

Provider remittance advice guidance for batched items or services

Overview

Under the No Surprises Act, certain items and services can be batched and considered jointly by the Independent Dispute Resolution (IDR) entity as part of 1 payment determination. Items and services can be batched when **all** the following apply:

- The items and services were provided by the same provider
- The items and services were covered by the same plan or issuer
- The items and services are the same or similar
- The items and services were furnished within the same 30-business-day period, or the same 90-calendar-day period



What is the No Surprises Act?

- The No Surprises Act protects patients from surprise balance billing for defined out-of-network items and services
- The protections of the law won't apply if the member chooses to receive items and services from an out-of-network health care professional, with some exceptions
- It applies to individual, small group and large group fully insured markets and self-insured group plans
- The fastest way to submit a negotiation request is through the UnitedHealthcare Provider Portal

The following information and images provide additional details regarding the provider remittance advice (PRA) and how to determine which claims should be batched together under 1 payment determination:

1 Same provider

The items or services were provided by one of the following:

- Same provider
- Same group of providers
- Same facility
- Same air ambulance provider

They are considered the same if they're billed with the same National Provider Identifier (NPI) number and/or tax ID number (TIN).

PRA location:

You can find the following in the box at the top-right corner:

- TIN
- NPI number
- Payee name

United HealthCare Services, Inc.
ABC SERVICE CENTER
PO BOX 000000
CITY, STATE 00000-0000
PHONE: 1-877-000-0000

STD: PRA COMPANY LOGO

PROVIDER REMITTANCE ADVICE

PAYMENT DATE: 00/00/00
TIN: 000000000
NPI: 000000000
PAYEE NAME: COMPANY
PAYMENT NUMBER: XX00000000X
PAYMENT AMOUNT: \$000.00
GROUP NUMBER: 000000

ABC MEDICAL COMPANY
1234 MAIN STREET
CITY, STATE 00000-0000

PAYMENT DATE: 00/00/00
TIN: 000000000
NPI: 000000000
PAYEE NAME: COMPANY
PAYMENT NUMBER: XX00000000X
PAYMENT AMOUNT: \$000.00
GROUP NUMBER: 000000
GROUP NAME: COMPANY

| LINE CONTROL NUMBER | DATES OF SERVICE | SUB PROCD | ADJ PROCD | MOD | REV | UNITS | SUB UNITS | CHARGE | AMOUNT ALLOWED | ADJ AMOUNT | GRP CD | CLM ADJ | CLM PAYMENT | PATIENT RESPONSIBILITY | REMARKS/NOTES |
|---------------------|---------------------|-----------|-----------|-----|-----|-------|-----------|----------|----------------|------------|--------|---------|-------------|------------------------|---------------|
| XX0000X | 01/19/22 - 01/19/22 | 99203 | CS | | | 1 | 1 | \$000.00 | \$000.00 | \$000.00 | | | \$000.00 | | |

PATIENT: TWO FIRST LAST (FL)
SUBSCRIBER ID: XX00000000X SUBSCRIBER NAME: COMPANY CLAIM NUMBER: XX00000000X
CLAIM DATE: 00/00/00/00/00 DATE RECEIVED: 00/00/00 PRODUCT: XX00000000X
SEND PROV ID: XX00000000X SEND PROV: COMPANY

| PATIENT NUMBER | PATIENT ID | AUTH/REF NUMBER | DRG | DRG WEIGHT | CLAIM CHARGE AMOUNT | CLM ADJ AMT | GRP CD | CLM ADJ | CLM PAYMENT | PATIENT RESPONSIBILITY |
|----------------|------------|-----------------|-----|------------|---------------------|-------------|--------|---------|-------------|------------------------|
| XX0000X | | | | | \$000.00 | | | | \$000.00 | |

Service Line Details:
PAYMENT OF BENEFIT HAS BEEN MADE IN ACCORDANCE WITH THE TERMS OF THE MANAGED CARE SYSTEM.

2 Same plan or issuer

The items or services were covered by the same plan or issuer. The following information, combined, constitute the same plan or issuer:

- Issuer/third-party administrator legal entity name
- Group number
- Group name

PRA location:

You can locate the following in the box at the top-right corner:

- Group name
- Group number

Locate the following information in the top-left corner:

- For self-insured plans: The third-party administrator's legal entity name (e.g., United HealthCare Services, Inc.)

United HealthCare Services, Inc.
ABC SERVICE CENTER
PO BOX 000000
CITY, STATE 00000-0000
PHONE: 1-877-000-0000

STD: PRA COMPANY LOGO

PROVIDER REMITTANCE ADVICE

PAYMENT DATE: 00/00/00
TIN: 000000000
NPI: 000000000
PAYEE NAME: COMPANY
PAYMENT NUMBER: XX00000000X
PAYMENT AMOUNT: \$000.00
GROUP NUMBER: 000000
GROUP NAME: COMPANY

ABC MEDICAL COMPANY
1234 MAIN STREET
CITY, STATE 00000-0000

United HealthCare Services, Inc.
ABC SERVICE CENTER
PO BOX 000000
STATE 00000-0000

PAYMENT DATE: 00/00/00
TIN: 000000000
NPI: 000000000
PAYEE NAME: COMPANY
PAYMENT NUMBER: XX00000000X
PAYMENT AMOUNT: \$000.00
GROUP NUMBER: 000000
GROUP NAME: COMPANY

| LINE CONTROL NUMBER | DATES OF SERVICE | SUB PROCD | ADJ PROCD | MOD | REV | UNITS | SUB UNITS | CHARGE | AMOUNT ALLOWED | ADJ AMOUNT | GRP CD | CLM ADJ | CLM PAYMENT | PATIENT RESPONSIBILITY | REMARKS/NOTES |
|---------------------|---------------------|-----------|-----------|-----|-----|-------|-----------|----------|----------------|------------|--------|---------|-------------|------------------------|---------------|
| XX0000X | 01/19/22 - 01/19/22 | 99203 | CS | | | 1 | 1 | \$000.00 | \$000.00 | \$000.00 | | | \$000.00 | | |

PATIENT: TWO FIRST LAST (FL)
SUBSCRIBER ID: XX00000000X SUBSCRIBER NAME: COMPANY CLAIM NUMBER: XX00000000X
CLAIM DATE: 00/00/00/00/00 DATE RECEIVED: 00/00/00 PRODUCT: XX00000000X
SEND PROV ID: XX00000000X SEND PROV: COMPANY

| PATIENT NUMBER | PATIENT ID | AUTH/REF NUMBER | DRG | DRG WEIGHT | CLAIM CHARGE AMOUNT | CLM ADJ AMT | GRP CD | CLM ADJ | CLM PAYMENT | PATIENT RESPONSIBILITY |
|----------------|------------|-----------------|-----|------------|---------------------|-------------|--------|---------|-------------|------------------------|
| XX0000X | | | | | \$000.00 | | | | \$000.00 | |

Service Line Details:
PAYMENT OF BENEFIT HAS BEEN MADE IN ACCORDANCE WITH THE TERMS OF THE MANAGED CARE SYSTEM.

2 Same plan or issuer (cont.)

PRA location:

- **For fully insured plans:** The issuer's legal entity name (e.g., UnitedHealthcare Insurance Company)

If not located on the PRA, you can also find the group name and group number on the member's ID card.

UnitedHealthcare Insurance Company

PROVIDER REMITTANCE ADVICE

PAYMENT DATE: 00/30/00
 TIN: 000000000
 NPI: 000000000
 PAYEE NAME: COMPANY
 PAYMENT NUMBER: X00000000X
 PAYMENT AMOUNT: \$900.00
 GROUP NUMBER: 00000
 GROUP NAME: COMPANY

CLAIM NUMBER: X00000000X
 PRODUCT: X00000000X

| LINE CTRL# | DATES OF SERVICE | SUB PROD/ SVC/ MOD | ADI PROD/ SVC/ MOD | MOD | REV | UNITS | SUB UNITS | CHARGE | AMOUNT ALLOWED | ADI AMOUNT | GRP CD | CLM ADJ RSN CD | CLM PAYMENT AMOUNT | PAYMENT RESPONSIBILITY | REMARKS/ NOTES |
|------------|---------------------|--------------------|--------------------|-----|-----|-------|-----------|----------|----------------|------------|--------|----------------|--------------------|------------------------|----------------|
| X00000X | 01/19/02 - 01/19/02 | | 9928 | CS | | 1 | 1 | \$900.00 | \$900.00 | \$900.00 | | | \$900.00 | | |

PAYMENT OF BENEFITS HAS BEEN MADE IN ACCORDANCE WITH THE TERMS OF THE MANAGED CARE SYSTEM.

PATIENT: TWO FIRST LAST (FL)

SUBSCRIBER ID: X00000000X
 CLAIM DATE: 00/00/0000/00/00
 SEND PROV ID: X00000000X

SUBSCRIBER NAME: COMPANY
 DATE RECEIVED: 00/00/00
 SEND PROV: COMPANY

CLAIM NUMBER: X00000000X
 PRODUCT: X00000000X

PATIENT CONTROL NUMBER: X00000X

PATIENT ID: X00000X

AUTH/REF NUMBER: 9928

DRG: CS

DRG WEIGHT: 1

CLAIM CHARGE AMOUNT: \$900.00

CLM ADJ AMT: \$900.00

GRP CD: CS

CLM ADJ RSN CD: CS

CLM PAYMENT AMOUNT: \$900.00

PAYMENT RESPONSIBILITY: CS

Service Line Details:

| LINE CTRL# | DATES OF SERVICE | SUB PROD/ SVC/ MOD | ADI PROD/ SVC/ MOD | MOD | REV | UNITS | SUB UNITS | CHARGE | AMOUNT ALLOWED | ADI AMOUNT | GRP CD | CLM ADJ RSN CD | CLM PAYMENT AMOUNT | PAYMENT AMOUNT | REMARKS/ NOTES |
|------------|---------------------|--------------------|--------------------|-----|-----|-------|-----------|----------|----------------|------------|--------|----------------|--------------------|----------------|----------------|
| X00000X | 01/19/02 - 01/19/02 | | 9928 | CS | | 1 | 1 | \$900.00 | \$900.00 | \$900.00 | | | \$900.00 | \$900.00 | |

PAYMENT OF BENEFITS HAS BEEN MADE IN ACCORDANCE WITH THE TERMS OF THE MANAGED CARE SYSTEM.

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3 Same or similar items or services

The items or services were the same or similar. They are considered the same or similar if they're billed under the same service code. Or if applicable, a comparable code under a different procedural code system, such as CPT®, HCPCS or diagnosis-related group (DRG) with any modifiers.

PRA location:

You can find the **procedure code**, **service code** and **modifier** information on the PRA.

UnitedHealthcare Insurance Company

PROVIDER REMITTANCE ADVICE

PAYMENT DATE: 00/30/00
 TIN: 000000000
 NPI: 000000000
 PAYEE NAME: COMPANY
 PAYMENT NUMBER: X00000000X
 PAYMENT AMOUNT: \$900.00
 GROUP NUMBER: 00000
 GROUP NAME: COMPANY

CLAIM NUMBER: X00000000X
 PRODUCT: X00000000X

| LINE CTRL# | DATES OF SERVICE | SUB PROD/ SVC/ MOD | ADI PROD/ SVC/ MOD | MOD | REV | UNITS | SUB UNITS | CHARGE | AMOUNT ALLOWED | ADI AMOUNT | GRP CD | CLM ADJ RSN CD | CLM PAYMENT AMOUNT | PAYMENT RESPONSIBILITY | REMARKS/ NOTES |
|------------|---------------------|--------------------|--------------------|-----|-----|-------|-----------|----------|----------------|------------|--------|----------------|--------------------|------------------------|----------------|
| X00000X | 01/19/02 - 01/19/02 | | 9928 | CS | | 1 | 1 | \$900.00 | \$900.00 | \$900.00 | | | \$900.00 | | |

PAYMENT OF BENEFITS HAS BEEN MADE IN ACCORDANCE WITH THE TERMS OF THE MANAGED CARE SYSTEM.

PATIENT: ONE FIRST LAST (FL)

SUBSCRIBER ID: X00000000X
 CLAIM DATE: 00/00/0000/00/00
 SEND PROV ID: X00000000X

SUBSCRIBER NAME: COMPANY
 DATE RECEIVED: 00/00/00
 SEND PROV: COMPANY

CLAIM NUMBER: X00000000X
 PRODUCT: X00000000X

PATIENT CONTROL NUMBER: X00000X

PATIENT ID: X00000X

AUTH/REF NUMBER: 9928

DRG: CS

DRG WEIGHT: 1

CLAIM CHARGE AMOUNT: \$900.00

CLM ADJ AMT: \$900.00

GRP CD: CS

CLM ADJ RSN CD: CS

CLM PAYMENT AMOUNT: \$900.00

PAYMENT RESPONSIBILITY: CS

Service Line Details:

| LINE CTRL# | DATES OF SERVICE | SUB PROD/ SVC/ MOD | ADI PROD/ SVC/ MOD | MOD | REV | UNITS | SUB UNITS | CHARGE | AMOUNT ALLOWED | ADI AMOUNT | GRP CD | CLM ADJ RSN CD | CLM PAYMENT AMOUNT | PAYMENT AMOUNT | REMARKS/ NOTES |
|------------|---------------------|--------------------|--------------------|-----|-----|-------|-----------|----------|----------------|------------|--------|----------------|--------------------|----------------|----------------|
| X00000X | 01/19/02 - 01/19/02 | | 99283 | CS | | 1 | 1 | \$900.00 | \$900.00 | \$900.00 | | | \$900.00 | \$900.00 | |

PAYMENT OF BENEFITS HAS BEEN MADE IN ACCORDANCE WITH THE TERMS OF THE MANAGED CARE SYSTEM.

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Same 30- or 90-day period

The items or services were provided within the same 30-business-day period or the same 90-calendar-day period.

PRA location:

You can find the **dates of service** on the PRA.

Your Independent Dispute Resolution (IDR) rights

After the Open Negotiation period is exhausted, you may have the right to file an Independent Dispute Resolution (IDR) through the Centers for Medicare & Medicaid Services (CMS) portal. If you file an IDR, please forward a copy of the completed Notice of IDR Initiation form you submitted to UnitedHealthcare at uhg_idr_disputes@uhc.com. Please also use this email address when the CMS IDR form prompts you to provide an email address for UnitedHealthcare.

PROVIDER REMITTANCE ADVICE

United HealthCare Services, Inc.
ABC SERVICE CENTER
PO BOX 000000
CITY, STATE 00000-0000
PHONE: 1-877-000-0000

ABC MEDICAL COMPANY
1234 MOCKINGBIRD LANE
CITY, STATE 00000-0000

PATIENT: ONE FIRST LAST (FL)

| PATIENT CONTROL NUMBER | PATIENT ID | ADP/REF NUMBER | DRG | DRG WEIGHT | CLAIM CHARGE AMOUNT | CLM ADJ AMT | GRP CD | CLM ADJ RSN CD | CLAIM PAYMENT AMOUNT | PATIENT RESPONSIBILITY |
|------------------------|------------|----------------|-----|------------|---------------------|-------------|--------|----------------|----------------------|------------------------|
| XX0000X | | | | | \$000.00 | | | | \$000.00 | |

SERVICE LINE DETAILS

| LINE CTRL# | DATES OF SERVICE | SUB PROD/ SVC/ MOD | ADJ PROD/ SVC/ MOD | REV | UNITS | S/R UNITS | CHARGE | AMOUNT ALLOWED | ADJ AMOUNT | GRP CD | CLM ADJ RSN CD | PAYMENT AMOUNT | REMARKS/NOTES |
|------------|---------------------|--------------------|--------------------|-----|-------|-----------|----------|----------------|------------|--------|----------------|----------------|---------------|
| XX0000X | 01/19/22 - 01/19/22 | 99283 | CS | | 1 | | \$000.00 | \$000.00 | \$000.00 | | | \$000.00 | |

PATIENT: TWO FIRST LAST (FL)

| LINE CTRL# | DATES OF SERVICE | SUB PROD/ SVC/ MOD | ADJ PROD/ SVC/ MOD | REV | UNITS | S/R UNITS | CHARGE | AMOUNT ALLOWED | ADJ AMOUNT | GRP CD | CLM ADJ RSN CD | PAYMENT AMOUNT | REMARKS/NOTES |
|------------|---------------------|--------------------|--------------------|-----|-------|-----------|----------|----------------|------------|--------|----------------|----------------|---------------|
| XX0000X | 01/19/22 - 01/19/22 | 99283 | CS | | 1 | | \$000.00 | \$000.00 | \$000.00 | | | \$000.00 | |

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Questions?

For more information about the No Surprises Act, please see the [CMS No Surprises Act page](#). If you have questions about a specific claim, please connect with us through chat 24/7 in the [UnitedHealthcare Provider Portal](#).

Please note: Images and sample data are for demonstration purposes only.

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Health plan coverage provided by UnitedHealthcare of Arizona, Inc., UHC of California DBA UnitedHealthcare of California, UnitedHealthcare Benefits Plan of California, UnitedHealthcare Community Plan, Inc., UnitedHealthcare of Colorado, Inc., UnitedHealthcare of Florida, Inc., UnitedHealthcare of Georgia, Inc., UnitedHealthcare of Illinois, Inc., UnitedHealthcare of the Mid-Atlantic, Inc., UnitedHealthcare of Mississippi, Inc., MAMSI Life and Health Insurance Company, UnitedHealthcare of New Mexico, Inc., UnitedHealthcare of New York, Inc., UnitedHealthcare Insurance Company of New York, UnitedHealthcare of North Carolina, Inc., UnitedHealthcare of Ohio, Inc., UnitedHealthcare of Oklahoma, Inc., UnitedHealthcare of Oregon, Inc., UnitedHealthcare of Pennsylvania, Inc., UnitedHealthcare of South Carolina, Inc., UnitedHealthcare of Texas, Inc., UnitedHealthcare Benefits of Texas, Inc., UnitedHealthcare of Utah, Inc., UnitedHealthcare of Washington, Inc., UnitedHealthcare of Wisconsin, Inc., Optimum Choice, Inc., Oxford Health Insurance, Inc., Oxford Health Plans (NJ), Oxford Health Plans (CT), Inc., All Savers Insurance Company, Rocky Mountain Health Maintenance Organization Incorporated, Tufts Health Freedom Insurance Company or other affiliates. Administrative services provided by OptumHealth Care Solutions, LLC, OptumRx, Oxford Health Plans LLC, United HealthCare Services, Inc., Tufts Health Freedom Insurance Company or other affiliates. Behavioral health products provided by U.S. Behavioral Health Plan, California (USBHPC), United Behavioral Health (UBH), or its affiliates.

