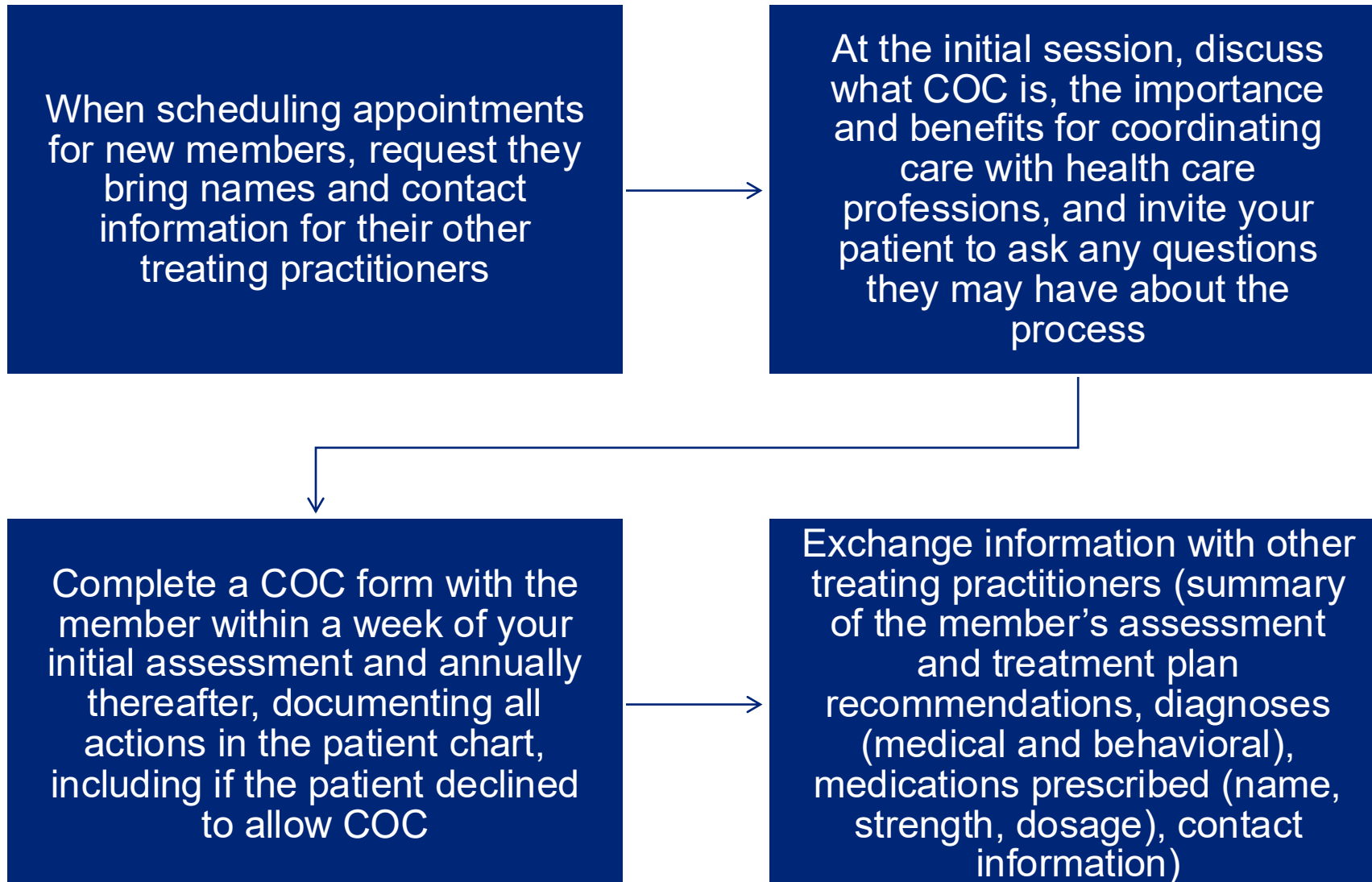
- Use of checklists and respecting member consent ensures transparent and respectful coordination efforts.

Support Through Resources and Advocacy

- Provider resources and advocate teams help resolve communication barriers and improve care delivery.



Guidelines for Effective Communication





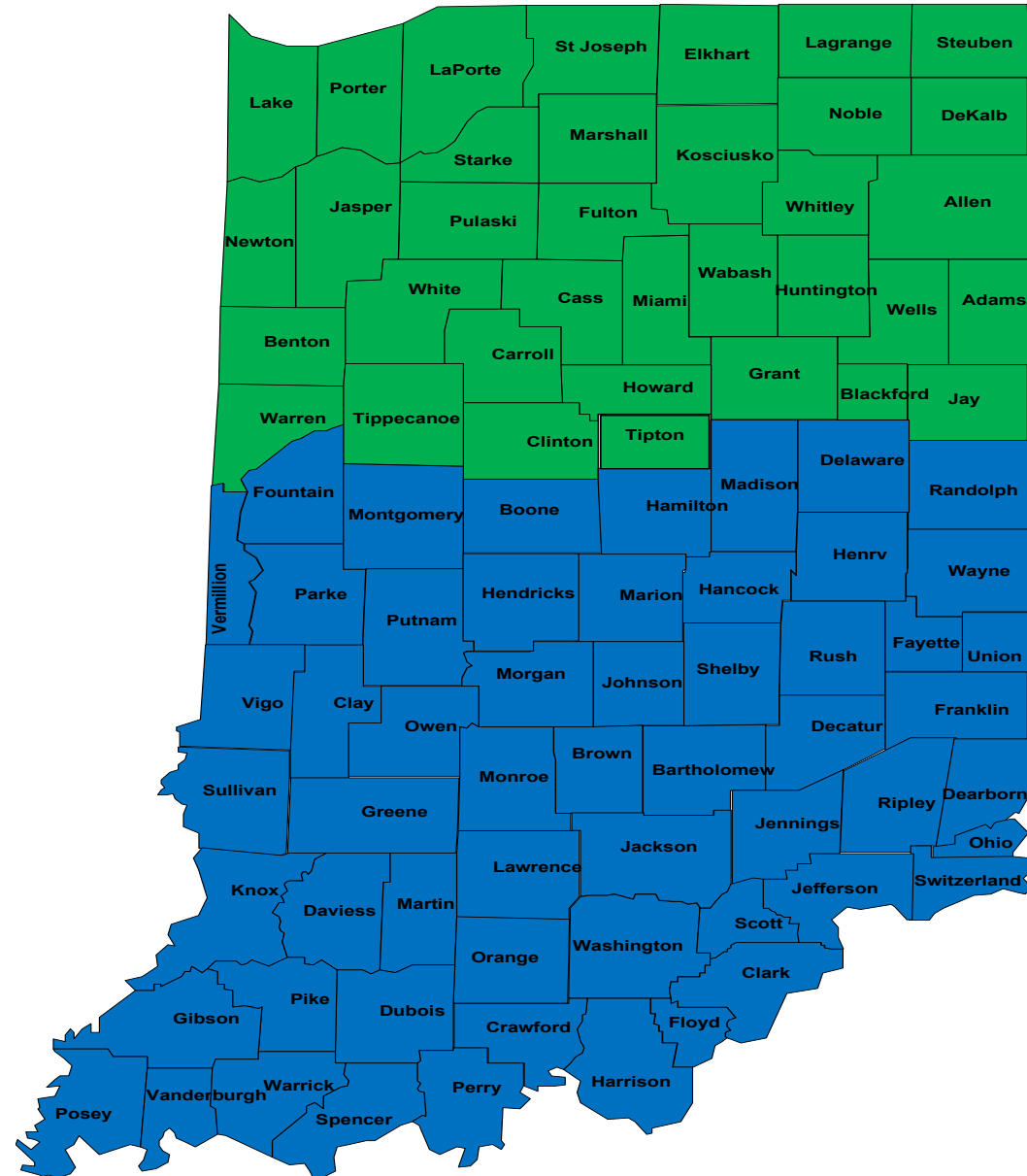
Behavioral Health Contacts

Your Optum Behavioral Health Advocate Team

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Thank you

Questions?



United
Healthcare