DATE FORM COMPLETED: _____

United Behavioral Health Claim Inquiry/Adjustment Request Form

(Not for use by California providers; see instructions at bottom of page)

Instructions: This form is to be completed by United Behavioral Health contracted clinicians or hospitals to request a claim adjustment for a United Behavioral Health (including PacifiCare Behavioral Health) member.
There are two stages available: 1) Claim Inquiry/Adjustment Request and 2) Formal Provider Dispute* (See attached description)

☐ UBH Contracted Individual Clinician ☐ UBH Contracted HOSPITAL ☐ UBH Contracted Group

☐ First Submission (Claim Inquiry/Adjustment Request) – I understand by checking "First Submission" this request will be handled as a Claim Adjustment. Please allow 30 days to process this request. After 30 days, if you have not received an adjustment, please contact Customer Service by calling the telephone number on the back of the member's identification card.
Mail Address: For UBH Members - P.O. Box 30757 Salt Lake City UT 84130
For PBH Members - P.O. Box 30602 Salt Lake City UT 84130
(NOTE: This is the first step in resolving a claims issue. It is recommended that you complete the Claim Inquiry/Adjustment Request before you submit a Provider Dispute.)

☐ Subsequent Submission (Formal Provider Dispute) – I understand by checking Subsequent Submission this request will be considered a Provider Dispute, and all pertinent information to support the Dispute is attached.
Mail Address: For UBH Members - P.O. Box 30757 Salt Lake City UT 84130
For PBH Members - P.O. Box 30602 Salt Lake City UT 84130

ENROLLEE/MEMBER INFORMATION

Enrollee ID: _____

Enrollee Name: Last_____ First_____ MI_____

Patient Name: Last_____ First_____ MI_____

Control / Claim #: _____ D.O.S. _____ Billed Amount_____

CLINICIAN/HOSPITAL INFORMATION

Tax Identification Number: _____ NPI Number: _____

Clinician Name (as listed on PRA / EOB): Last _____First_____MI_____

and/or Facility/Group Name_____

Contact Person: _____ Phone Number: _____

REASON FOR REQUEST

☐ ***1.*** **Claim previously denied / closed as "Exceeds Filing Time"** *(attach valid proof of timely filing)*

☐ ***2.*** **Claim previously denied / closed for "Additional Information"** (*provide description and/or requested documents)*

☐ ***3.*** **Claim previously denied / closed for lack of Authorization/Notification** (*include notification information*)

☐ ***4.*** **Claim previously denied / closed for "Coordination of Benefits" information** *(attach primary carrier's EOB)*

☐ ***5.*** **Claim previously processed but contracted rate applied incorrectly resulting in over/underpayment** *(explain below)*

☐ ***6.*** **I am resubmitting a corrected claim** *(explain correction below)*

Comments: _____

_____

Required Attachments: Copy of Provider Remittance Advice (PRA) and Claim form (with corrections if necessary)

Additional Information: Other required attachments as listed above

NO NEW CLAIMS SHOULD BE SUBMITTED WITH THIS FORM.
SUBMIT A SEPARATE FORM FOR EACH ENROLLEE

This form is to be completed by United Behavioral Health contracted clinicians or hospitals to request a claim adjustment for a United Behavioral Health (including PacifiCare Behavioral Health) member. You may also call the telephone number on the back of the member's identification card for information on how to request claim reviews.
For claim inquiries in California, do not use this form. Instead, please call the telephone number listed on the Explanation of Benefits (EOB) or the Provider Remittance Advice (PRA) for assistance.

Formal Provider Dispute Process

Your Right to Dispute an Adverse Determination on Your Own Behalf

You or your authorized representative, on your own behalf, have the right to dispute the adverse determination made by United Behavioral Health (UBH). You may initiate this dispute in writing by completing the "UBH Claim Inquiry/Adjustment Request Form" and checking the "Subsequent Submission" checkbox. This will be considered a Formal Provider Dispute.

The First Level Provider Dispute Process

The Provider Dispute process can be initiated for post service requests only.

You must request a Provider Dispute review within one hundred eighty (180) calendar days of the date you received your adverse determination letter from UBH. Disputes received outside of this timeframe will not be processed.

UBH will notify you or your authorized representative of the dispute resolution (including any additional levels of the dispute process, as applicable) in writing within thirty (30) calendar days of the receipt of your request.

If UBH does not receive the minimum necessary information to process your dispute as described above, UBH will send written notice to you within thirty (30) calendar days of our receipt of your request that contains 1) a description of the information needed from you to process your dispute, and 2) a statement that failure to provide the requested information within thirty (30) calendar days of receipt will result in the closure of the request with no further review.

For Colorado Providers, UBH will provide you the opportunity to present your rationale for your dispute in person, or via an alternative method, such as a teleconference.