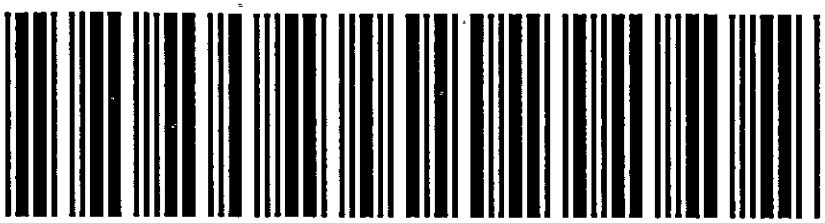
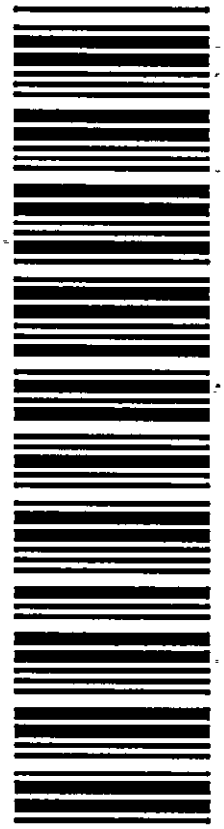


Patch II

9102111173358

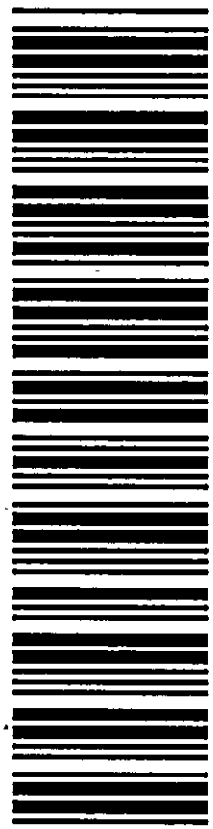


00BREAK00

Document Separator

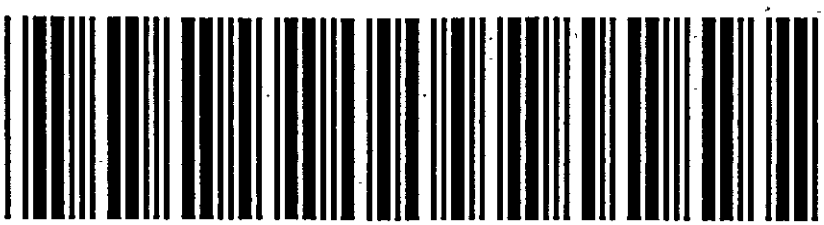
Used to Separate Each Transaction

00BREAK00



SourceHOV, Inc
4050 South 500 West
Salt Lake City, UT 84123

00BREAK00



EDINBURG EMERG MEDICINE ASSOC PA
P.O. BOX 731651
DALLAS, TX 75373-1651

PATIENT & INSURANCE INFORMATION
PATIENT NAME: CONTRERES,MARK
PATIENT DOB: 11/03/1995
DATE OF SERVICE: 07/03/2020
INSURANCE GROUP #: 9W1974
INSURANCE POLICY / ID: 919544367
TOTAL CHARGES: $1,517.00

PROVIDER & CLAIM INFORMATION
PROVIDER: EDINBURG EMERG MEDICINE ASSOC PA
NPI: 1942467113
TAX ID: 261973804
INVOICE NUMBER: 68420355
CLAIM NUMBER: CK63009325 0443169339
MAIL DATE: 04/14/2021

9102111173358

UNITED HEALTHCARE
ATTN: APPEALS DEPARTMENT
PO BOX 30555
759 SALT LAKE CITY, UT 84130-0555

Dear Plan/Claims Administrator:

We hereby serve notice to you of our provider appeal related to the above-referenced patient's recent visit and resulting underpayment for services provided by our non-participating emergency provider for CPT: 99284. This claim should have been processed at the amount of **$831.00.**

The allowed amount(s) you applied on this claim is underpaid based on the Texas laws for out-of-network providers providing emergency services and out-of-network facility-based physicians. See Tex. Ins. Code §§ 1271.155 (HMOs); 1301.0053 (Exclusive Provider Benefit Plans); 1551.228 & 1551.229 (Texas Employees Group Benefits Act); 1575.171 & 1575.172 (Texas Public School Employees Group Benefits Program); and 1579.109; 1579.110 & 1579.111 (Texas School Employees Uniform Group Health Coverage).

The Texas laws noted above require the plan to reimburse out-of-network emergency services and facility-based physicians using the usual and customary rate or an agreed rate. The Parties have not agreed on any amount lower than the usual and customary rate for the services in question. Our usual charges were previously billed to you and are commensurate with the charges of other providers in the community for similar services. Accordingly, you should immediately reprocess the above referenced claim and remit payment for the full amount of our charges in accordance with Texas law.

By law, we can elect for mandatory binding arbitration no later than 90 days after the date we received the initial payment for the services at issue to resolve the dispute over the reimbursement in accordance with chapter 1467 of the Texas Insurance Code.

Please note that we are authorized to act on behalf of CONTRERES,MARK in the above-referenced claim and a copy of the patient's written authorization is on file in our office.

I appreciate your assistance with this reconsideration and look forward to hearing back from you on the status of it at your earliest convenience. Please contact me should you need additional information to process my request.

Sincerely,

Breon Terrance
Revenue Recovery Associate
P - 337.609.2343 F - 337.593.1882

UnitedHealthcare Claim Reconsideration Request Form

UnitedHealthcare®

Instructions: This form is to be completed by UnitedHealthcare - contracted physicians, hospitals or other health care professionals to request a claim reconsideration for members enrolled in commercial benefit plans administered by UnitedHealthcare and Medicare plans administered by SecureHorizons® and Evercare®.
Mail Address: Send all Claim Reconsideration requests to the address on the back of the members identification card (ID), or the address on the EOB or PRA. NOTE: If you are receiving the consolidated 835, you may verify the enrollee's correspondence address using the eligibility search function on UnitedHealthcareOnline.com

☐ Physician ☐ Hospital ☐ Other health care professional (Lab, Durable Medical Equipment (DME), etc.) Date Form Completed: 04/14/2021

No new claims should be submitted with this form. Please submit a separate form for each claim.

Member Information

Member ID:	Control / Claim:	Date of Service:	Billed Amount:
919544367	CK63009325 0443169339	07/03/2020	$1,517.00

Member Name: Last	First	MI
CONTRERES	MARK	

Street Address	State	ZIP
PO BOX 332	TX	78562

Patient Name: Last	First	MI
CONTRERES	MARK	

Physician/Healthcare Professional Information

Tax Identification Number (TIN):	Phone Number	Email Address
261973804	337.609.2343	breon_terrance@scp-health.com

Physician Name (as listed on Provider Remittance Advice (PRA)/Explanation of Benefits (EOB):

Last	First	MI
REYNA MD	ISABEL	

Street Address	State	Zip
200 Corporate Blvd, Lafayette	LA	70508

Facility/Group Name	Contact Person:
EDINBURG EMERG MEDICINE ASSOC PA	Breon Terrance

Option Amount Owed

$831.00

Reason for Request

☐ 1. Previously denied / closed as "Exceeds Filing Time" What should I submit as evidence of timely filing?

Electronic claims - include confirmation that UnitedHealthcare or one of its affiliates received and accepted your claim.
Paper claims - include a copy of a screen print from your accounting software to show the date you submitted the claim.
The accounting software information must also include proof that the claim is for the correct patient and the correct visit.

• Proof of timely filing could also include other insurance carrier's denial/rejection, EOB, letter indicating terminated coverage, not a plan participant, etc.

☐ 2. Previously denied / closed for "Additional Information" (provide description and/or requested documents)
☐ 3. Previously denied / closed for "Coordination of Benefits" information (attach primary carrier's EOB)
☐ 4. Resubmission of a corrected claim (explain correction below)
☐ 5. Previously processed but contracted rate applied incorrectly resulting in over/underpayment (explain below)
☐ 6. Resubmission of "Prior Notification Information" (including notification information)
☐ 7. Resubmission of "Bundled claim" (including all supporting information)
☑ 8. Other (Explain below)

Please include what you are expecting from UniteHealthcare to close UnitedHealthcare's portion of this claim in your practice management system, including dollar amount if possible.

Comments: As a non-par provider we have been underpaid for the emergency service(s) provided to your member. Please reprocess the claim at a higher allowed amount that meets the rule requirements for out-of-network emergency services on the attached letter.

If, after you have received a response upon completion of the Claim Reconsideration process, you still do not agree with the outcome of the claim reconsideration, you may submit a letter of appeal and receipt of a response from UnitedHealthcare. To submit a formal appeal, submit a letter outlining your dispute, any supporting documentation, including our response to the reconsideration request, and the date your reconsideration stage was completed to:
UnitedHealthcare Provider Appeals P.O. Box 30559 Salt Lake City, UT 84130-0559
Required attachments:
• Copy of PRA or EOB • Claim form (with corrections if necessary) • Other required attachments as listed above.

You may have additional rights under state law. For review of claims for members enrolled in other benefit plans, please refer to one or more of the following for information on requesting claim reviews: the website for the entity listed on the member's health care ID card, the EOB for the applicable claim or UnitedHealthcareOnline.com. You may also call the telephone number on the member's health care ID card for information on how to request claims reviews.

UHC1060b_041511

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