RAINTREE PAYOR SET:

RT Code: *10003 United Primary Payor, PO Box 30985, Salt Lake City, UT 84130*
RT Code: *20854 United Healthcare Choice, PO Box 30555, Salt Lake City, UT 84130*
RT Code: *11579, United Healthcare – Medicare Advantage Plan, PO Box 31362, Salt Lake City, UT 84131*
RT Code: *10689, United Healthcare (supplemental), PO Box, 31375, Salt Lake City, UT 84131*
RT Code: *20288, United Healthcare Shared Services (used for GEHA), PO Box 30783, Salt Lake City, UT 84130*

***Always check the "quick group check" in Optum to see if authorization is required.
***Always verify benefits specifically to PT even if secondary to ME.

BENEFITS: United Healthcare website -- https://www.unitedhealthcareonline.com. If you cannot pull benefits from UHC, call customer service and/or member service phone # listed on card.

- *Enter Corporate Information for Step 1, Step 2, Step 3 and Step 4 then Submit*

Corporate Information ❓
Check the eligibility for a specific member by following the simple steps below.

Step 1: Provider/ Organization You Are Representing.
PHOENIX REHAB HEALTH SERVICES ▾

Step 2: Select a corporate name.
PHOENIX REHAB HEALTH SERVICES ▾

Step 3: Select the Tax ID number.
232918467 ▾

Step 4: Type and Select the Provider/Physician name. (Press the down arrow key [↓] to see available options).
NIGGEL,THOMAS - 002432437 ⇕

Submit Reset

UHC Benefits: You can search by Member ID and Date of Birth, Member ID and Name, Name, Date of Birth and State or SSN and Date of Birth

You can click on ID Card Image for current Member card, then click >Select to pull up Eligibility and Benefits.

PHOENIX
Rehabilitation and Health Services, Inc.

First Name	Last Name	Relationship	Member ID	Group Number	Date of Birth	Policy Start Date	Policy End Date	Product Name	ID Card	Select
		Subscriber				01/01/2017	12/31/9999	Choice Plus	🟨	🟡

Patient and Benefits Information

1. Lists Patient Information and Product Information
2. Gives Deductible and Out of Pocket Information
3. Policy Start and End Dates
4. Lists Copayment/Coinsurance

Patient and Benefits Information

First Name	Last Name	Gender	Date Of Birth	Address
		Female		

Member ID	Group number	Insurance Type	Funding Type	Product	UHC Primary	COB Update Information
		Commercial	Insured by United	Choice Plus	Yes	No Member COB Update Needed

Primary Care Physician

No Primary Care Provider Found

This member has a tiered benefit plan. To determine if you are a tier 1 provider for this member, check the physician directory for this member's plan.

Deductible Individual Limit/Met	Out of Pocket Individual Limit/Met	Policy Start date	Policy End date	Virtual Visits
$500.00 / $500.00	$2500.00 / $1838.69	1/1/2017	12/31/9999	Yes

Deductible Family Limit/Met	Out of Pocket family Limit/Met	HSA	HRA	
$1000.00 / $500.00	$5000.00 / $1848.69	No	No	

Copayment/Coinsurance

	Professional (Physician)Visit	Professional (Specialist)Visit	Hospital Inpatient	Hospital Outpatient	Hospital Emergency Medical	Select a service ▼	Select a service ▼	Select a service ▼
Copayment	$20.00	$30.00	$0.00	$0.00	$100.00	-	-	-
Coinsurance	0.0%	0.0%	20.0%	20.0%	0.0%	-	-	-

5. Benefit Category – find PT/OT/ST, Home Health, Special Services
   1. Scroll down till you come to **Rehabilitation and Habilitative Services Outpatient Therapy and Manipulative Treatment –** Look in the Plan Network column for Benefits for either PT or OT.

▼ Benefit Category

Please select the service from the dropdown below.

Benefit Category

Select a Benefit category ▾

Select a Benefit category
Prescription Drugs
Mental and Nervous
PT/OT/ST,Home Health,Special Services
Chemical Dependency
Infertility,Family Planning
FlexSpendAcc
Lifetime Max
Coinsurance
Hospital Services,Radiology-Inpatient/Outpatient,Lab
Copays,Outpatient Services,Physician Services,Well Visits-Pediatric and Adult,Immunizations,Allergy,Visi
Deductibles
Other Benefits

Situation	2007 CHOICE PLUS WITH COPAY PS1 PLAN 80/60	2007 CHOICE PLUS WITH COPAY PS1 PLAN 80/60
	NETWORK	NON-NETWORK
Rehabilitation and Habilitative Services Outpatient Therapy and Manipulative Treatment Short-term outpatient rehabilitation services for: • Physical therapy; • Occupational therapy; • Manipulative treatment • Speech therapy; • Post-cochlear implant aural therapy; • Cognitive rehabilitation therapy following a post-traumatic brain injury or cerebral vascular accident; • Pulmonary rehabilitation therapy; and Also known as Respiratory Therapy. • Cardiac rehabilitation therapy. For all rehabilitation services, a licensed therapy provider, under the direction of a Physician, must perform the services. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility. The Plan will pay Benefits for speech therapy only when the speech impediment or dysfunction results from Injury, Sickness, stroke, cancer, Autism Spectrum Disorders or a Congenital Anomaly Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if rehabilitation goals have previously been met.	**80%** of eligible expenses.after satisfying thedeductible. Any combination of Network and Non-Network Benefits is limited as follows: • **25** visits of physical therapy per calendar year. • **25** visits of occupational therapy per calendar year. • **25** visits of manipulative treatment per calendar year • **25** visits of speech therapy per calendar year. • **25** visits of post-cochlear implant aural therapy per calendar year • **25** visits of cognitive rehabilitation therapy per calendar year.	**60%** of eligible expensesafter satisfying thedeductible. Any combination of Network and Non-Network Benefits is limited as follows: • **25** visits of physical therapy per calendar year. • **25** visits of occupational therapy per calendar year. • **25** visits of manipulative treatment per calendar year • **25** visits of speech therapy per calendar year. • **25** visits of post-cochlear implant aural therapy per calendar year • **25** visits of cognitive rehabilitation therapy per calendar year. Member is encouraged to obtain OON Prior Authorization with Medical Necessity but will not be penalized for non-compliance with Notification Requirements.

ALWAYS CHECK MY OPTUM HEALTH FOR AUTHORIZATION REQUIREMENTS

Authorization Process: Check to see if Authorization is required for all UHC members, by going to https://www.myoptumhealthphysicalhealth.com/logon.asp and logging in using the Company ID/Password (please DO NOT CHANGE) – this password does change every 90 days – Trish Marcoaldi will notify of this change.
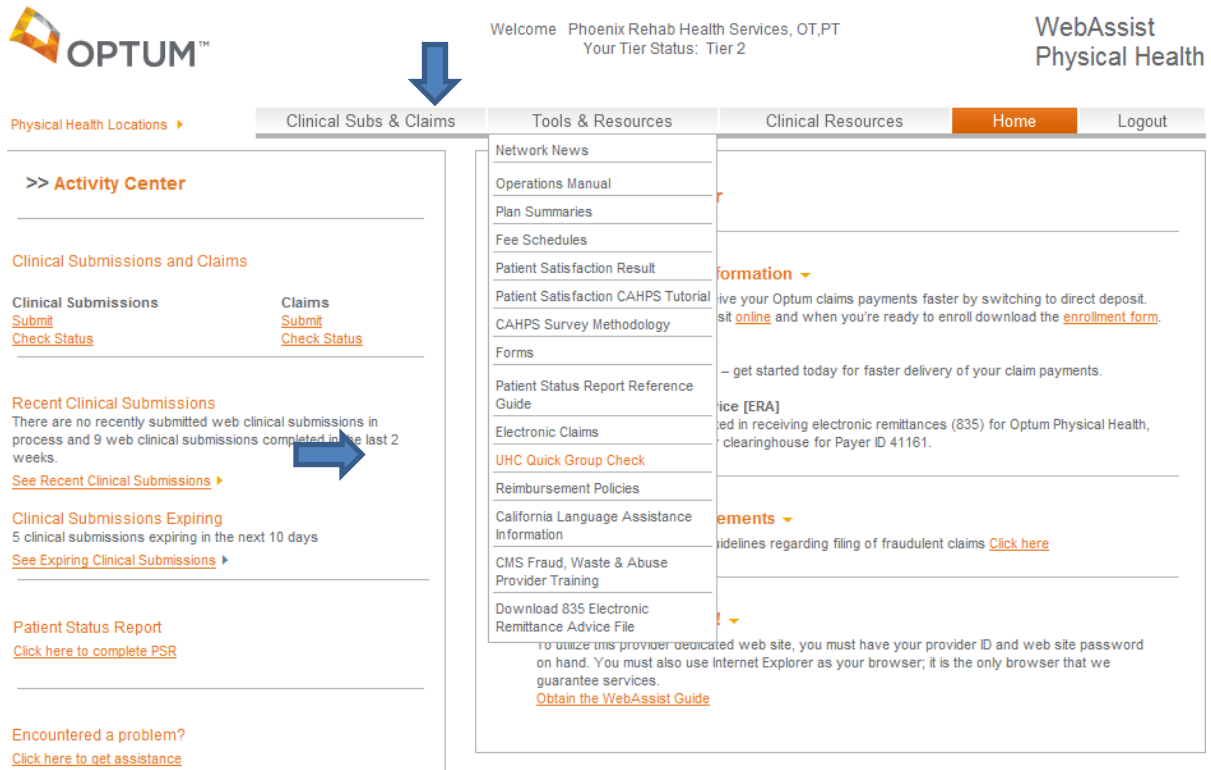
ID#: 683286
Password: Summer#123 *(as of 08/2018)*

- **To check if Auth is required you MUST have the Member Group Number.**

- **You only have 10 days to get an authorization, and they will not Retro Authorization.**

The Medicare Advantage Plans of United Healthcare that have 5 digit group # do not require authorization and are not managed by Optum Health. Sometimes when entering the 5 digit group # on the Optum Health Website it will tell you authorization is required. This is an error on the website.   Please ask United Healthcare when verifying benefits if authorization is required thru Optum Health. According to the contact person at Optum Health, they manage 6 digit group numbers and/or letters.

1. Go to Tools & Resources (only hover with your cursor)
2. Select UHC Quick Group Check from Menu

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3. Enter Group Number into "Member's Group Number" and hit Submit

UHC Quick Group Check

For UnitedHealthcare, a Clinical Submission is required for the majority of members.
Certain groups do not have this requirement. Enter the members group number
below to determine if required

Member's Group Number: [_____]

Submit   Reset

a. If Authorization is not required, you will get the following message:

Not Required for Group 168504.

b. If Authorization is required, you will get the following message:

Please submit for Group's **7J7034** members.

Click here to submit using the online form.

4. Click "here" to go to "Submit a Patient Summary Form" (Auth)
   - OR
5. Go To Clinical Subs & Claims (only hover with your cursor)
6. Select Submit a Clinical Sub

Clinical Subs & Claims
Submit a Clinical Sub
Clinical Sub Status
Submit a Claim
Claims Status
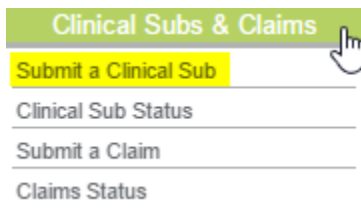
Complete the Patient Summary Form Online
1. Need Diagnosis
2. Provider Completed Section
3. Need the Current Functional Measure Scale (Neck Index, DASH, Back Index, LEFS, SBST or Other)
4. Patient Completed Portion from the Patient Summary Form

PHOENIX
Rehabilitation and Health Services, Inc.

Patient Summary Form
PSF-750 (Rev: 7/1/2015)

Patient Information

| Patient name | Last | First | MI | ○ Female ○ Male | | Patient date of birth |

| Patient address | | City | | State | Zip code |

| Patient insurance ID# | Health plan | Group number |

| Referring physician (if applicable) | Date referral issued (if applicable) | Referral number (if applicable) |

Provider Information

1. Name of the billing provider or facility (as it will appear on the claim form)   2. Federal tax ID(TIN) of entity in box #1

| 1 MD/DO | 2 DC | 3 PT | 4 OT | 5 Both PT and OT | 6 Home Care | 7 ATC | 8 MT | 9 Other _____ |

3. Name and credentials of the individual performing the service(s)

4. Alternate name (if any) of entity in box #1   5. NPI of entity in box #1   6. Phone number

7. Address of the billing provider or facility indicated in box #1   8. City   9. State   10. Zip code

---

Provider Completes This Section:

Date you want THIS submission to begin:

Patient Type
1. New to your office
2. Est'd, new injury
3. Est'd, new episode
4. Est'd, continuing care

Cause of Current Episode
1. Traumatic
2. Unspecified
3. Repetitive
4. Post-surgical →
5. Work related
6. Motor vehicle

Date of Surgery

Type of Surgery
1. ACL Reconstruction
2. Rotator Cuff/Labral Repair
3. Tendon Repair
4. Spinal Fusion
5. Joint Replacement
6. Other _____

Diagnosis (ICD codes)
Please ensure all digits are entered accurately

1°
2°
3°
4°

Nature of Condition
1. Initial onset (within last 3 months)
2. Recurrent (multiple episodes of < 3 months)
3. Chronic (continuous duration > 3 months)

DC ONLY
Anticipated CMT Level
○ 98940   ○ 98942
○ 98941   ○ 98943

Current Functional Measure Score
Neck Index [   ]   DASH [   ]   (other FOM)
Back Index [   ]   LEFS [   ]

Patient Completes This Section:
(Please fill in selections completely)

Symptoms began on:

Indicate where you have pain or other symptoms:

1. Briefly describe your symptoms:

2. How did your symptoms start?

3. Average pain intensity:
Last 24 hours: no pain (0)(1)(2)(3)(4)(5)(6)(7)(8)(9)(10) worst pain
Past week: no pain (0)(1)(2)(3)(4)(5)(6)(7)(8)(9)(10) worst pain

4. How often do you experience your symptoms?
(1) Constantly (76%-100% of the time) (2) Frequently (51%-75% of the time) (3) Occasionally (26% - 50% of the time) (4) Intermittently (0%-25% of the time)

5. How much have your symptoms interfered with your usual daily activities? (including both work outside the home and housework)
(1) Not at all   (2) A little bit   (3) Moderately   (4) Quite a bit   (5) Extremely

6. How is your condition changing, since care began at this facility?
(0) N/A — This is the initial visit   (1) Much worse (2) Worse (3) A little worse (4) No change (5) A little better (6) Better (7) Much better

7. In general, would you say your overall health right now is...
(1) Excellent   (2) Very good   (3) Good   (4) Fair   (5) Poor

Patient Signature: X _____   **Date:** _____

PATIENT SUMMARY FORM ONLINE

Submit a Clinical Sub	Clinical Sub Status	Submit a Claim	Claims Sta

Patient Summary Form   * - Requ

>> Patient Information

Last Name: Jane   **First Name:** Smith   **MI:** M   **Sex:** F   **DOB:** 05/29/198

Address: 112 Main St   **City:** Punxsutawney   **State:** PA   **Zip:** 15767

ID#: 80924564   **Health Plan:** UnitedHealthcare   **Group:** 7J7034

>> Referral Information

Physician: _____   **Date Issued:** _____ *mm/dd/yyyy*   **Referral Number:** _____

   (if applicable)   (if applicable)   (if applicab

>> Provider Information

Phoenix Rehab Health Services, PT   **Office Location:** 71 N Juniata St Ste A, Lewistown PA

* **Credentials:** ☐ MD/DO   ☐ DC   ☐ PT   ☐ OT   ☐ Both PT and OT   ☐ Home Care   ☐ ATC   ☐ MT   ☐ Other _____

>> Provider Completes This Section

* **Date you want THIS submission to begin:** _____ *mm/dd/yyyy*

* **Patient Type:**

   ○ 1 - New to your office   ○ 2 - Est'd, new injury   ○ 3 - Est'd, new episode   ○ 4 - Est'd, continuing care

* **Nature of Condition:**

   ○ 1 - Initial onset (within last 3 months)   ○ 2 - Recurrent (multiple episodes of < 3 months)   ○ 3 - Chronic (continuous duration > 3

* **Cause of Current Episode:**

   ☐ Traumatic   ☐ Unspecified   ☐ Repetitive   ☐ Post-surgical   ☐ Work related   ☐ Motor vehicle

* **Diagnosis (ICD code):**

   _____ _____ _____ _____

Current Functional Measure Score:

Neck Index ____		Back Index ____	Keele STarT Back Screening Tool (SBST)
DASH ____		LEFS ____	____ ____
			(other)

>> Patient Completes This Section

Symptoms began on: _____ *mm/dd/yyyy*

Briefly describe your symptoms:

_____

How did your symptoms start?

_____

Average pain intensity:

Last 24 hours: no pain ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 **worst pain**

Past week: no pain ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 **worst pain**

How often do you experience your symptoms?

○ 1 - Constantly (76% - 100% of the time) ○ 2 - Frequently (51% - 75% of the time)

○ 3 - Occasionally (26% - 50% of the time) ○ 4 - Intermittently (0% - 25% of the time)

How much have your symptoms interfered with your daily activities?

○ 1 - Not at all ○ 2 - A little bit ○ 3 - Moderately ○ 4 - Quite a bit ○ 5 - Extremely

How is your condition changing, since care at *this* facility?

○ N/A - This is the initial visit ○ 1 - Much worse ○ 2 - Worse ○ 3 - A little worse

○ 4 - No change ○ 5 - A little better ○ 6 - Better ○ 7 - Much better

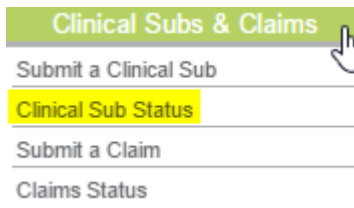In general, would you say your overall health right now is...

○ 1 - Excellent ○ 2 - Very good ○ 3 - Good ○ 4 - Fair ○ 5 - Poor

Completion Date: [   ] *mm/dd/yyyy*

○ Print Page ▬▬▬▬▬

**Please print this page for you records before clicking the Submit button.

1. Click Print Page and Submit Authorization, Print Confirmation Page
2. Scan Printed Page & Confirmation Page into RT Case Documents for Case as Type: Financial – Auth Submission Forms
3. Document in Benefits - Date, Auth submitted via Optum. Initials
4. Check Back for Authorization 3-5 Days by logging into Optum.
5. Go to Clinical Subs & Claims (only hover with your cursor)
6. Select Clinical Sub Status
7. Far Left Column will be >>Patients:
8. Click on letter of patient last name
9. Find patient name / DOB

Clinical Subs & Claims

Submit a Clinical Sub
Clinical Sub Status
Submit a Claim
Claims Status

>> Patients

A B C D E F G H I J K L M
N O P Q R S T U V W X Y Z

PATIENT NAME   PATDOB

10. Open Authorization and Print

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Please Note: Response Letters will be available online for 6 months after Optum Decision Date.

Clinical submissions on file for the selected patient

Reference Number	Patient Name	Date of Birth	Requested From	Status	Letter	Attachment(s)
▓▓▓▓▓	▓▓▓ ▓▓▓	▓▓▓▓▓	01/05/2017	Completed	Open Letter	NA

Showing 1 - 1 of 1   ◁◁ Page 1 of 1 ▷▷ ▷┤ 10 ▼

11. Enter Authorization into the Insurance / Payor
12. Scan into patients Case Documents as Type: Financial – Authorization

OPTUM – RESUBMISSION FOR DENIAL AND/OR CHANGE START DATE

1. Log In Optum
2. Select Green Clinical Subs & Claim Tab – Upper Left-hand corner
    a. Select Patient from your list on the left
    b. Submit clinical submission
3. Patient summary form comes up (with the patient you picked from list)
4. Pick office location
5. Next screen will come up then
    a. Provider information – complete
    b. Is this an Administrative correction to previous submission? (YOU WILL NEED YOUR ORIGINAL CINICAL SUBMISSION REFERENCE#)
        i. Check mark the Box
        ii. Drop down question will come up – (pick which one you want)
            1. Patient information
            2. Provider information
            3. Date you want to correct – submission to start
            4. CMT code
            5. Diagnosis code
    c. Provider completes this section (see attached example for reference)
        i. In this section there will be a drop-down box – pick the most accurate reason for clinical submission correction
        ii. The complete the entire information (get from your original clinical submission)
6. PRINT FORM
7. SUBMIT

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