UnitedHealth Group®

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APPEAL PO BOX 30573 or FAX 801-938-2109, SLC, UT-RMO WEST

FAX

04/22/2021 1042

United Health Group - West, Central and Cirrus RMO
Operated by Firstsource Solutions
1355 South 4700 West
Salt Lake City, UT 84104

UnitedHealthcare®

A UnitedHealth Group Company

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UnitedHealthcare®

Single Paper Claim Reconsideration Request Form

This form is to be completed by physicians, hospitals or other health care professionals for paper Claim Reconsideration Requests for our members.

NOTE
- **Please submit a separate Claim Reconsideration Request form for each request.**
- **No new claims should be submitted with this form.**
- **Do not use this form for formal appeals or disputes. Continue to use your standard appeals process for formal appeals or disputes.**

Please refer to the attached Claim Reconsideration Reference Guide, your provider administrative manual or our provider website for additional details including where to send paper Claim Reconsideration Requests. You may verify the member's address using the eligibility search function on the website listed on the member's health care ID card.

☑ Physician ☐ Hospital ☐ Other Health Care Professional (Lab, Durable Medical Equipment (DME), etc.)

Member information **Date form completed** 4/21/2021

Member ID	Control / Claim #	Date of Service		Billed Amount
968768859	CP82098076 0449667063	8-14-2020		$139.00
Member Last Name		First Name		MI
MCCLAIN		STEVEN		A
Street Address		City	State	Zip
151 OAK RIDGE LN		DUNN	NC	28334
Patient: Last Name		First Name		MI
MCCLAIN		STEVEN		A

Physician/Health care professional information

Tax Identification Number (TIN): 561348830 Phone Number (with area code): 844-821-8142

Email Address:

Physician or other Health Care Professional Name/as listed on Provider Remittance Advice (PRA)/Explanation of Benefits (EOB)
Last Name FALTER First RICHARD MI T

Street Address PO BOX 3219 City INDIANAPOLIS State IN Zip 46206-3219

Facility/Group Name VALLEY RADIOLOGY Contact Person Anne Thompson

Expected amount owed NC Contact Fax Number (with area code) 855-208-8650

Reason for request: *(More information on the definition reasons listed below and what documentation needs to be submitted can be found on the Claim Reconsideration Request definition sheet on UnitedHealthcareOnline.com)*

- ☐ 1. Previously denied / closed as "Exceeds Filing Time"
- ☐ 2. Previously denied / closed for "Additional Information"
- ☐ 3. Previously denied / closed for "Coordination of Benefits" information
- ☐ 4. Resubmission of a corrected claim
- ☐ 5. Previously processed but rate applied incorrectly resulting in over/underpayment (Network Providers - Check your fee schedules)
- ☐ 6. Resubmission of "Prior Notification Information"
- ☑ 7. Resubmission of a claim with "Bundled" services
- ☐ 8. Medical Records Submission
- ☐ 9. Other *(explain below)*

Please include what you are expecting from UnitedHealthcare regarding this Claim Reconsideration Request to close this out in your practice management system, including dollar amount if possible.

Comments
PATIENT HAD MULTIPLE EXAMS ON THIS DOS. ATTACHED REPORTS TO SUPPORT LEVEL OF SERVICE. PLEASE RECONSIDER FOR PROCESSING.

Required attachments
- Copy of PRA or EOB
- Claim Form is ONLY required for Corrected Claims Submissions
- Other required attachments as listed above

You may have additional rights under individual state laws. Please review the provider website, your provider administrative guide or your provider agreement/contract if you need more information.

Doc#: PCA11850_20140312

From: 8885551212 Page: 2/3 Date: 4/22/2021 10:42:31 AM

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WAIVER OF LIABILITY STATEMENT

968768859
Medicare/HIC Number

STEVEN MCCLAIN
Enrollee's Name

VALLEY RADIOLOGY
Provider

8-14-2020
Dates of Service

UNITED HEALTHCARE
Health Plan

I hereby waive any right to collect payment from the above-mentioned enrollee for the aforementioned services for which payment has been denied by the above-referenced health plan. I understand that the signing of this waiver does not negate my right to request further appeal under 42 CFR 422.600.

[redacted]

4/21/2021
Date

VALLEY REGIONAL IMAGING AND CAROLINA REGIONAL RAD

Patient: Mcclain Steven D Acct: 5956740
DOB: 02/28/1991 M MRN: 197200
Doctor: Distell Bruce Acc Num:5956740200814
Ref Dr: DAVE NAILESH DOS: 08/14/2020
Order: CT SHOULDER ARTHROGRAM LEFT

Patient: MCCLAIN, STEVEN D
DOB: Feb 28, 1991
Patient No: 197200
Ordering Physician:DAVE, NAILESH
Exam Date: Aug 14, 2020 Exam No: 5956740
*_ == _**_ == _**_ == _*

EXAM: CT SHOULDER ARTHROGRAM LEFT

INDICATION:
Left shoulder pain

TECHNIQUE:
Routine CT arthrogram of left shoulder Dose reduction techniques utilized for this exam include ALARA (As Low As Reasonable Achievable), AEC (Automated Exposure Control) and Iterative Reconstruction.

COMPARISON:
None.

FINDINGS:
Normal appearance of the intra-articular contrast with no evidence of cartilage loss. Intact labrum, biceps tendon and rotator cuff. No contrast in the subacromial-subdeltoid bursa. Mild bony proliferation of the distal clavicle with relatively maintained AC joint.

IMPRESSION:
Mild chronic bone proliferation at the distal clavicle. Otherwise negative

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Electronically signed by: Bruce Distell, MD 8/14/2020 3:45 PM

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