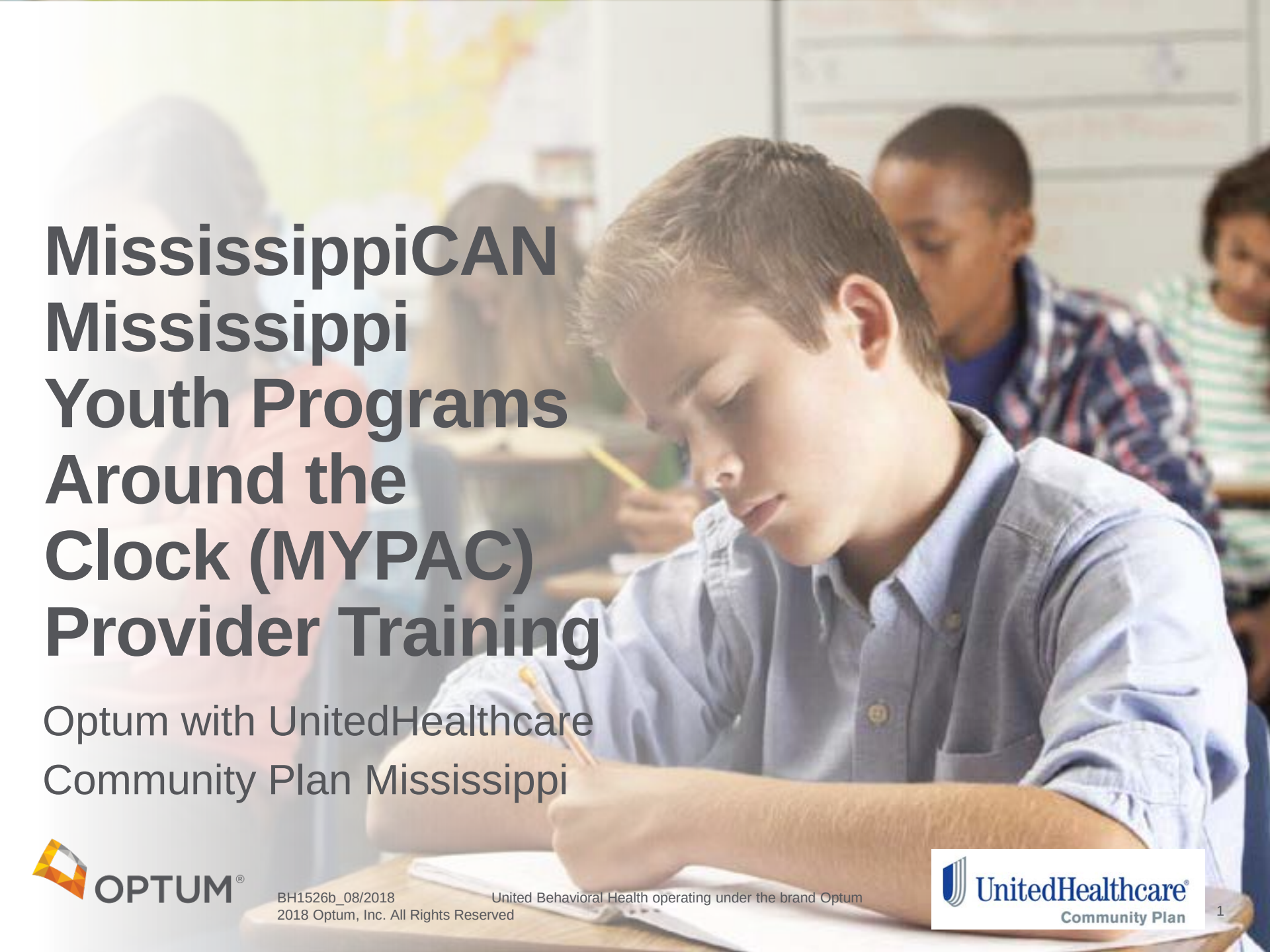

MississippiCAN Mississippi Youth Programs Around the Clock (MYPAC) Provider Training

Optum with UnitedHealthcare Community Plan Mississippi

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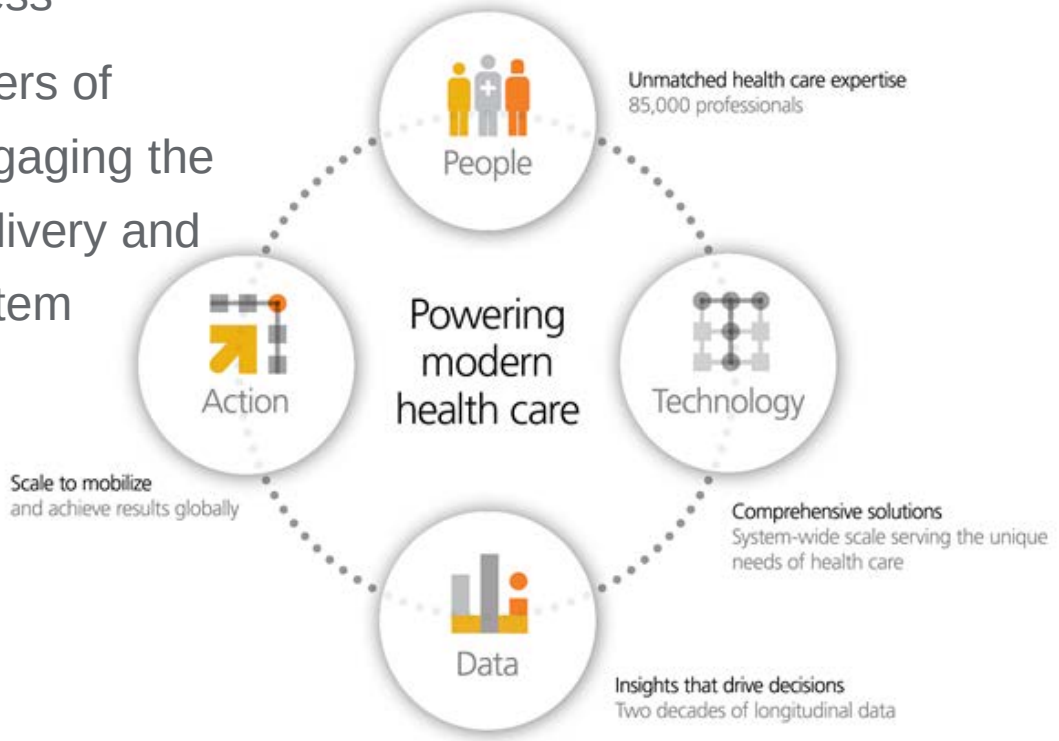
UnitedHealthcare® Community Plan

Who is Optum?

- Optum is a collection of people, capabilities, competencies, technologies, perspectives and partners sharing the same simple goal: to make the health care system work better for everyone
- Optum works collaboratively across the health system to improve care delivery, quality and cost-effectiveness
- We focus on three key drivers of transformative change: engaging the consumer, aligning care delivery and modernizing the health system infrastructure



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UnitedHealth Group Structure

UNITEDHEALTH GROUP®

OPTUM®

Helping make the health system work better for everyone

Information and technology-enabled health services:

- Technology solutions
- Pharmacy solutions
- Intelligence and decision support tools
- Health management and interventions
- Administrative and financial services

UnitedHealthcare®

Helping people live healthier lives

Health care coverage and benefits:

- Employer & Individual
- Medicare & Retirement
- Community & State
- Military & Veterans
- Global

BH1526b_08/2018 United Behavioral Health operating under the brand Optum
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Optum and You

Achieving our Mission:

- Starts with Providers
- Serves Members
- Applies global solutions to support sustainable local health care needs

From risk identification to integrated therapies, our mental health and substance abuse solutions help to ensure that people receive the right care at the right time from the right providers.

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Specialty Network Services

Customers we serve:

- 50% of the Fortune 100 and 34% of the Fortune 500
- Largest provider of global Employee Assistance Programs (EAP), covering more than 19 million lives in over 140 countries
- Local, state and federal government contracts (Public Sector)

Serving almost 43 million members:

- 1 in 6 insured Americans
- The largest network in the nation, delivering best in class density, discounts and quality segmentation
- More than 140,000 practitioners; 4,200 facilities with 9,000 facility locations

Simultaneous NCQA and URAC accreditation

URAC
ACCREDITED
HEALTH UTILIZATION
MANAGEMENT

MANAGED BEHAVIORAL HEALTHCARE ORGANIZATION
NCQA
ACCREDITATION
FULL

Staff expertise:

- Multi-disciplinary team of 50 staff Medical Directors (e.g., child and adolescent, medical/psychiatric, Board Certified Behavior Analysts, and addiction specialists) just to name a few

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MSCAN MYPAC Program Overview

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What is MSCAN MYPAC?

- Mississippi Youth Programs Around the Clock (MYPAC) is a home and community-based Medicaid program for children and youth with Serious Emotional Disturbance (SED), that follows the High Fidelity Wraparound process
- MYPAC provides an array of services, as an alternative to traditional Psychiatric Residential Treatment Facilities (PRTF)
- Wraparound is an all-inclusive planning process that is youth-guided and family-driven. This process is based on a strength-based philosophy of care that brings community services and natural supports together from various parts of the youth and family's life
- The all-inclusive planning process is a way to help children and youth with complex mental health needs, and their families, achieve their hopes and dreams
- Based on the Wraparound model, these are home and community based services that are intensive and time limited. The purpose is to diffuse the current crisis, stabilize the living arrangement, promote reunification, or prevent the utilization of out of home services
- Please refer to the Division of Medicaid Administrative Code Title 23 Part 206 Chapter 2: Mental Health Services at the following link: https://medicaid.ms.gov/wp-content/uploads/2014/10/AdminCode-Part_206.pdf for all program requirements

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Members who are eligible for MYPAC

- Be under age 21 upon admission, with a serious emotional disturbance (SED), as per the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM)
- Be covered under MississippiCAN
- Exceed the resources of a single agency or service provider
- Experience multiple acute hospital stays
- Has been recommended for residential care
- Has interruptions in delivery of services with multiple agencies
- Immediate Risk of requiring admission to a PRTF or receiving services in a PRTF but transitioning back to the community
- Individuals enrolled in Children's Health Insurance Program (CHIP) are not eligible for MYPAC services
- Please refer to the Division of Medicaid Administrative Code Title 23 Part 206 Chapter 2: Mental Health Services at the following link: medicaid.ms.gov/wp-content/uploads/2014/10/AdminCode-Part_206.pdf for all program requirements

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MississippiCAN MYPAC Provider Participation Requirements

- Mental health providers who meet the Mississippi Department of Mental Health (DMH) certification requirements and whose proposal package has been approved by the Division of Medicaid's Office of Mental Health to provide MYPAC services
- Have a current MYPAC specific Medicaid number
- Certified to provide wraparound facilitation services under the State Plan Rehabilitation Option
- Have a psychiatrist on staff
- Have appropriate clinical staff to provide needed therapy services
- Have procedures in place for availability and response twenty-four (24) hours a day, seven (7) days a week.
- Please refer to the Division of Medicaid Administrative Code Title 23 Part 206 Chapter 2: Mental Health Services at the following link: medicaid.ms.gov/wp-content/uploads/2014/10/AdminCode-Part_206.pdf for all participation requirements

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Optum MYPAC Program Member Information

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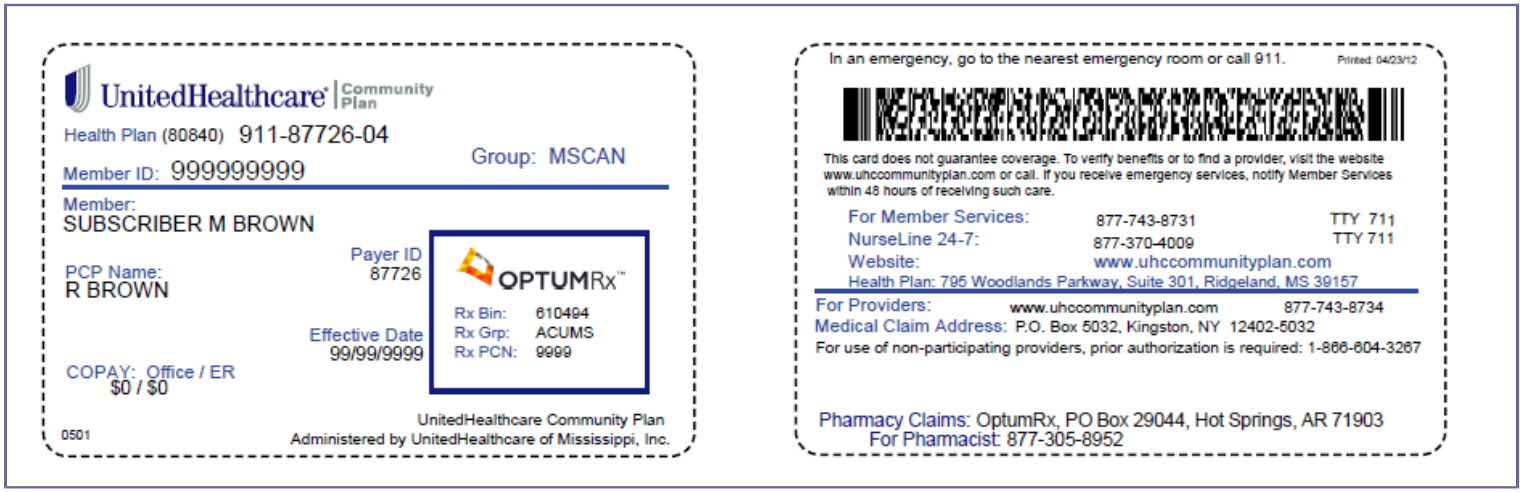
Member ID Card

- Will be sent directly to the member
- The member's ID number will be their Medicaid number
- All relevant contact information will be on the back of the card for both medical and behavioral customer service



Please note this image is for illustrative purposes only.

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Member Rights and Responsibilities

- Members have the right to be treated with respect and recognition of his or her dignity, the right to personal privacy, and the right to receive care that is considerate and respectful of his or her personal values and belief system
- Members have the right to disability related access per the Americans with Disabilities Act
- You will find a complete copy of Member Rights and Responsibilities in the Provider Network Manual
- These can also be found on the website: **providerexpress.com**
- These rights and responsibilities are in keeping with industry standards. All members benefit from reviewing these standards in the treatment setting
- We request that you display the Rights and Responsibilities in your waiting room, or have some other means of documenting that these standards have been communicated to the members

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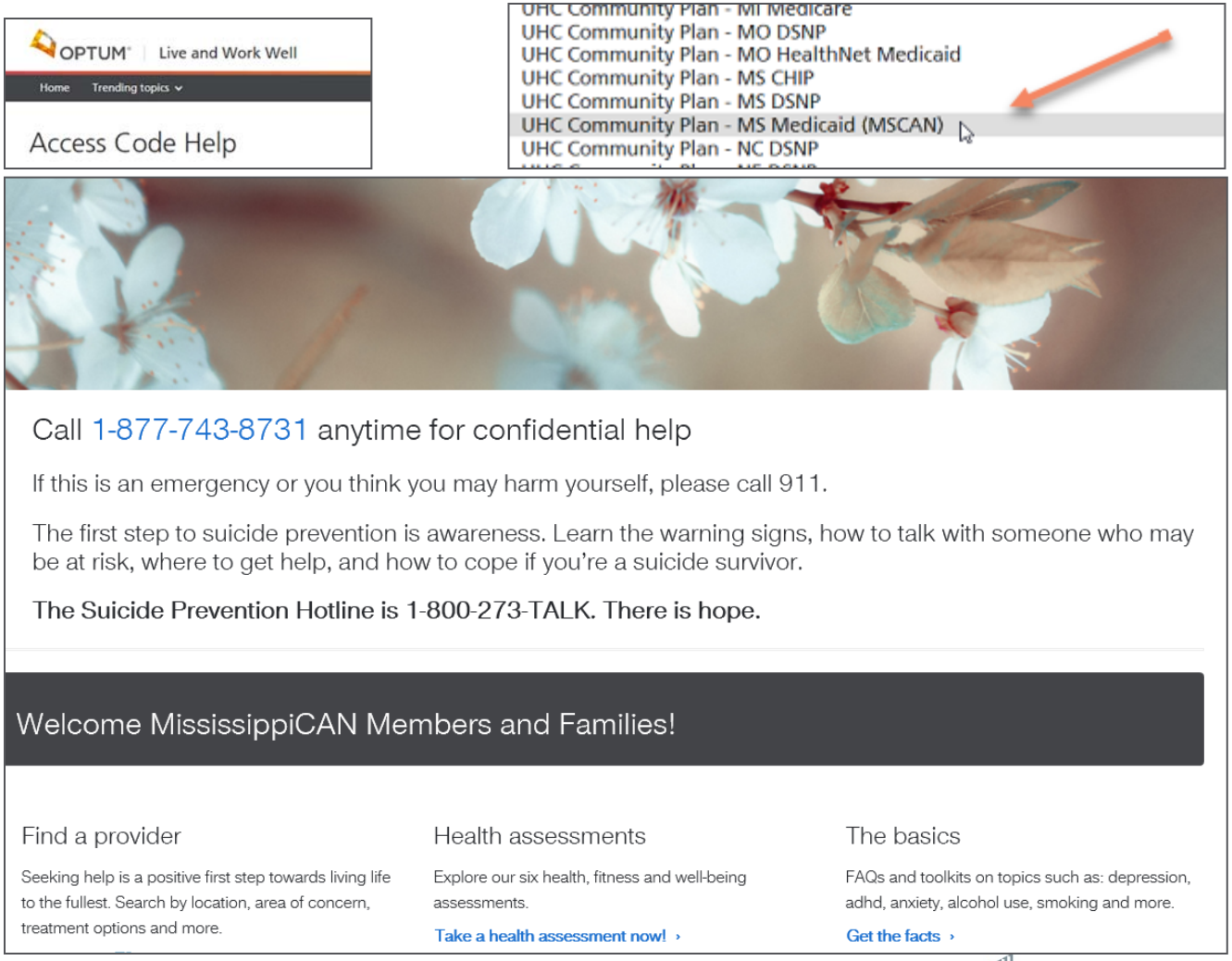
Member Website

liveandworkwell.com



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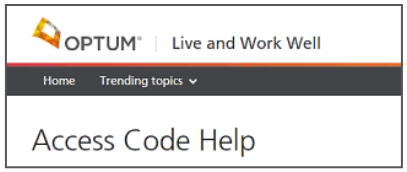
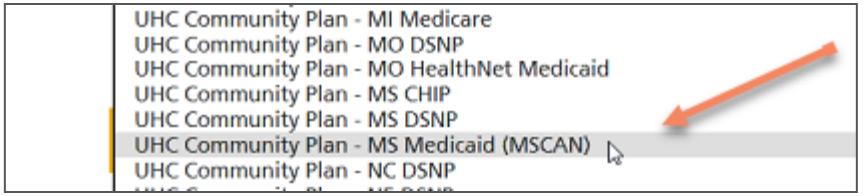
Member Website

- liveandworkwell.com makes it simple for members to:
  - Identify network clinicians and facilities
  - Locate community resources
  - Find articles on a variety of wellness and work topics
  - Take self-assessments





- The search engine allows members and providers to locate in-network providers for behavioral health and substance use disorder services.
- Providers can be located geographically, by specialty, license type and expertise.
- The website has an area designed to help members manage and take control of life challenges.

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MYPAC Service Requirements

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Intake

At Intake:

- Copy front and back of the member's insurance card
- Record subscriber's name and date of birth

Suggested information:

- Provide subscriber with your HIPAA policies
- Provide subscriber with consent for billing using protected health information including signature on file
- Always get a consent for services
- Informed Consent: services, to leave voicemail, email, etc.
- Billing policies and procedures
- Release of Information to communicate with other providers

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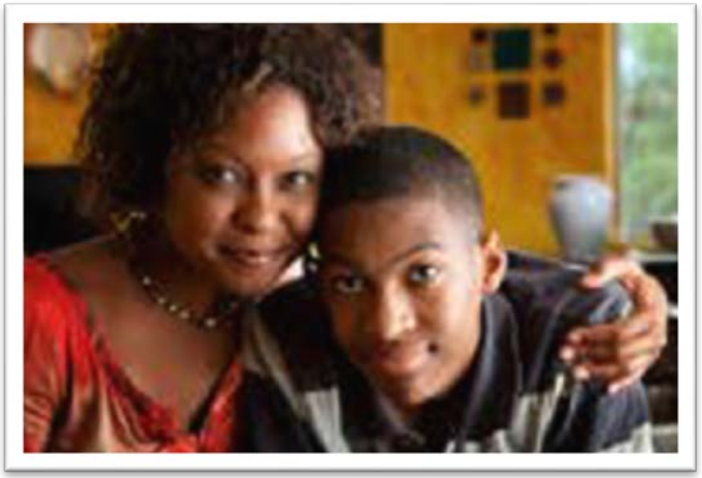
MYPAC Eligibility and Prior Authorization

- Call the number on the back of the member's insurance card to see if member is eligible for your services or verify on provider portal
- Check benefit coverage relating to both the service (MYPAC) and the diagnosis on provider portal or by calling the number on the member's insurance card.
- Make sure all services **receive prior approval from Optum before beginning MYPAC services**
- When calling the Optum Care Advocate you must have:
  - member's name,
  - ID #,
  - date of birth,
  - address



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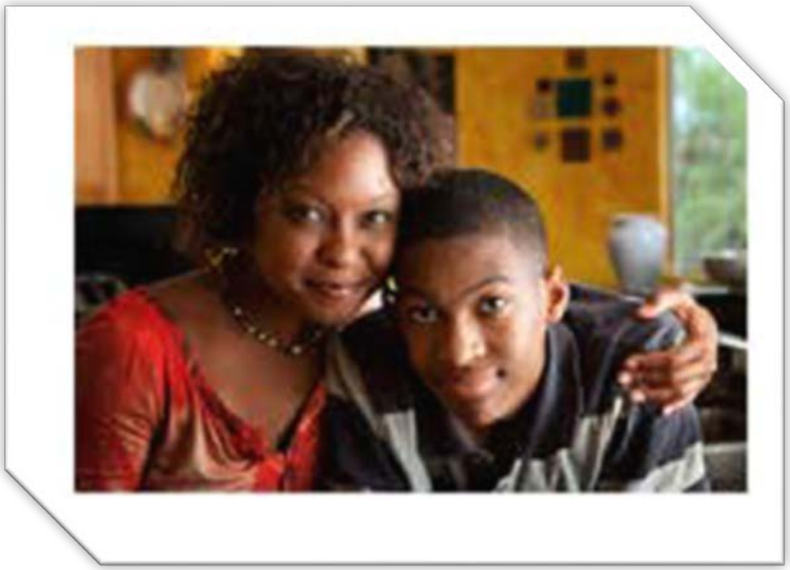
Assessment/Treatment Plan Requirements

- Prior authorization IS required for MYPAC
- Treatment Plan Authorization Requests can be initiated by calling **1-877-743-8734**
- MYPAC Must Meet Medical Necessity – this applies to initial and concurrent reviews



For more information, please see the Treatment Plan Guidelines at https://www.providerexpress.com/content/ope-provexpr/us/en/our-network/welcomeNtwk/wMS.html

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MYPAC Treatment Plan Requirements (cont.)

Meeting Medical Necessity

Goals are:

- Related to the core behavioral difficulties
- Objective
- Individualized
- Measurable

Includes, but not limited to:

- Baseline assessment with mastery goal treatment planning
- Transition Plan to lower level of care
- Discharge Criteria
- Behavior Reduction Plan/Crisis Plan
- Parent/Guardian Goals
- Management with supervision, therapeutic intervention and 24/7 wraparound services
- Relevant psychological information
- Coordination of care with other Mental Health providers, if needed
- Not educational in nature

For more information, please see the Treatment Plan Guidelines at https://www.providerexpress.com/content/ope-provexpr/us/en/our-network/welcomeNtwk/wMS.html

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Clinical Information Requirements for Each Review

- Confirmation member has an DSM-V diagnosis
- Any medical or other mental health diagnoses
- Any other mental health or medical services member is in
- Any medications member is taking
- How many hours per week is member in school (if applicable)?
- Parent/Guardian participation in member's treatment
- Why is the MYPAC needed now?
- How long has member been in services?
- Goals must not be educational or academic in nature; they must focus only on the core behavioral difficulties
- Discharge criteria
- Must meet medical necessity (see *Provider Express* for the Level of Care Guidelines and Coverage Determination Guidelines)

For more information, please see the Treatment Plan Guidelines at https://www.providerexpress.com/content/ope-provexpr/us/en/our-network/welcomeNtwk/wMS.html

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Concurrent Reviews

The same information will be needed for each review:

- Any medical or other mental health diagnoses
- Any other mental health or medical services member is receiving
- Any medications member is taking
- How many hours per week is member in school (if applicable)?
- Parent/Guardian participation in member's treatment

- Progress or lack thereof
- Goals must not be educational or academic in nature – focusing only on the behavioral difficulties
- Discharge criteria
- Must meet medical necessity

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Discharge Planning

Must include the following components in every plan

- Anticipated date of discharge
- Objective, measurable goals that would need to be met for the member to be discharged
- Identify next level of care for the member, (e.g., school-based services only, outpatient therapy)---Include contact info if appropriate
- Member and/or parent/guardian agreement with plan
- How to resume services if needed
- Resources in the community for the parent/guardian and member
- How discharge is coordinated with the school and other providers

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Release of Information

- We release information only to the individual, or to other parties designated in writing by the individual, unless otherwise required or allowed by law
- Members must sign and date a Release of Information for each party that the individual grants permission to access their PHI, specifying what information may be disclosed, to whom, and during what period of time
- The member may decline to sign a Release of Information which must be noted in the Treatment Record; the decline of the release of information should be honored to the extent allowable by law
- PHI may be exchanged with a network clinician, facility or other entity designated by HIPAA for the purposes of Treatment, Payment, or Health Care Operations

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Coding, Billing and Reimbursement

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MSCAN Medicaid Program MYPAC Provider Fee Schedule

MYPAC	Procedure Code	Required Procedure Code Modifier	Number of Units	Unit equals	Rate
	H2022	HT	115	1 day	$347.74

- Prior authorization for MYPAC is issued for a 365 day period.
- Procedure Code H2022 will be certified for **115 units per year** (This assumes services being delivered 3 times a week).
- A billable unit must consist of at least thirty (30) minutes face-to-face contact with the MYPAC participant, family, or a Child and Family Team member, for the purpose of the Individualized Service Plan (ISP) implementation.
- **All billable contacts with a Child and Family team member, that do not include the MYPAC participant, will require the 2nd modifier-HS. The number of billable contacts where the MYPAC participant is not present is limited to four (4) per month.**
- Case management or respite codes will not be authorized in conjunction with MYPAC/IOP.
- No other mental health services will be authorized/reimbursed during the MYPAC Program.

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Claims Submission

Required Claim Forms

- Form 1500 (CMS-1500 form)

Claims/Customer Service # :

- Phone: **1-866-556-8166**
- Fax: **1-855-312-1470**

Electronic Claims Payer ID:

- 87726

Paper Claims:

When submitting behavioral Claims by paper, please mail claims to:

United Healthcare
P.O. Box 5032
Kingston, NY 12402-5032

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Claims Submission (Cont.)

- If not submitting claims online, providers must submit claims using the current 1500 Claim Form with appropriate coding
- UnitedHealthcare Community Plan requires that you initially submit your claim within 180 days of the date of service
- When a provider is contracted as a group, the payment is made to the group, not to an individual
- All claim submissions must include:
  - Member name, Medicaid identification number and date of birth
  - Provider's Federal Tax I.D. number
  - National Provider Identifier (NPI)
  - Providers are responsible for billing in accordance with nationally recognized CMS Correct Coding Initiative (CCI) standards. Additional information is available at cms.gov

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Claims Submission Option 1- Online

Log on to uhcprovider.com:

- Secure HIPAA-compliant transaction features streamline the claim submission process
- Performs well on all connection speeds
- Submitting claims closely mirrors the process of manually completing a CMS-1500 form
- Allows claims to be paid quickly and accurately

You must have a registered user ID and password to gain access to the online claim submission function:

- To obtain a user ID, call toll-free **1-866-842-3278**

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Claims Submission Option 2 - EDI/Electronically

- Electronic Data Interchange (EDI) is an exchange of information
- Performing claim submission electronically offers distinct benefits:
  - **Fast** - eliminates mail and paper processing delays
  - **Convenient** - easy set-up and intuitive process, even for those new to computers
  - **Secure** - data security is higher than with paper-based claims
  - **Efficient** - electronic processing helps catch and reduce pre-submission errors, so more claims auto-adjudicate
  - **Notification** - you get feedback that your claim was received by the payer; provides claim error reports for claims that fail submission
  - **Cost-efficient** - you eliminate mailing costs, the solutions are free or low-cost

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Claims Submission Option 2 - EDI/Electronically (cont.)

- You may use any clearinghouse vendor to submit claims
- Payer ID for submitting claims is 87726

- Additional information regarding EDI is available on:

  https://www.uhcprovider.com/en/health-plans-by-state/mississippi-health-plans/ms-comm-plan-home.html

  and for additional support: uhcprovider.com

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Electronic Payment & Statements (EPS)

With EPS, you receive electronic funds transfer (EFT) for claim payments, plus your EOBs are delivered online:

- Lessens administrative costs and simplifies bookkeeping
- Reduces reimbursement turnaround time
- Funds are available as soon as they are posted to your account

To receive direct deposit and electronic statements through EPS you need to enroll at myservices.optumhealthpaymentservices.com.
Here's what you'll need:

- Bank account information for direct deposit
- Either a voided check or a bank letter to verify bank account information
- A copy of your practice's W-9 form

If you're already signed up for EPS with UnitedHealthcare Commercial or UnitedHealthcare Medicare Solutions, you will automatically receive direct deposit and electronic statements through EPS for UnitedHealthcare Community Plan when the program is deployed.

*Note: For more information regarding enrollment, please call **1-866-842-3278**, option 5, or go to UHCprovider.com > Electronic Data Exchange or for Support call **1-800-210-8315** or email : ac_edi_ops@uhc.com*

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Claims Tips

To ensure clean claims remember:

- An NPI number is always required on all claims
- A complete diagnosis is also required on all claims

Claims filing deadline

- Providers should refer to their contract with United to identify the timely filing deadline that applies

Claims Processing

- Clean claims, including adjustments, will be adjudicated within 14 days of receipt

Balance Billing

- The member cannot be balance billed for behavioral services covered under the contractual agreement

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Claims Tips (Cont.)

Member Eligibility

Provider is responsible to verify member eligibility through DHS website

Coding Issues

Coding issues including incomplete or missing diagnosis Invalid or missing HCPC/CPT examples:

- Submitting claims with codes that are not covered services
- Required data elements missing, (e.g., number of units)

Provider information missing/incorrect

Example: provider information has not been completely entered on the claim form or place of service

Prior Authorization Required

Prior Authorization is required for all services or when additional units are being requested

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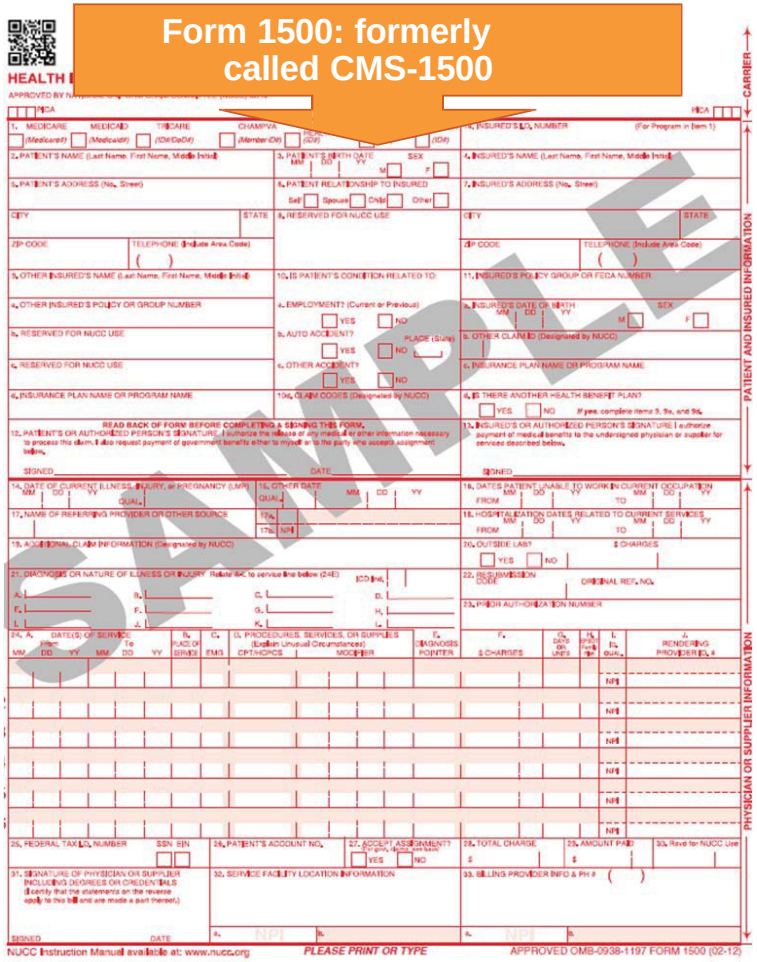
1500 Claim Form

All billable services must be coded. Coding can be dependent on several factors:

- Type of service (assessment, treatment, etc.)
- Use appropriate modifier for specific provider type
- Rate per unit
- Place of service (home or clinic)
- Duration of therapy (1 hr vs. 15 min)
- One DOS per line



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Claims Submission Review Upon Receipt

- It is a MississippiCAN requirement that all care providers listed on a claim are enrolled with DOM and are eligible to participate in the Mississippi Medicaid program.
- Our claims edit will help ensure your claims meet this requirement.
- Our system will look for a match between the care providers on a claim and their DOM enrollment information.
- If the information matches, the claim will be processed. If the care provider information doesn't match, the claim will be returned to the submitter by a 277 claim status response electronically; or if a paper claim was submitted a reject letter will be generated and mailed to the provider.

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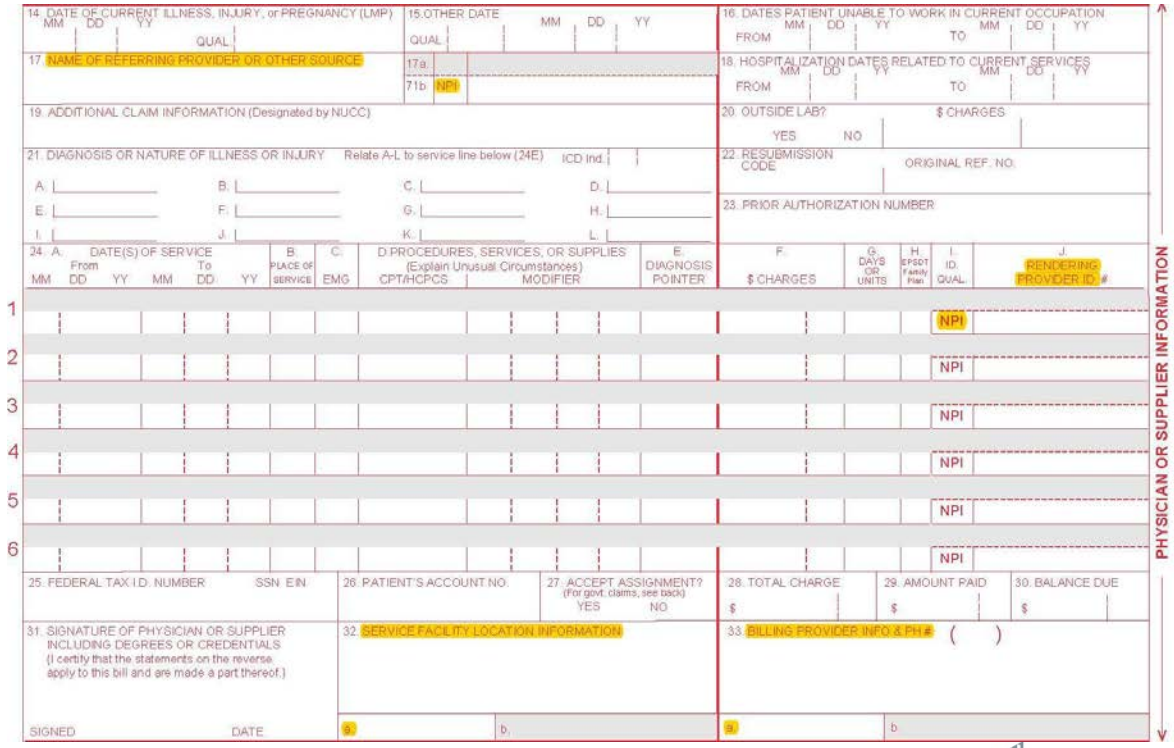
Claim Revision Edits- What to Check for:

The HCFA 1500 Form has 4 sections where provider information is stored, they have been highlighted for easy reference. The CRE Edit will review each section when a provider name and NPI number is populated.

- ✓ **17b – Referring, Prescribing physician and NPI number**
- ✓ **24J – Rendering physician and NPI number**
- ✓ **32A – Service location and NPI number**
- ✓ **33A – Billing provider and NPI number**



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EDI Claim Revision Edits - What to Check for:

Through the electronic claims submission process, UHC will be validating physician data in the following loop and segments if applicable

ANSI ASC X12N 5010 837P

- 2420A NM – Rendering Provider
- 2420C NM – Service Facility Location
- 2420D NM – Supervising Provider
- 2420E NM – Ordering Provider
- 2420F NM – Referring Provider
- 2010AA NM – Billing Provider

ANSI ASC X12N 5010 837I

- 2010AA NM – Billing Provider
- 2310A NM – Attending Provider
- 2310B NM – Operating Provider
- 2310C NM – Other Operating Provider
- 2310D NM – Rendering Provider
- 2310E NM – Service Facility Location
- 2310F NM – Referring Provider

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Appeals and Grievances

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Appeals

- An Appeal is a request for review related to an Adverse Benefit Determination.
- Providers can request an Appeal directly within 30 calendar days of receiving notice of Adverse Benefit Determination.
- Appeals will be acknowledged in writing within 10 calendar days.
- Appeals will be resolved within 30 calendar days (Expedited resolution upon request).

Appeal requests can be made orally or in writing;
however, an oral request to appeal shall be followed up by a written, signed, appeal.

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Services While In Appeal

- You may continue to provide service following an adverse determination, but the member should also be informed of the adverse determination
- The member or the member representative should be informed that the care will become the financial responsibility of the member from the date of the adverse determination forward
- The member must agree in writing to these continued terms of care and acceptance of financial responsibility. You may charge no more than the Optum contracted fee for such services, although a lower fee may be charged
- If, subsequent to the adverse benefit determination and in advance of receiving continued services, the member does not consent in writing to continue to receive such care and we uphold the determination regarding the cessation of coverage for such care, you cannot collect reimbursement from the member pursuant the terms of your Agreement

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Grievances

We strive for the best customer service, but if you have a grievance please contact us:

- Call **1-866-556-8166** and a Customer Service representative will assist with the grievance process

- Or send a written grievance to:

  United Behavioral Health
  Appeals & Grievances
  P.O. Box 30512
  Salt Lake City, Utah 84130-0512

  Fax: **1-855-312-1470**

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Resources

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Provider Contracting

We are interested in contracting with you for the above named services. Our goal is to make sure Medicaid recipients who qualify for these services are able to access the state approved providers for these services through their appropriate CCO.

Please contact us so that we can get you the application, start the credentialing process and work together to serve these unique populations in Mississippi.

Rusty Palmer, LPC-S
Network Manager (MS)-North
Optum / United Behavioral Health
james.palmer@optum.com
Phone: 1-651-495-5298
Fax: 1-855-291-7422

Dawn Teeter
Network Manager (MS)-South
Optum/United Behavioral Health
dawn.teeter@optum.com
Phone: 1-952-687-4121
Fax: 1-844-328-5129

Adam T. Pancake, LPC, NCC
Interim Network Manager for Mississippi
Optum / United Behavioral Health
adam.pancake@optum.com
Phone: 1-770-200-6735
Fax: 1-855-228-3939

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UnitedHealthcare Provider Website

uhcprovider.com

Secure transactions for Medicaid include:

- Check eligibility and authorization or notification of benefits requirements
- Submit professional claims and view claim status
- Make claim adjustment requests
- Register for Electronic Payments and Statements (EPS)
- To request a user ID to the secure transactions on the uhcprovider.com, select New User from the home page
- You may also obtain additional information through the help desk at **1-866-842-3278**

NOTE: For member eligibility, claim status, and reference materials, go to > *Tools and Resources* > *UnitedHealthcare Community Plan Resources Customer Service* *for website support:* **1-800-600-9007**

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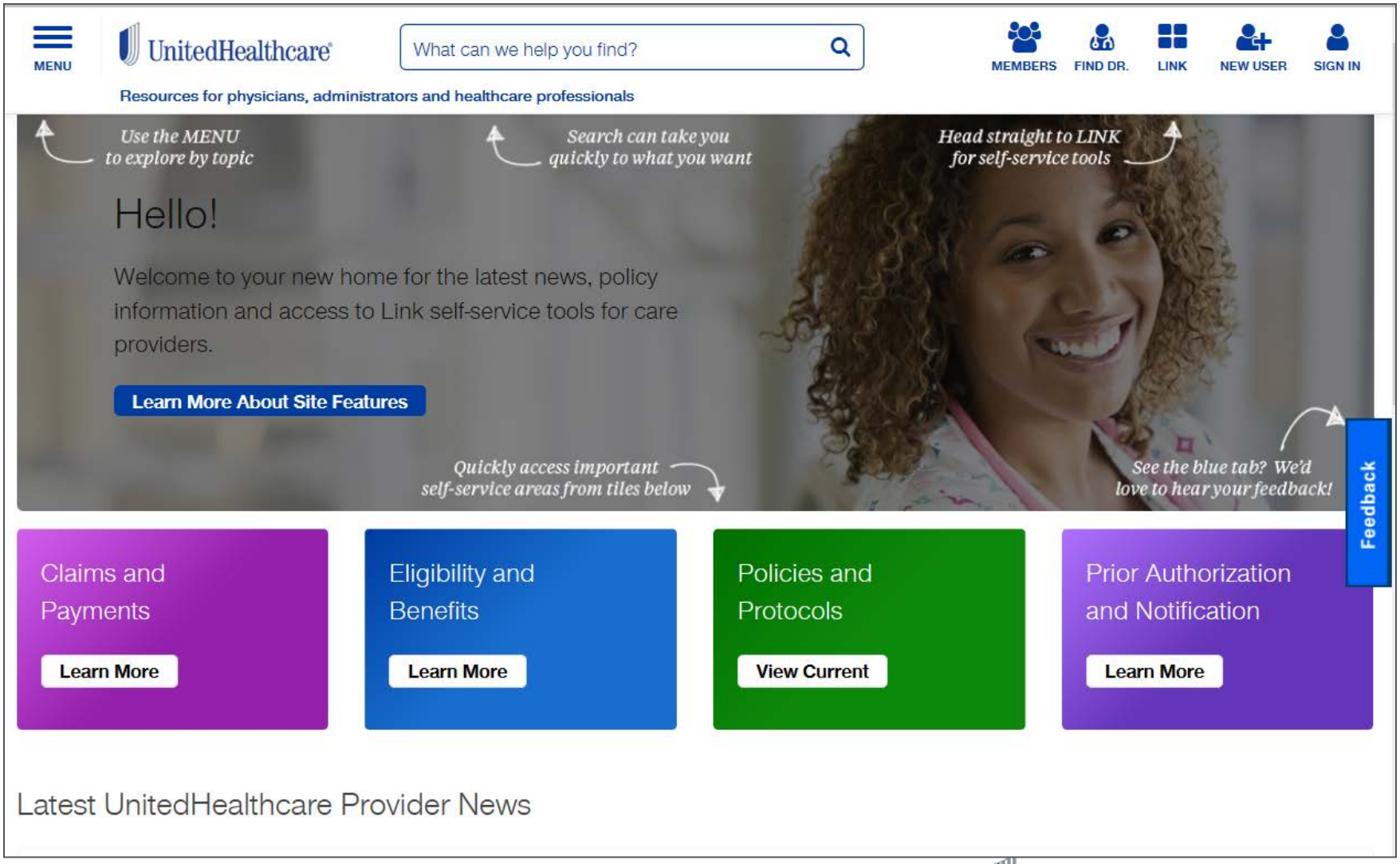
UHCProvider.com Main Login Page



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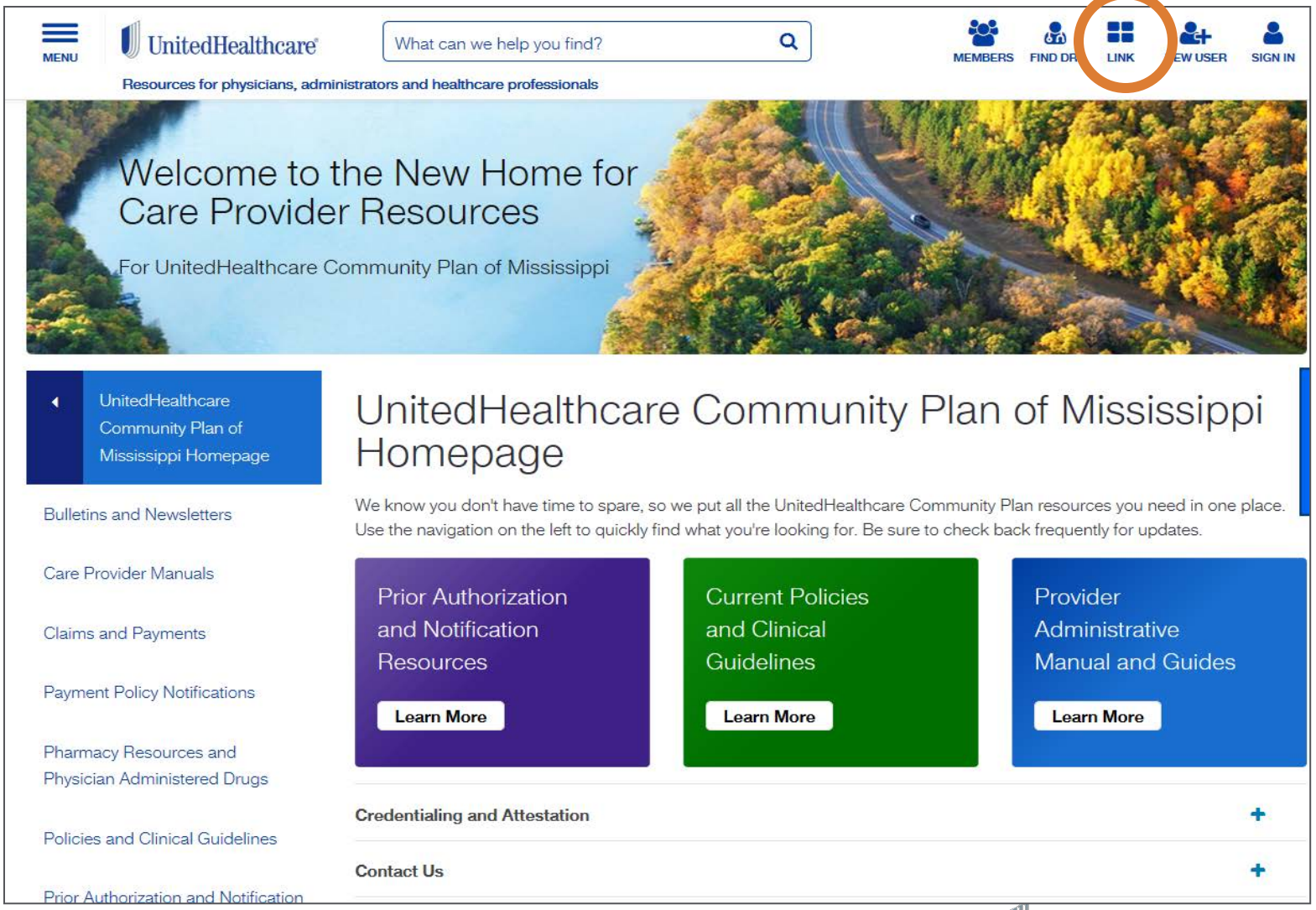
UnitedHealthcare Online – Login Page



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About Link and Optum ID's

- Create an Optum ID
- Manage your Optum ID
- What is an Optum ID?

- **Use self-service**:
to retrieve your Optum ID
or reset your password
- Unlock your account
- Manage your profile

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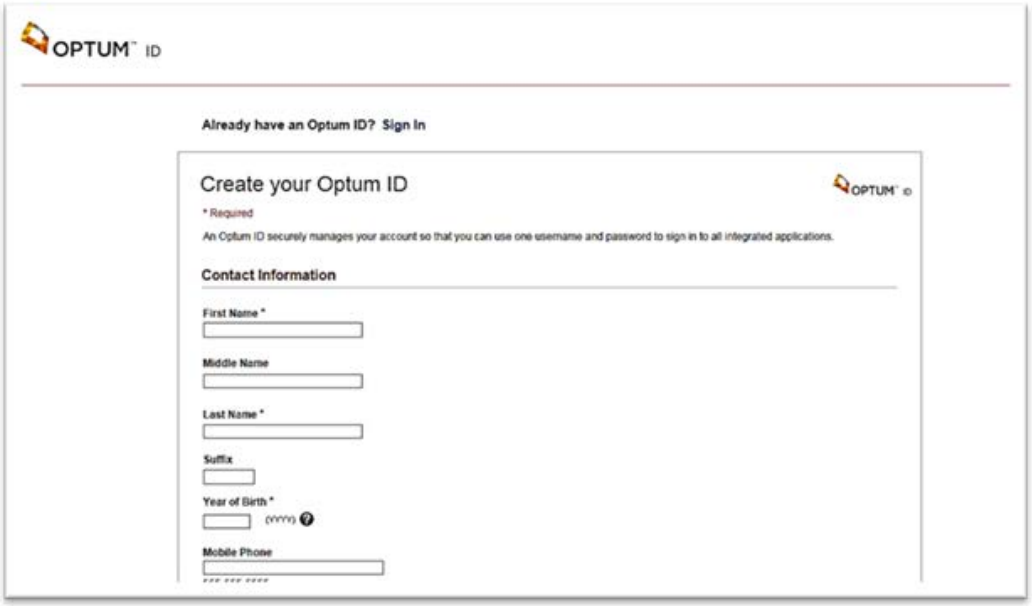
Optum ID Registration

- Register for your Optum ID online for immediate access to secure Transactions
- No fees apply
- *Provider Express* Support Center available from 7 am to 9 pm CST toll free at 1-866-209-9320
- Live chat feature also available under “Contact Us” > Website Support



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Review of Link and Optum ID's

uhcprovider.com

Provides clinicians with access to the latest news, policy information and to Link self-service tools for care providers.

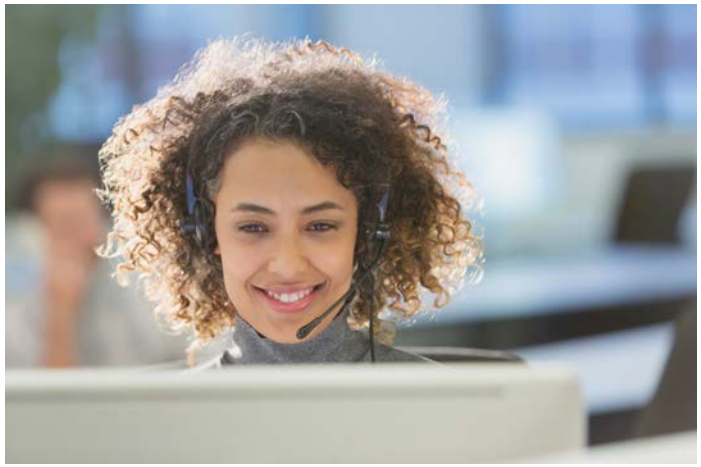
Create an Optum ID

In order to access secure content on UHCprovider.com or to access Link self-service tools to submit claims, verify eligibility or to check for prior authorization requirements, you first need to have an Optum ID that has been connected to the Tax ID of your practice, facility or organization.

Video: Accessing Link via UHCprovider.com

Need an Optum ID? Please register to create your Optum ID.

Have an Optum ID, but need to connect a Tax ID? To start the process, sign in with your Optum ID on UHCprovider.com and click "No" when asked if you received a registration letter that included a security code. From that point, complete the required fields for the form as prompted. For help see the Accessing Link - Quick Reference Guide.



Need help accessing certain applications on Link?

If you are unable to access specific Link Self-Service application using your Tax ID connected Optum ID login, please contact your organization's practice administrator – they are the only ones able to manage and make changes to account access.

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Provider and Member Resources

UnitedHealthcare Community Plan is aware of the important role of the member's support team. Family, guardians or representatives can be a big help in getting the right services, and can use this information to assist in supporting the member.

UnitedHealthcare Community Plan in coordination with Optum Specialty Networks coordinates and manages the physical, mental health/substance use and pharmacy benefits for members.

Important Telephone Numbers
Member Services and Care Coordination
Phone numbers are:

- Members – **1-877-743-8731**
- Providers – **1-877-743-8734**

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Additional Provider and Member Resources

An extensive condition-based library covering key behavioral and medical topics can be found on liveandworkwell.com under the Health and Well-Being Center within BeWell.

- Abuse & Neglect: Child
- Abuse: Domestic Violence
- Abuse & Neglect: Elder
- ADHD (Adult)
- ADHD (Youth)
- Alzheimer's & Dementia
- Anxiety
- Arthritis
- Asthma
- Autism
- Bipolar (Adult)
- Bipolar (Youth)
- Cancer
- Childhood Illness
- Chronic Pain
- Depression (Adult)
- Depression (Youth)
- Diabetes
- Eating Disorders (Adult)
- Eating Disorders (Youth)
- Heart Disease/Circulatory
- HIV
- Infertility
- Obesity
- Personality Disorders
- Obsessions & Compulsions
- Phobias
- Postpartum Depression
- Post-Traumatic Stress Disorder
- Schizophrenia (Adult)
- Schizophrenia (Youth)
- Sexual Problems
- Stress
- Traumatic Brain Injury

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Questions?

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Thank you.

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UnitedHealthcare® Community Plan