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UnitedHealthcare®

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CLARK SCHILLINGER EMER GROUP PC
P.O. BOX 731651
DALLAS, TX 75373-1651

PATIENT & INSURANCE INFORMATION
PATIENT NAME: TERRIQUEZ,JULIO
PATIENT DOB: 10/07/1989
DATE OF SERVICE: 11/06/2018
INSURANCE GROUP #: 715316
INSURANCE POLICY / ID: 971263138
TOTAL CHARGES: $2,028.00

PROVIDER & CLAIM INFORMATION
PROVIDER: CLARK SCHILLINGER EMER GROUP PC
NPI: 1770804353
TAX ID: 824933457
INVOICE NUMBER: 53603571
CLAIM NUMBER: 74801360570064637729
MAIL DATE: 04/07/2021

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UNITED HEALTHCARE ESCALATION UNIT
ATTN: APPEALS DEPARTMENT
PO BOX 30573
SALT LAKE CITY, UT 84130-0573
1662

Dear Plan/Claims Administrator:

We hereby serve notice to you of our **2nd** provider appeal related to the patient's recent visit and resulting underpayment for services provided by our non-participating emergency provider for CPT:99285. This claim should have been processed at the amount of **$1,323.00.**

This claim is underpaid based on The Greater of Three (GOT) regulation for out-of-network emergency services. See 45 C.F.R. § 147.138(b)(3)(i). The regulation requires the plan to reimburse out-of-network emergency services using the greater of (1) the amount negotiated with in-network providers for the emergency service furnished; (2) the amount for the emergency service calculated using the same method the plan generally uses to determine payments for out-of-network services (such as the usual, customary, and reasonable charges) or (3) the amount that would be paid under Medicare for the emergency service. Therefore, your rate of reimbursement for the services in question should be at or above the rate determined by FAIR Health (www.fairhealth.org), [because that amount typically complies with the GOT regulation, insofar as it may be considered the usual and customary rate in the industry].

The low amount you have allowed is not only unlawful, it puts the patient into the middle of the payment adjudication process between the provider and plan. This is the opposite of what "Patient Protections" are intended to be, which was the genesis of the GOT regulation under the Affordable Care Act (42 U.S.C. § 300gg-19a). The GOT regulation set forth minimum payment standards to ensure that a plan or issuer does not pay an unreasonably low amount to an out-of-network emergency service provider, so that patients are not left with an unnecessarily large bill.

We request that you immediately reprocess the above referenced claim with an allowed amount that is compliant with the GOT regulation.

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

Please contact me upon receipt of this grievance to both confirm receipt and provide an expected completion date.

Sincerely,

Breon Terrance
Revenue Recovery Associate
P - 337.609.2343 F - 337.593.1882

The content is intended for the addressee. If you received this in error, please immediately notify the sender or the privacy officer at 800-893-9698 Ext. 1225. Since the content may be confidential, proprietary, legally privileged or private healthcare information, please take care to not use, disclose, distribute, print or copy any of the contents.

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: 04/07/2021

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:
971263138	74801360570064637729	11/06/2018	$2,028.00

Member Name: Last	First	MI
TERRIQUEZ	JULIO	

Street Address	State	ZIP
7668 GOOD FORTUNE CT	NV	89139

Patient Name: Last	First	MI
TERRIQUEZ	JULIO	

Physician/Healthcare Professional Information

Tax Identification Number (TIN):	Phone Number	Email Address
824933457	337.609.2343	breon_terrance@scp-health.com

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

Last	First	MI
EDSON MD	DARREN.	

Street Address	State	Zip
200 Corporate Blvd, Lafayette	LA	70508

Facility/Group Name	Contact Person:
CLARK SCHILLINGER EMER GROUP PC	Breon Terrance

Option Amount Owed

$1,323.00

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.

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UNITED HEALTHCARE ESCALATION UNIT
ATTN: APPEALS DEPARTMENT
PO BOX 30573
1338 SALT LAKE CITY UT 84130-0573

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