I'm not a bot

An initial coverage decision about your Part D drugs is called a “coverage decision.” A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your prescription drugs. We are making a coverage decision for you whenever we decide what is covered for you and how much we pay. In some cases, we might decide a drug is not covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can make an appeal. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn't covered under your plan, that isn't a coverage determination. You need to call or write to us to ask for a formal decision about the coverage. Drug requirements and limitations For certain prescription drugs, special rules restrict how and when the plan covers them. A team of doctors and pharmacists developed these rules to help our members use drugs in the most effective ways. These special rules also help control overall drug costs, which keeps your drug coverage more affordable. Some covered drugs may have additional requirements or limits that help ensure safe, effective and affordable drug use. If there is a restriction for your drug, it usually means that you (or your doctor) will have to use the coverage decision process and ask us to make an exception. We may or may not agree to waive the restriction for you. You can find out if your drug has any additional requirements or limits by looking for the abbreviations next to the drug names in the plan's drug list. To find the plan's drug list go to View plans and pricing and enter your ZIP code. Choose one of the available plans in your area and view the plan details. You’ll find the form you need in the Helpful Resources section. Some drugs covered by the Medicare Part D plan have "limited access" at network pharmacies because: The FDA says the drug can be given out only by certain facilities or doctors These drugs may require extra handling, provider coordination or patient education that can't be done at a network pharmacy Requirements and limits apply to retail and mail service. These may include: Prior Authorization (PA) The plan requires you or your doctor to get prior authorization for certain drugs. This means the plan needs more information from your doctor to make sure the drug is being used correctly for a medical condition covered by Medicare. If you don't get approval, the plan may not cover the drug. Quantity Limits (QL) The plan will cover only a certain amount of this drug , or a cumulative amount across a category of drugs (such as opioids), for one co-pay or over a certain number of days. These limits may be in place to ensure safe and effective use of the drug. If your doctor prescribes more than this amount or thinks the limit is not right for your situation, you and your doctor can ask the plan to cover the additional quantity. Step Therapy (ST) There are effective, lower-cost drugs that treat the same medical condition as this drug. You may be required to try one or more of these other drugs before the plan will cover your drug. If you have already tried other drugs or your doctor thinks they are not right for you, you and your doctor can ask the plan to cover this drug. Medicare Part B or Medicare Part D Coverage Determination (B/D) Depending on how this drug is used, it may be covered by either Medicare Part B (doctor and outpatient health care) or Medicare Part D (prescription drugs). Your doctor may need to provide the plan with more information about how this drug will be used to make sure it's correctly covered by Medicare. NOTE: If you do not get approval from the plan for a drug with a requirement or limit before using it, you may be responsible for paying the full cost of the drug. IN ADDITION TO THE ABOVE, YOU CAN ASK THE PLAN TO MAKE THE FOLLOWING EXCEPTIONS TO THE PLAN'S COVERAGE RULES You can ask the plan to make an exception to the coverage rules. There are several types of exceptions that you can ask the plan to make. Formulary Exceptions You can ask the plan to cover your drug even if it is not on the plan's drug list (formulary). If a formulary exception is approved, the non-preferred brand co-pay will apply. You cannot ask for an exception to the copayment or coinsurance amount we require you to pay for the drug. Cost Sharing Exceptions If your drug is in a cost-sharing tier you think is too high, you and your doctor can ask the plan to make an exception in the cost-sharing tier so that you pay less for it. Drugs in some of our cost-sharing tiers are not eligible for this type of exception. For example, if we grant your request to cover a drug that is not in the plan's Drug List, we cannot lower the cost-sharing amount for that drug. In addition: Tier exceptions are not available for drugs in the Specialty Tier. Tier exceptions are not available for drugs in the Preferred Generic Tier. Tier exceptions are not available for branded drugs in the higher tiers if you ask for an exception for reduction to a tier level that does not contain branded drugs used for your condition. Tier exceptions are not available for biological (injectable) drugs if you ask for an exception for reduction to a tier that does not contain other biological (injectable) drugs. Tier exceptions may be granted only if there are alternatives in the lower tiers used to treat the same condition as your drug. Generally, the plan will only approve your request for an exception if the alternative drugs included in the plan’s formulary, the lower-tiered drug or additional utilization restrictions would not be as effective in treating your condition and/or would cause you to have adverse medical effects. An exception is a type of coverage decision. Similar to other types of coverage decisions, if we turn down your request for an exception, you can appeal our decision. How to request a coverage determination (including benefit exceptions) Call the UnitedHealthcare Customer Service number to request a coverage determination (coverage decision). When requesting a formulary or tiering exception or asking for the plan to cover an additional amount of a drug with a quantity limit or asking for the plan to waive a step therapy requirement, a statement from your doctor supporting your request is required. Usually, the coverage decision will be made within 72 hours after we receive the request or your doctor's supporting statement (if required). You can request an expedited (fast) coverage decision if you or your doctor believe that your health could be seriously harmed by waiting up to 72 hours for a decision. If your request to expedite is granted, we must give you a decision no later than 24 hours after we receive your request or prescribing doctor's supporting statement. If you are a continuing member in the plan, you may notice that a formulary medication which you are currently taking is either not on the formulary or its cost-sharing or coverage is limited in the upcoming year. If you are affected by a change in drug coverage you can: Work with your doctor (or other prescriber) and ask the plan to make an exception to cover the drug. If we approve your request, you’ll be able to get your drug at the start of the new plan year. Find a different drug that we cover. You can call Customer Service to ask for a list of covered drugs that treat the same medical condition. You should discuss that list with your doctor, who can tell you which drugs may work for you. In some situations, we will cover a one-time, temporary supply. During the time when you are getting a temporary supply of a drug, you should talk with your doctor to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug. To initiate a coverage determination request, please contact UnitedHealthcare. Have the following information ready when you call: Member name Member date of birth Medicare Part D Member ID number Name of the medication Physician's phone number Physician fax number (if available) You may also request a coverage decision/exception by logging on to www.optumrx.com and submitting a request. If you are a new user with www.optumrx.com, you will need to register before you can access the Prior Authorization request tool. Once you have registered, you will find the Prior Authorization tool under the Health Tools Menu. Once your request has been submitted, we will attempt to contact your prescriber to get a supporting statement and/or additional clinical information needed to make a decision. Download this form to request an exception: Medicare Part D Coverage Determination Request Form – for use by members and providers This is a CMS-model exception and prior authorization request form developed specifically for use by all Medicare Part D prescribing physicians or members. You may use this form or the Prior Authorization Request Forms listed below. To have your doctor make a request Your doctor or provider can contact UnitedHealthcare at 1-800-701-9054 TTY 711 for the Prior Authorization department to submit a request, or fax toll-free to 1-844-403-1028. The plan's decision on your exception request will be provided to you by telephone or mail. In addition, the initiator of the request will be notified by telephone or fax. Your doctor can also request a coverage decision by going to www.professionals.optumrx.com. To inquire about the status of a coverage decision, contact UnitedHealthcare. Please refer to your plan’s Appeals and Grievance process located in Chapter 9: What to do if you have a problem or complaint (coverage decisions, appeals, complaints) of the Evidence of Coverage document or your plan’s member handbook. Note: Existing plan members who have already completed the coverage determination process for their medications may not be required to complete this process again. What happens if we deny your request? If we deny your request, we will send you a written reply explaining the reasons for denial. If an initial decision does not give you all that you requested, you have the right to appeal the decision. See How to appeal a decision about your prescription coverage. How to appoint a representative to help you with a coverage determination or an appeal. The representative can be a permanent one, such as a Power of Attorney, or it can be someone you name to help you only during the coverage determination case. Click here to find and download the CMS Appointment of Representation form. Both you and the person you have named as an authorized representative must sign the representative form. For Coverage Determinations Part C/B/D OptumRX Prior Authorization Department P.O. Box 25183 Santa Ana, CA 92799 Fax: 1-844-403-1028 For Appeals Part C/B P.O. Box 6103, MS CA124-0187 Cypress, CA 90630-0023 Fax -Standard: 1-844-226-0356 Fax-Expedited: 1-866-373-1081 Standard Phone: 1-800-701-9054 TTY 711 Expedited Phone number: 1-877-262-9203 TTY 711 8 a.m. - 8 p.m. 7 Days Oct-Mar; M-F Apr-Sept Website: myuhc.com/communityplan Part D: P.O. Box 6106, MS CA124-0197, Cypress, CA 90630-0016 Fax -Standard: 1-866-308-6294 Fax-Expedited: 1-866-308-6296 Part D Standard Phone: 1-800-701-9054 TTY 711 Part D Expedited Phone number: 1-800-308-6296 TTY 711 Website: myuhc.com/communityplan If your prescribing doctor calls on your behalf, no representative form is required. Second Level Appeals If we say no to all or part of your Level 1 appeal, your appeal will automatically go on to Level 2. The Level 2 appeal is conducted by an Independent Review Organization that is not connected to us. You do not need to do anything to start a Level 2 appeal. Medicare rules require we automatically send your appeal to Level 2 if we do not fully agree with your Level 1 appeal. If you are not satisfied with the decision at the Level 2 appeal, you may be able to continue through additional levels of appeal. The process for coverage decisions and making appeals deals with problems related to your benefits and coverage for prescription drugs, including problems related to payment. This is the process you use for issues such as whether a drug is covered or not and the way in which the drug is covered. An initial coverage decision about your Part D drugs is called a "coverage determination.", or simply put, a "coverage decision." A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your prescription drugs. We are making a coverage decision for you whenever we decide what is covered for you and how much we pay. In some cases we might decide a drug is not covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can make an appeal. Drug requirements and limitations For certain prescription drugs, special rules restrict how and when the plan covers them. A team of doctors and pharmacists developed these rules to help our members use drugs in the most effective ways. These special rules also help control overall drug costs, which keeps your drug coverage more affordable. Some covered drugs may have additional requirements or limits that help ensure safe, effective and affordable drug use. And some drugs may require a coverage determination to verify whether they are covered by the Medicare Part D plan. The coverage determination process allows you or your prescriber to request coverage of drugs with additional requirements or ask for exceptions to your benefits. You can find out if your drug has any additional requirements or limits by looking for the abbreviations next to the drug names in the plan's drug list. To find the plan's drug list go to "Find a Drug" and download your plan's Formulary. Some drugs covered by the Medicare Part D plan have "limited access" at network pharmacies because: The FDA says the drug can be given out only by certain facilities or doctors These drugs may require extra handling, provider coordination or patient education that can't be done at a network pharmacy Requirements and limits apply to retail and mail service. These may include: Prior Authorization (PA) The plan requires you or your doctor to get prior authorization for certain drugs. This means the plan needs more information from your doctor to make sure the drug is being used correctly for a medical condition covered by Medicare. If you don't get approval, the plan may not cover the drug. Quantity Limits (QL) The plan will cover only a certain amount of this drug for one co-pay or over a certain number of days. These limits may be in place to ensure safe and effective use of the drug. 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Note: If you do not get approval from the plan for a drug with a requirement or limit before using it, you may be responsible for paying the full cost of the drug. IN ADDITION TO THE ABOVE, YOU CAN ASK THE PLAN TO MAKE THE FOLLOWING EXCEPTIONS TO THE PLAN'S COVERAGE RULES You can ask the plan to make an exception to the coverage rules. There are several types of exceptions that you can ask the plan to make. Formulary Exceptions You can ask the plan to cover your drug even if it is not on the plan's drug list (formulary). If a formulary exception is approved, the non-preferred brand co-pay will apply. Cost Sharing Exceptions If your drug is in a cost-sharing tier you think is too high, you and your doctor can ask the plan to make an exception in the cost-sharing tier so that you pay less for it. Drugs in some of our cost-sharing tiers are not eligible for this type of exception. 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You can call Customer Service to ask for a list of covered drugs that treat the same medical condition. You should discuss that list with your doctor, who can tell you which drugs may work for you. In some situations, we will cover a one-time, temporary supply. During the time when you are getting a temporary supply of a drug, you should talk with your doctor to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug. To initiate a coverage determination request, please contact UnitedHealthcare. Have the following information ready when you call: Member name Member date of birth Medicare Part D Member ID number Name of the medication Physician's phone number Physician fax number (if available) Coverage Decisions for Medical Care Part C – Contact Information: Write: UnitedHealthcare Customer Service Department (Organization Determinations) P.O. Box 29675 Hot Springs, AR 71903-9675 Call: 1-866-842-4968 TTY: 711 Calls to this number are free. Hours of Operation: 8 a.m. - 8 p.m. local time, 7 days a week Fax: 1-501-262-7072 Coverage Decisions for Part D Prescription Drugs – Contact Information: Write: UnitedHealthcare Part D Coverage Determinations Department P.O. Box 31350 Salt Lake City, UT 84131-0365 Call: 1-866-842-4968 TTY: 711 Calls to this number are free. Hours of Operation: 8 a.m. - 8 p.m. local time, 7 days a week Fax: 1-800-527-0531 You may also request a coverage decision/exception by logging on to www.optumrx.com and submitting a request. If you are a new user with www.optumrx.com, you will need to register before you can access the Prior Authorization request tool. Once you have registered, you will find the Prior Authorization tool under the Health Tools Menu. Once your request has been submitted, we will attempt to contact your prescriber to get a supporting statement and/or additional clinical information needed to make a decision. Download this form to request an exception: Medicare Part D Coverage Determination Request Form (PDF)(54.6 KB) – for use by members and providers This is a CMS-model exception and prior authorization request form developed specifically for use by all Medicare Part D prescribing physicians or members. You may use this form or the Prior Authorization Request Forms listed below. To have your doctor make a request Your doctor or provider can contact UnitedHealthcare at 1-800-711-4555 for the Prior Authorization department to submit a request, or fax toll-free to1-844-403-1028 call at 1-866-842-4968 (TTY 711), 8 a.m. –8 p.m. local time, 7 days a week. The plan's decision on your exception request will be provided to you by telephone or mail. In addition, the initiator of the request will be notified by telephone or fax. Your doctor can also request a coverage decision by going to www.professionals.optumrx.com. To inquire about the status of a coverage decision, contact UnitedHealthcare. Please refer to your plan’s Appeals and Grievance process located in Chapter 9: What to do if you have a problem or complaint (coverage decisions, appeals, complaints) of the Evidence of Coverage document or your plan’s member handbook. Note: Existing plan members who have already completed the coverage determination process for their medications in 2024 may not be required to complete this process again. What happens if we deny your request? If we deny your request, we will send you a written reply explaining the reasons for denial. If an initial decision does not give you all that you requested, you have the right to appeal the decision. See How to appeal a decision about your prescription coverage. How to appoint a representative to help you with a coverage determination or an appeal. The representative can be a permanent one, such as a Power of Attorney, or it can be someone you name to help you only during the coverage determination case. Click here to find and download the CMS Appointment of Representation form. Both you and the person you have named as an authorized representative must sign the representative form. For Coverage Determinations Mail: OptumRx Prior Authorization Department P.O. Box 25183 Santa Ana, CA 92799 Fax: 1-844-403-1028 For Appeals Mail: Medicare Part D Appeals and Grievance Department P.O. Box 6103, MS CA120-0368 Cypress, CA 90630-0023 Fax -Standard: 1-866-308-6294 Fax-Expedited: 1-866-308-6296 Part D Standard Phone: 1-866-480-1086 TTY 711 Part D Expedited Phone number: 1-855-409-7041 TTY 711 If your prescribing doctor calls on your behalf, no representative form is required. Or you can call us at: 1-888-867-5511 TTY 711. Available 8 a.m. - 8 p.m. local time, 7 days a week. Walk through the instructions for UHC's appeal process very carefully. They have specific instructions that must be followed, or the appeal won't go throughUsing the online portal, Link, will process much faster and you can get a higher volume of claims resolvedMake sure you have a copy of the insurance card on hand or you might send the appeal to the incorrect locationThe idea of challenging the insurance company on a denial may sound like a scary process. But in reality if you stop to look at the process, you can find a clear and logical path to disputing a denial or rejection. So far, we have covered Aetna and Cigna's appeal process, this blog we will look at United Healthcare's (UHC) appeal process and advise you on the process. First, you will want to locate the UHC appeal form. If you don't have a copy of that form, you can find it here. Once you pull up the form you will notice that this appeal form is much longer than Aetna or Cigna's appeal form. The UHC appeal form includes several important instructions, so walk through the instructions for UHC's appeal process very carefully. They have specific instructions that must be followed, or the appeal won't go through. The form that UHC supplies walks through the corrected claim process and the claim reconsideration process. Usually, submitted a corrected claim is the best chance of getting a claim reprocessed without having to go through the appeal process. The claim reconsideration form is 5 pages and on the 5th page you will find the form for UHC commercial, UHC Medicare Advantage, and United Healthcare West claims. Here are some helpful tips when looking at UHC appeals: Always submit a separate form for each claim that you are disputing No new claims can be submitted with the form Check your provider manual for other dispute or grievance processesOn the form, you will see 8 options for the request. On page 2 of the guide, UHC defines each one to help you determine the best selection for the denial. Read through these carefully and make the best selection based on the explanation of benefits that you received with the denial. Next, to mail the form, you will want to look at the Explanation of Benefits or the back of the patient's insurance ID card. UHC does not have a standard appeals mailing address, so this is a critical detail. However, if you are mailing an appeal to the Empire Plan you can send appeals to United Healthcare Empire PlanFilling out the form is pretty straightforward.You will first fill out the patient's demographic information along with your NPI and Tax ID. Then you will fill out your contact information with the expected amount owed. Then you will select on of the eight reasons for the reconsideration Then you will add any additional comments or additions Finally, you will send in the appeal form to the correct locationBe sure to log the appeal in the patient's chart and set a reminder for yourself to follow up on the appeal. When documenting your follow-ups, include the number that you called, the name of the representative that you spoke with, the content of your discussion, and the reference number for your call. You can reference this information at a later time. We understand that using paper for appeals can be a laborious process. This is why UHC created Link. Using the online portal, Link, will process much faster and you can get a higher volume of claims resolved. This is a much faster way to go about appeals without the hassle of a paper form. Don't hesitate to reach out to our team of professional billers if you have an appeal that is stuck in processing or you are trying to troubleshoot the process of getting sticky claims to process. Most network health care professionals (primary and ancillary) and facilities that provide services to UnitedHealthcare® Medicare Advantage (including D-SNP), UnitedHealthcare Community Plan (Medicaid) and commercial plan members are required to submit reconsiderations and pre- and post-service appeals digitally. We also recommend that out-of-network health care professionals submit pre- and post-service appeals electronically. Eliminate mail delays Receive decisions an average of 5 days faster Provide real-time information Decrease data entry and increase automation Pre-service appeal options Peer-to-peer review* What it is: A discussion where a provider can learn more about a pre-service denial of coverage for inpatient/outpatient services and present previously unavailable clinical information to a UnitedHealthcare medical director. When to do it: Although this varies by plan and/or state, most reviews need to be requested within 24 hours of coverage denial. Timing: The review request time frame is dependent on case type and any applicable state guidelines. Inpatient cases must be submitted within 3 business days and outpatient cases within 21 calendar days from posted denial. To begin, complete the peer-to-peer scheduling request form; this takes about 5–10 minutes. Please note: This review can be done prior to submitting an appeal. Pre-service appeals What it is: Before a planned health care service is performed, a pre-service appeal is a request to change a denial of coverage. This process is based on what is outlined in the member’s benefit plan. When to do it: Initiate a pre-service appeal if a peer-to-peer review is not possible or an adverse determination has been received. Timing: The pre-service appeal should be made prior to a planned health care service. *Available for UnitedHealthcare-managed prior authorizations, not third-party vendors What it is: Except where prohibited by applicable law you must follow a 2-step process when you don’t agree with a claim determination. First, you must submit a claim reconsideration request. If you don’t agree with the outcome of the reconsideration, you may submit an appeal. Timing: You have 12 months to complete the following steps: Step 1: File a claim reconsideration request. Step 2: File an appeal if you disagree with the outcome of the claim reconsideration decision. You can use either the UnitedHealthcare Provider Portal or an API to submit a reconsideration. For information on submitting reconsiderations in the portal, please view our interactive guide. You can use either the UnitedHealthcare Provider Portal or an API to submit a post-service appeal. For information on submitting post-service appeals in the portal, please view our interactive guide. Step 1: Reconsideration Step 2: Post-service appeal You can use either the UnitedHealthcare Provider Portal or an API to submit a reconsideration. For information on submitting reconsiderations in the portal, please view our interactive guide. You can use either the UnitedHealthcare Provider Portal or an API to submit a post-service appeal. For information on submitting post-service appeals in the portal, please view our interactive guide. Frequently asked questions Expand All add_circle_outline Timelines vary. Please refer to your Participation Agreement for timely filing information. An expedited appeal may be available if the time needed to complete a standard appeal could seriously jeopardize the member’s life, health or ability to regain maximum function. If you have already provided the service, an expedited or urgent appeal is not available. Submit the claim based on the service provided. You’ll receive immediate confirmation of receipt and a tracking number. Use TrackIt to check status. Peer-to-peer review and pre-service appeals Expand All add_circle_outline To request an urgent pre-service appeal on behalf of the member, follow the information in the pre-service denial letter and submit electronically. We consider requests urgent when: The standard review time frame risks the life or health of the member The member’s ability to regain maximum function is jeopardized The member’s severe pain is not able to be managed without the care or treatment requested When the health care professional appeals on behalf of the covered person, you may be required to provide authorization and/or patient consent when completing a pre-service appeal. An assignment of benefits does not constitute designation of an authorized representative. Reconsiderations and post-service appeals Expand All add_circle_outline From the claim details page, scroll down or jump to Act on Claim and select Explore available actions. Options are enabled and may change based on the details and status of the claim. A benefit of online submission includes the process for determining whether it is eligible for a reconsideration or appeal by systematically applying plan rules. Corrected claims replace an original claim submission that had incorrect information. For example, you may submit a corrected claim through the UnitedHealthcare Provider Portal or Electronic Data Interchange (EDI) 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. After reconsideration or appeal review: If UnitedHealthcare determines that a claim is eligible for additional payment, you will receive an updated explanation of benefits (EOB) or provider remittance advice (PRA), which serves as notification of the review outcome. If the original claim status is upheld, you may see a letter in Document Library outlining the decision details. If you submitted the reconsideration electronically, you can check status using the PIQ reference number in either the portal Claims section or within TrackIt. If you intend to pursue your potential issue beyond the reconsideration and appeal process, you must follow the Notice of Dispute process outlined in your Participation Agreement. You may electronically submit 20 or more reconsiderations for paid or denied claims with the same administrative issue (attachments are not required). Go to UHCprovider.com > Sign In > Claims & Payments > Claims Research Project. Connect with us through chat 24/7 in the UnitedHealthcare Provider Portal. Most plans require that you submit your claim Appeal request for review to us in writing through the Member Service Request Form or a letter to the P.O. Box listed on the instruction page of the Member Service Request Form. Once we receive your request for review, we will assign an appeals coordinator to conduct a full and fair review within the timeframe required by law. The first request for an appeal should be sent to us no later than 180 days after you receive the EOB, unless your plan allows a longer time period for submitting an appeal. Please check your health benefits plan (e.g. Certificate of Coverage or Summary Plan Description) for more details. For questions about your appeal rights, an adverse benefit determination, or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272). Your state consumer assistance program may also be able to help you.