

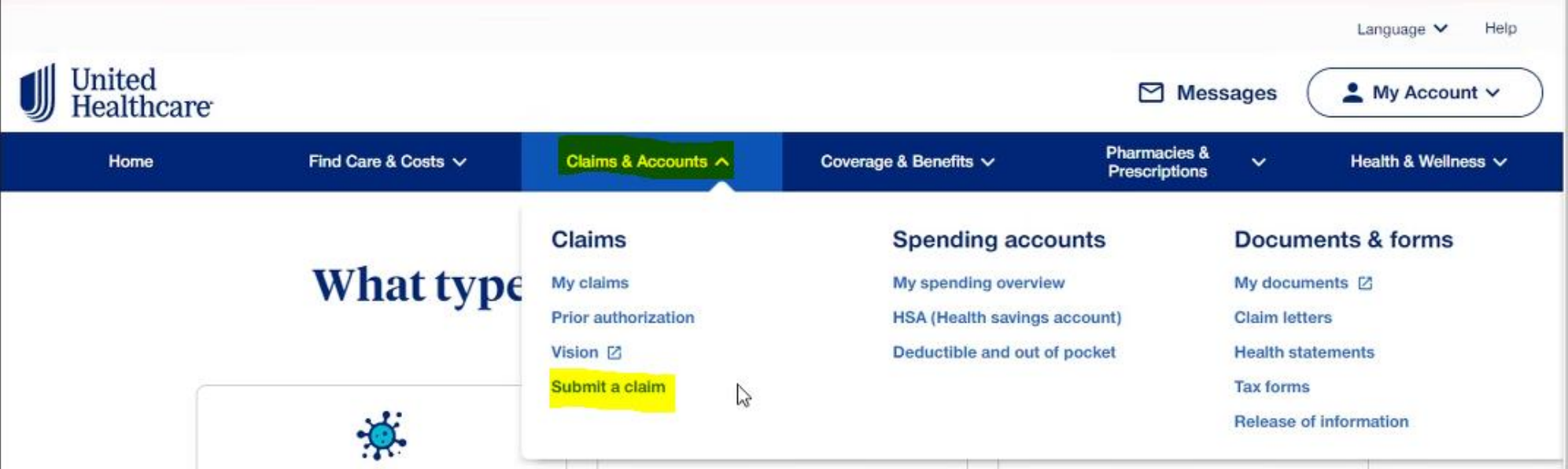


Medical Reimbursement Member Experience

United
Healthcare

Medical Reimbursement Experience

- Navigate to the 'Claims & Accounts' Tab from the Home Page and select 'Submit a claim'








Medical Reimbursement Experience

- Members will select the 'Start a claim' under the Medical benefit category

Home Find Care & Costs Claims & Accounts Coverage & Benefits Pharmacies & Prescriptions Health & Wellness


What type of claim would you like to submit?

Choose a claim from the list below

 COVID-19 At-Home Test For purchase of at-home test kits (Not for tests given by a provider) For test kits purchased by 5/11/2023(End of COVID-19 PHE) Start a claim	 Dental For dental and orthodontic services Start a claim	 Medical For qualified services and purchases including foreign care, professional COVID testing, DME, physical therapy and more Start a claim
 Mental Health For provider visits, substance use treatment and other services Start a claim	 Prescription Drugs For prescriptions covered through your Optum Rx plan Start a claim	





Medical Reimbursement Experience



Direct medical reimbursement form

For members seeking reimbursement for out-of-network services

Estimated time to complete:  **10 minutes**


Claim processing:  **10-15 business days**

Attention: This form applies to those that have insurance through their employer or have an individual plan through UnitedHealthcare and log in through myuhc.com. This excludes members with plans from Expat and Empire.

What you'll need

- Subscriber and patient information
- Amount charged and date for each procedure or service
- Easy to read medical claim, record, or receipt
- Proof of payment including procedure or service codes, if applicable

Important to know

 **This form is not for COVID-19 at-home test reimbursements.**
Go to your [COVID-19 resource page](#) to learn about submitting a request for at-home tests.

- This form is only for out-of-network claims
- You need to submit a separate form for each claim
- Confirm your plan benefits before submitting gym membership/equipment or Sweat Equity® claims
- Do not use this form if you are seeking reimbursement for a facility claim. Instead, print out and complete the [Facility medical claim form](#), and mail it to the address on the back of your ID card.
- Completing this form does not guarantee reimbursement

[Start new claim form](#)

- In order to get started the following is needed:
 - Subscriber ID and Plan/group #
 - Amount charged and date for each procedure or service
 - Easy to read medical claim, record, or receipt
 - Proof of payment
- Important things to know:
 - This form is only for out-of-network claims
 - You'll submit a separate form for each claim
 - Confirm your plan benefits before submitting
 - Reimbursement requests typically take 10-15 business days to process
 - Completing this form does not guarantee reimbursement
- Click **Start new claim form**



Medical Reimbursement Experience- Email Verification

United Healthcare **Direct medical reimbursement form**

1 Email verification 2 Member information 3 Patient information 4 Payer information 5 Sub

Let's verify your contact information

Please enter your email address. Click "Send code" and we'll email you a code to verify your address is valid. If you do not receive an email, please confirm the address entered is correct or check your spam folder.

Enter your email address *

Send code

Back

United Healthcare **Direct medical reimbursement form**

1 Email verification 2 Member information 3 Patient information 4 Payer information 5 Sub

Let's verify your contact information

Please enter your email address. Click "Send code" and we'll email you a code to verify your address is valid. If you do not receive an email, please confirm the address entered is correct or check your spam folder.

Enter your email address *

Resend code

Code sent. Please check your email for your code and enter it below.

Enter code *

Validate code

Back

- Verifying contact information is the first step of the experience.
- The submitter must follow the instructions on the page. A PIN will be sent to the email address provided on the experience.
- An email will be generated to the email address entered. Enter verification code from the email into the **Enter Code** field.
- Select **Validate code**.
 - Note: This is a one-time verification code.





Medical Reimbursement Experience-Subscriber Information

The screenshot shows the 'Subscriber information' section of a medical reimbursement form. At the top, the United Healthcare logo is on the left, and the title 'Direct medical reimbursement form' is in the center. Below the title is a progress bar with six steps: 2 Subscriber information (active), 3 Patient information, 4 Payer information, 5 Submission type, and 6 Attachments. The main heading is 'Subscriber information', followed by a note: 'Fields marked with an asterisk * are required'. Below that is a instruction: 'Please complete the subscriber's information. The subscriber is the policyholder.' Three input fields are highlighted with a red border: 'Member ID *', 'Subscriber's date of birth *' (with a placeholder 'mm/dd/yyyy'), and 'Group number *'. Each field has a question mark icon to its right. At the bottom are 'Back' and 'Next' buttons.

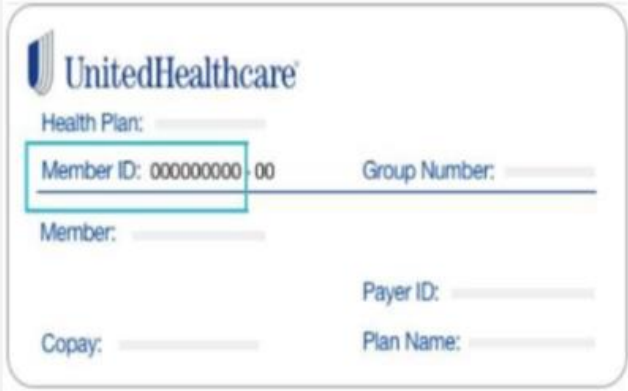
- Subscriber information is the next section of the experience.
 - Real-time member validation logic is applied using:
 - **Member ID**
 - **Group number**
 - **Subscriber's date of birth**
 - Due to privacy, member name and address information will auto populate and pass on the back end. This information will not be visible on the experience.
- If the user is logged into myuhc.com, some information may prefill:
 - Member ID number
 - Group number





Medical Reimbursement Experience-Subscriber Information

Member ID *  



Enter the Member ID located on the subscriber's ID card. Do not include numbers after the dash, spaces, or special characters (use 123456789 instead of 123456789-00)



Subscriber's date of birth *  

mm/dd/yyyy

Enter the subscriber's date of birth mm/dd/yyyy. Please ensure you're entering the subscriber's information. The subscriber is the policyholder.

Group number *  

Enter the group number located on the subscriber's ID card. Don't include numbers after the dash or space (use 1234567 instead of 1234567-00)

- Tool tip information is available to help guide the submitter to find their information.
- A picture of the ID card is also available.



Medical Reimbursement Experience-Patient Information

The screenshot shows the 'Patient information' panel of a United Healthcare Direct medical reimbursement form. At the top, the United Healthcare logo is on the left, and the title 'Direct medical reimbursement form' is in the center. Below the title is a progress bar with five steps: 3 Patient information (active), 4 Payer information, 5 Submission type, 6 Attachment details, and 7 Reimbursement details. The 'Patient information' section has a sub-header and a note: 'Fields marked with an asterisk * are required'. A red box highlights a selection area with the text 'Please select who this submission is for, we will accept one claim form per patient *' and three radio buttons: 'Subscriber', 'Spouse' (selected), and 'Dependent'. Below this, another red box highlights two input fields: 'Patient's first name *' and 'Patient's date of birth *'. The date of birth field has a placeholder 'mm/dd/yyyy'. At the bottom of the form are 'Back' and 'Next' buttons.

- On the Patient Information panel, select who the submission is for.
- If the submission is for a spouse or dependent, enter their information:
 - **Patient's first name**
 - **Patient's date of birth**
- A real-time validation will take place.



Medical Reimbursement Experience-Payer Information

United Healthcare Direct medical reimbursement form

3 Payer information 4 Submission type 5 Attachment details 6 Review and submit

Payer information

Fields marked with an asterisk * are required

Coordination of benefits (COB) is the process of figuring out which of 2 or more insurance policies has the main responsibility of processing or paying a claim and how much the other policies will contribute.

Please make sure your COB information is up-to-date. If not, it may take us longer to process your submission. By verifying this information it will ensure your COB is up-to-date.

Do you have other medical insurance? *

Yes No

Back Next

- The Payer information section dynamically displays questions based on the radio button selection.
- If the member has other insurance, the primary payer EOB is a required attachment.
- When **No** is selected in this section, the submitter will continue to move forward with the experience.

United Healthcare Direct medical reimbursement form

3 Payer information 4 Submission type 5 Attachment details 6 Review and submit

Payer information

Fields marked with an asterisk * are required

Coordination of benefits (COB) is the process of figuring out which of 2 or more insurance policies has the main responsibility of processing or paying a claim and how much the other policies will contribute.

Please make sure your COB information is up-to-date. If not, it may take us longer to process your submission. By verifying this information it will ensure your COB is up-to-date.

Do you have other medical insurance? *

Yes No

Is the other insurance primary? *

Yes No

Select the type of the primary insurance *

Medicare Commercial

Primary insurance start date *

mm/dd/yyyy

Please upload the primary payers explanation of benefits

Accepted file types: DOC, DOCX, JPG, JPEG, MSG, PDF, PNG, TIF, TIFF, TXT

Maximum file size: 25 MB

EOB attachment

Upload attachment

Attached: 0



Medical Reimbursement Experience-Foreign/Cruise Ship

United Healthcare Direct medical reimbursement form

1 Payer information 4 Submission type 5 Attachment details 6 Review and submit

Submission type

Fields marked with an asterisk * are required

Did you receive your services on a cruise or in a foreign country? *

Yes No

Note: Puerto Rico, U.S. Virgin Islands, Guam, the Northern Mariana Islands, Saipan, Tinian, Rota, and American Samoa are U.S. territories, not foreign countries.

Back Next

- The initial submission type displayed is for cruise or foreign country reimbursement. In this section the form dynamically displays questions based on the radio button selection.
- If **Yes** is selected, cruise or foreign submission details are presented.
- The submitter is asked to enter the total amount in US dollars.

United Healthcare Direct medical reimbursement form

4 Submission type 5 Submission details 6 Attachment details 7 Review and submit

Submission details

Fields marked with an asterisk * are required

What country did the treatment take place in? *

Select the option that applies *

I am traveling internationally for pleasure

I am an expatriate or retiree living abroad

I am traveling internationally for business, but live in the U.S

Provider information

Individual Provider name or Facility name *

Provider address

Provider city Provider postal code Region Country

Start date of service * End date of service *

A brief explanation of the purpose of your health care provider visit (including services rendered and/or procedures performed) *

What is the total amount of the claim in U.S. Dollars? Currency paid in *

Back Next



Medical Reimbursement Experience-Submission Type

United Healthcare Direct medical reimbursement form

1 Payer information 2 Submission type 3 Provider information 4 Submission details

Submission type

Fields marked with an asterisk * are required

Did you receive your services on a cruise or in a foreign country? *

Yes No

Note: Puerto Rico, U.S. Virgin Islands, Guam, the Northern Mariana Islands, Saipan, Tinian, Rota, and American Samoa are U.S. territories, not foreign countries.

Please select the type of service being submitted for reimbursement. Make sure that the option selected is a service covered under the subscriber's medical benefit plan. Payment is not guaranteed because these reimbursement types could be specialty services specific to the subscriber's benefit plan.

Submission type *

Medical Claim (All other reimbursement types)

- Acupuncture
- Appeal and Grievance
- Behavioral Health
- Breast Pump or Nursing Bra
- COVID 19 Testing
- COVID 19 Vaccine Administration
- Durable Medical Equipment
- Electrolysis
- Gym / Fitness
- Hearing Aid
- Infant Formula
- Injectable Drug
- Laser Hair Removal
- Massage Therapy
- Medical Claim (All other reimbursement types)
- Prescription Reimbursement
- Speech Therapy
- Therapy (i.e. Physical Therapy, Occupational Therapy, Chiropractic Services)
- Vision-Lens, frames, or contact lens
- Voice Lesson

- If **No** is selected for cruise/foreign submissions, the submitter will be presented additional reimbursement types.
- Select the type of reimbursement being submitted.
- Only 1 reimbursement type can be selected at a time.
- There are 22 options available to members, and members will see the option to select '**Gym / Fitness**' for their specific reimbursement



Medical Reimbursement Experience – Submission Details

- Members will then be prompted to complete a series of questions regarding the membership start/end dates, amount requested, and total charge amount.
- Note: There are four options, Gym Membership, Gym Equipment, Sweat Equity, and Weight Loss.

Direct medical reimbursement form

Submission type 6 Submission details 7 Attachment details 8 Review and submit

Submission details

Fields marked with an asterisk * are required

Select your purchase or service *

Gym membership

Start date * End date * Total charge amount *

mm/dd/yyyy mm/dd/yyyy

Back Next



Medical Reimbursement Experience – Upload Attachments

- Members are required to submit their gym membership contract and receipt for reimbursement



Direct medical reimbursement form

✓ Submission type ✓ Submission details **7** Attachment details 8 Review and submit

Attachment details

Fields marked with an asterisk * are required

Your documentation must include the following:

1. Signatures from a facility representative or class administrator to prove the use.
2. Receipts or proof of payment that show the dates of your fitness facility visits and/or classes, with the name of the place.

Add up to 20 receipts. Each receipt should clearly show who received payment, the date and the amount paid.

Accepted file types: DOC, DOCX, JPG, JPEG, MSG, PDF, PNG, TIF, TIFF, TXT

Maximum file size: 25 MB

[Upload attachment](#)

Attached: 0

[Back](#) [Next](#)



Medical Reimbursement Experience – Review and Submit

- Prior to submitting, users are shown a summary of their entries.
- Click the **Edit** link to the right of each section to return to that panel and edit the entries.

The screenshot shows the 'Review and submit' section of the United Healthcare Direct medical reimbursement form. At the top, there is a progress bar with four steps: 'Provider information', 'Submission details', 'Attachment details', and 'Review and submit', with the last step being active. The form title is 'Direct medical reimbursement form'. Below the title, there are four tabs: 'Provider information', 'Submission details', 'Attachment details', and 'Review and submit', with the last tab selected. The main content area is titled 'Review and submit' and includes a note: 'Fields marked with an asterisk * are required'. Below this, there is a section 'Please review the information below.' followed by several sections, each with an 'Edit' link: 'Subscriber information', 'Payer information', 'Submission type', 'Provider information', and 'Submission details'. Each section contains a list of fields with their values. For example, in the 'Subscriber information' section, 'Member ID *' is a text field, 'Subscriber's date of birth *' is a date field, 'Group number *' is a text field, and 'Please select who this submission is for, we will accept one claim form per patient *' is a radio button selection with 'Subscriber' selected. In the 'Submission details' section, 'Diagnosis code(s) (ICD 10) *' is 'Z28', 'Procedure code (CPT/HCPCS code) *' is 'N/A', 'NDC number' is 'N/A', 'Units / quantity *' is '1', 'Start date of service *' is '01/01/2023', 'End date of service *' is '01/01/2023', and 'Total charge amount *' is a text field. At the bottom, there is an 'Attachment details' section with the question 'Are you uploading any of the following attachments with your claim (check all that apply) .' and a radio button selection with 'N/A' selected. Below this, there is a 'File Name' field with the value 'MedicalClaim.txt'.

United Healthcare Direct medical reimbursement form

Provider information Submission details Attachment details **Review and submit**

Review and submit

Fields marked with an asterisk * are required

Please review the information below.

Subscriber information [Edit](#)

Member ID *
Subscriber's date of birth *
Group number *
Please select who this submission is for, we will accept one claim form per patient * Subscriber

Payer information [Edit](#)

Do you have other medical insurance? * No

Submission type [Edit](#)

Did you receive your services on a cruise or in a foreign country? * No

Submission type * Medical Claim (All other reimbursement types)
 Office

Where were the services rendered? * Office

Provider information [Edit](#)

Provider Tax Identification Number (TIN) *
Individual provider or Provider group *
Provider group name *
Zip code *

Submission details [Edit](#)

Diagnosis code(s) (ICD 10) * Z28
Procedure code (CPT/HCPCS code) * N/A
NDC number N/A
Units / quantity * 1
Start date of service * 01/01/2023
End date of service * 01/01/2023
Charge amount *
Total charge amount *

Attachment details [Edit](#)

Are you uploading any of the following attachments with your claim (check all that apply) . N/A

File Name MedicalClaim.txt



Medical Reimbursement Experience– Complete the Submission

Do not eSign until you have read the below statements:

From time to time, United Healthcare Services, Inc., or their affiliates, subsidiaries, agents, contractors, or vendors (we or us) may be required by law to provide to you certain written notices or disclosures. Please read the information below carefully and agree to this Electronic Record and Signature Disclosure (ERSD). Please confirm your agreement by selecting the check-box next to 'I agree to use electronic records and signatures' before signing this document'.

Getting paper copies

By checking this box and signing below, I agree to use electronic records and signatures; and acknowledge that I have read, understand and agree to all of the above.

Note: You need to scroll through the information above before you can check the box.

Submitter signature *

Submission date

02/13/2023

[Back](#) [Submit](#)

- Scroll through and review the legal disclosure information.
- After reviewing, check the box to agree and enter the submitter's name under **Submitter signature**.
- Click **Submit**.
- The submitter will receive a confirmation message that the submission is successful, and that a copy of the submission can be downloaded, printed, or saved for their records.

Thank you for your submission!

Confirmation #

Submitted on:

What happens next?

- We'll send you a confirmation email when your submission is accepted. The email will be sent to the email address verified in this submission.
- If we need more information from you to accept your submission, we'll email you within one business day.
- If we need more information from you once we've accepted your submission, we'll reach out to you based on your preferences. It's important to respond as soon as possible to ensure your claim is processed quickly.
- Claims typically take 15 business days to process.
- You can check the status of your request by visiting the claims overview page in your member account. It may take a few days for your request to appear online.

Please download and save a copy of this submission for your records before closing this window.

Your pop-up blocker may be preventing you from opening/printing this page. Please disable your pop-up blocker for this site before continuing.

[Open PDF](#)

[Close](#)

