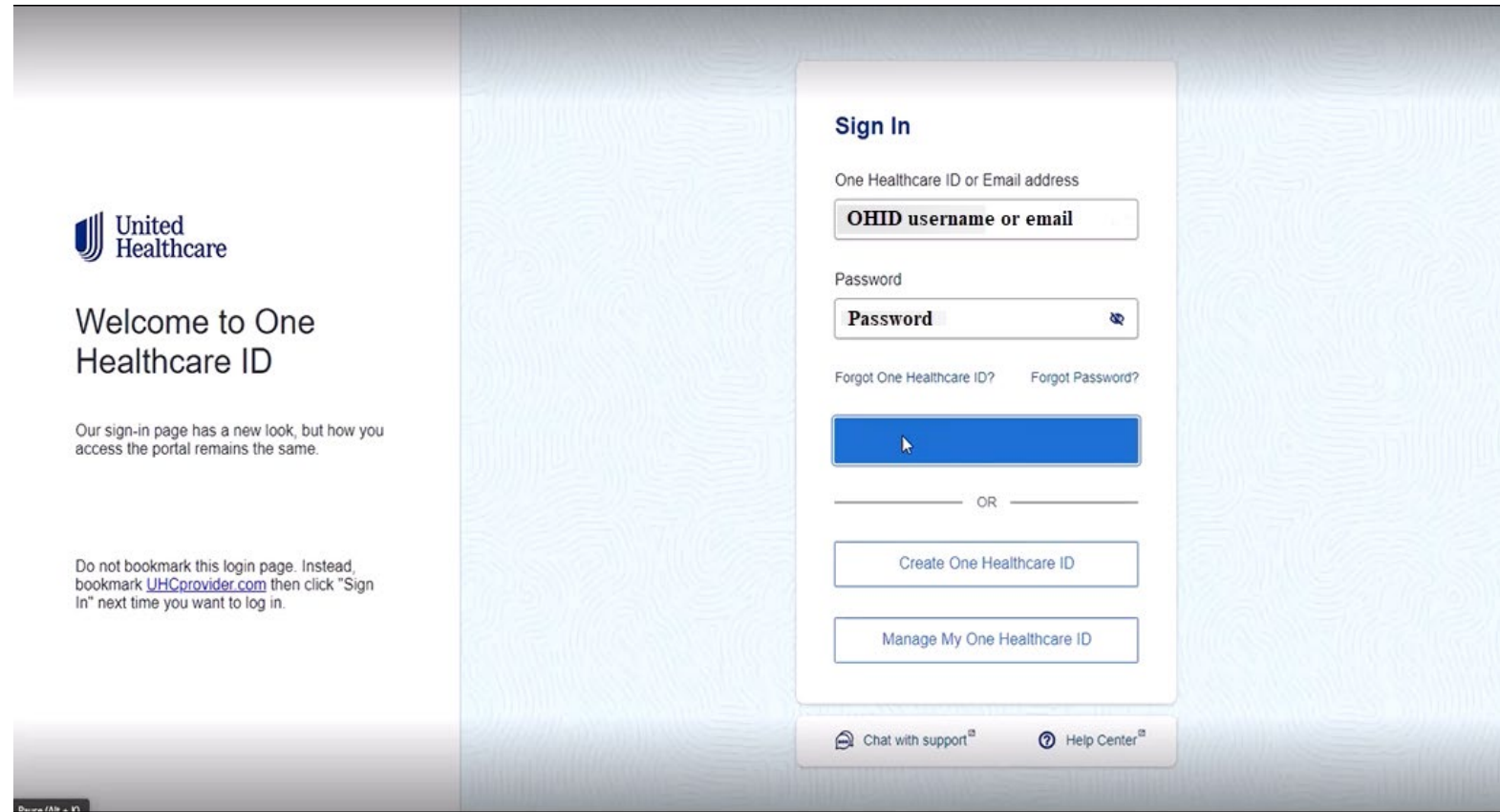




Rocky Mountain Health Plans Provider Portal Training Guide 2024

Logging Into UHC Portal Site

- Log in using the One Healthcare ID and password that has been assigned during the registration process.



The screenshot displays the United Healthcare login interface. On the left, the United Healthcare logo is positioned above the text "Welcome to One Healthcare ID". Below this, a message states: "Our sign-in page has a new look, but how you access the portal remains the same." Further down, it advises: "Do not bookmark this login page. Instead, bookmark UHCprovider.com then click 'Sign In' next time you want to log in."

On the right, the "Sign In" section contains the following elements:

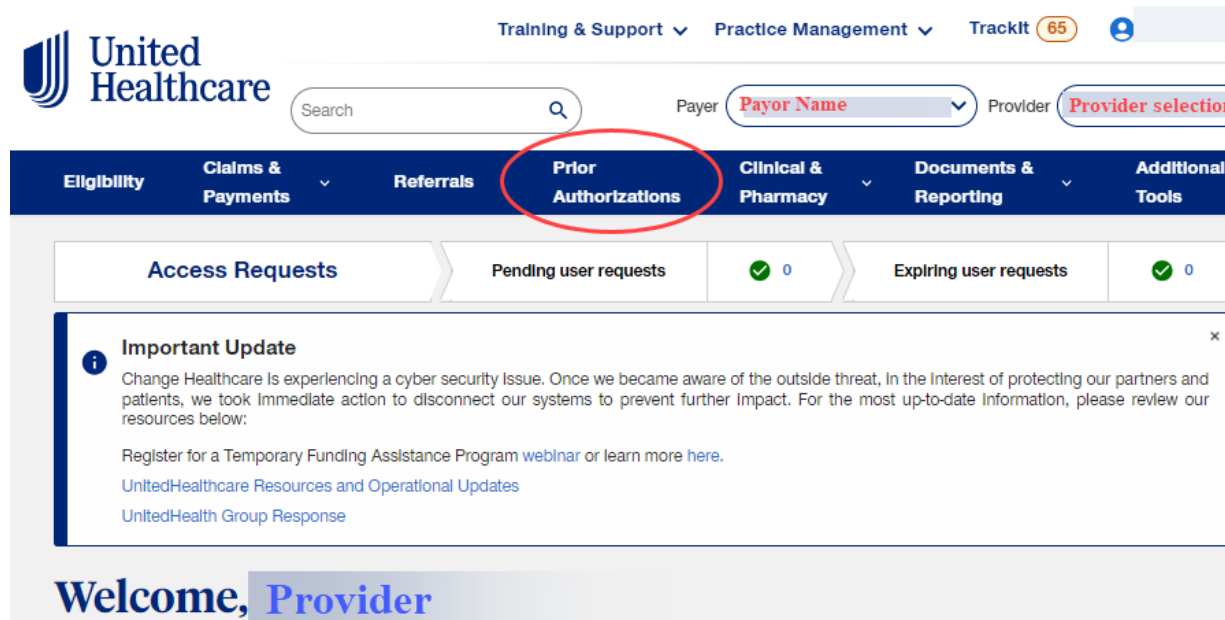
- A label "One Healthcare ID or Email address" above a text input field containing "OHID username or email".
- A label "Password" above a text input field containing "Password".
- Links for "Forgot One Healthcare ID?" and "Forgot Password?".
- A large blue button with a white cursor icon.
- A separator line with the text "OR" in the center.
- A button labeled "Create One Healthcare ID".
- A button labeled "Manage My One Healthcare ID".

At the bottom of the sign-in panel, there are two links: "Chat with support" and "Help Center".



Accessing RMHP Prior Auth in UHC Portal

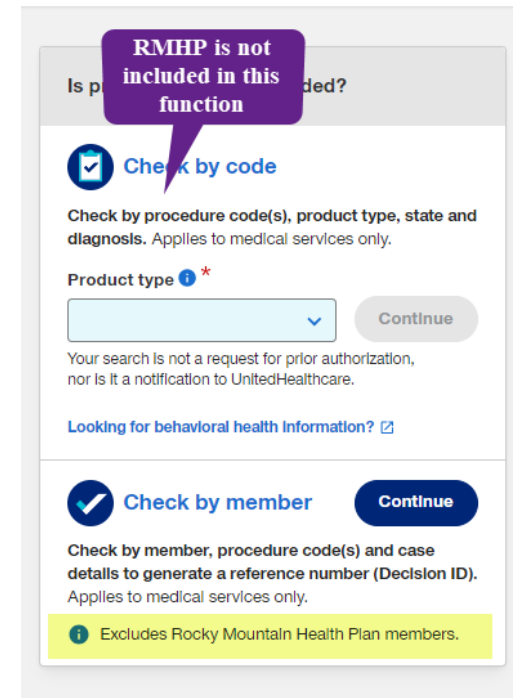
- Once logged in, you will select “Prior Authorizations” at the top in the blue ribbon.



- The next screen will have a “Check by code” section. This does not work for RMHP codes.

Prior Authorizations and Notifications

Shortcuts to page sections: [Create new prior authorization](#) | [Peer-to-peer](#)



Accessing RMHP Prior Auth in UHC Portal Cont'd

- To submit a prior auth for RMHP, select “**Standard medical requests**”.
- For EviCore/Radiology submit prior authorization on the EviCore provider website.

Create a new prior authorization submission

Currently selected provider: **Provider Name** [Edit](#)

Select a request category to **create a new prior authorization**. For some category types, such as radiology and cardiology, you will also be able to use this search to **view submission status**.

Select prior authorization type for submission *

Create new submission (existing submission status can be located below)

- Standard medical requests (not listed below)
- Genetic molecular testing
- Inpatient admission notifications
- Skilled nursing

Create new submission or view existing submission status

- Cardiology
- Gastroenterology endoscopy
- Oncology
- Physical health (physical therapy, occupational therapy and speech therapy)
- Radiology
- Radiation oncology
- Specialty pharmacy



Searching for Member

- Select the search criteria and type in required (*) information. The member information will populate once search is performed.

 Medical services only.

Select your search criteria *

Member ID & date of birth 

Member ID *

Member date of birth *

 Show optional fields

Expected service start date *

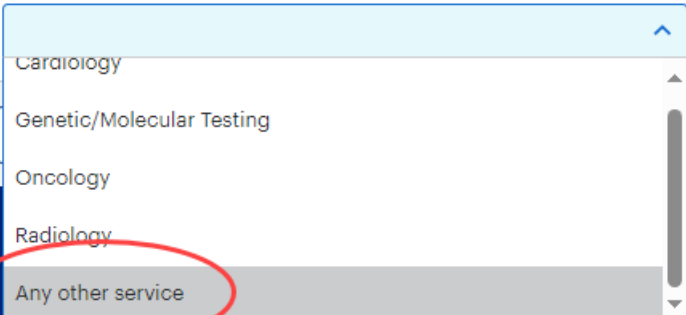


MM/DD/YYYY

- RMHP Members will show the below disclaimer. Select “**Any Other Service**” for physical/medical health including DME requests.

Prior authorization/notification details

This member is part of the Rocky Mountain Health Plan. What type of service are you requesting? *



Cardiology

Genetic/Molecular Testing

Oncology

Radiology

Any other service

UHC



Prior Auth Landing page

- After clicking on “Continue”, there will be a redirection notice (shown below). Click “Continue” to move on to the prior auth page.

You are being redirected.

 For the best experience, please enable popups for the UnitedHealthcare Provider Portal.

You are now leaving the UnitedHealthcare Provider Portal and being redirected to submit your Any other service prior authorization or notification request. If you are not automatically redirected in 5 seconds, please click the Continue button.

Please note:

- The Prior Authorization and Notification main menu will still be available behind the new window; when you're ready to return to the portal, simply close this window
- For security purposes, if you've been inactive for more than 30 minutes, the portal will automatically sign you out; you will need to sign in again to access the website
- If your portal session expires, you **won't** be automatically signed out of the UnitedHealthcare Any other service request website

Continue

- If your provider is not associated with your submission account, you will get the below notice and instruction. Request access by emailing RMHPPreAuthSupport@uhc.com

You are being redirected.

 For the best experience, please enable popups for the UnitedHealthcare Provider Portal.

You are now leaving the UnitedHealthcare Provider Portal and being redirected to submit your Any other service prior authorization or notification request. If you are not automatically redirected in 5 seconds, please click the Continue button.



Provider not recognized, you may need to register for the CO Authorization Portal separately, please contact RMHPPreAuthSupport@uhc.com to contact a representative.

automatically sign you out; you will need to sign in again to access the website

- If your portal session expires, you **won't** be automatically signed out of the UnitedHealthcare Any other service request website

Continue



Create Authorization: Selecting a Member

- Enter Member name or ID to search or click on the “Search” button to open additional search fields.

The screenshot displays the esette web application interface. On the left is a dark sidebar with a 'Search Menu' and a list of navigation items: Patients, Authorizations (with 'Submit Request' highlighted), My Authorizations, Case Management, Patient Search, Administration, and Resources. The main content area has a top bar with 'Submit Request' and navigation icons. Below this is the 'Create Authorization' section, which includes a 'Search Patients' input field, a 'SEARCH' button (circled in red with an arrow pointing to the right sidebar), and a message stating 'Patient ID is required.' Below the search field are 'CLEAR' and 'CREATE AUTH' buttons. A list of steps follows: Authorization Details, Document Medical Necessity, Attach Supporting Documentation, and Authorization Confirmation. On the right is a 'Search for Patient Plans' sidebar. It prompts the user to 'Enter at least one of the following combinations of search criteria:' and lists two options: 'Patient ID' and 'First Name & Last Name & Date of Birth'. Below these are input fields for Patient ID, Medicaid ID, First Name, Last Name, Date of Birth, PCP ID, PCP First Name, PCP Last Name, Health Plan (with a 'Select Health Plan' dropdown), and Line of Business (with a 'Select Line of Business' dropdown). At the bottom of the sidebar are 'SEARCH' (circled in red) and 'CLEAR' buttons.



Create Authorization: Selecting a Member Cont'd

- The member's name will appear at the top.
- If there is an existing authorization for the selected member, verify there is not already the same service on file with the same provider and dates.
- Click on the carrot next to the authorization number to see that information or click on the authorization summary.

> Create Authorization

Selected Patient: **Member Name (Member ID)**

> Open Existing Auths

Filter Auths

Click to open Authorization Summary

	Auth #	Type	Class	Sub Class	Request Date	Servicing Provider
>	O240604002	Pre-Service	Outpatient Facility	1 - Medical	6/4/2024 1:46:16 PM	000036525003
>	O240604001	Pre-Service	Home	11 - Durable Medical Equipment	6/4/2024 1:43:41 PM	001176841001
>	I240603001	Pre-Service	Acute Hospital	1 - Medical	6/3/2024 2:44:26 PM	000031535001
>	O240530002	Pre-Service	Outpatient Facility	2 - Surgical	5/30/2024 3:46:43 PM	001176841001

Open carrot to view request

	Auth #	Type	Class	Sub Class	Request Date	Servicing Provider
▼	O240604002	Pre-Service	Outpatient Facility	1 - Medical	6/4/2024 1:46:16 PM	000036525003

Diagnoses

Primary Dx	Diagnosis Code	Diagnosis Description
✓	D0362	MELANOMA IN SITU LEFT UPPER LIMB INCL SHOULDER
	C4361	MALIGNANT MELANOMA RIGHT UP LIMB INCL SHOULDER

Services

Primary Svc.	Determination	Reason	Service Code	Service Description
			29821	SHOULDER ARTHROSCOPY/SURGERY
			29820	Arthroscopy, shoulder, surgical; synovectomy, pa



Authorization: Selecting Appropriate Authorization Details

The screenshot shows a web form for authorization. Red boxes and arrows highlight the following elements:

- Location:** A dropdown menu with "123 ABC Street, Bora Bora" selected. A red box labeled "Location *" is above it, and a red box labeled "Location is required." is below it.
- Initial Service Date:** A calendar for June 2024. A red box labeled "Initial Service Date *" is above the date "5", and a red box labeled "Initial Service Date is required." is below it.
- Type:** A dropdown menu with "Pre-Service" selected. A red box labeled "Type *" is above it.
- Auth Class:** A dropdown menu with "Outpatient Facility" selected. A red box labeled "Auth Class *" is above it, and a red box labeled "Auth Class is required." is below it.
- Auth Sub Class:** A dropdown menu with "2 - Surgical" selected. A red box labeled "Auth Sub Class *" is above it.
- Buttons:** "CLEAR" and "+ CREATE AUTH" buttons are at the bottom right. The "+ CREATE AUTH" button is circled in red.

- Select the location of the provider submitting for.
- Select the appropriate “Auth Class” and corresponding “Auth Sub Class”**.
- Select start date of service (these dates will not populate into the service area of submission).
- Select the “Type” of authorization (always select pre-service).
- Once all appropriate options are selected, click on “+Create Auth” to move forward.

See next 3 pages to determine the appropriate auth class and auth sub class options to choose based on type of request being submitted.

****DO NOT submit Inpatient requests via the portal.****

ALL INPATIENT REQUESTS ARE TAKEN OVER THE PHONE or FAX.

Phone – (800)416-2157 or (970)248-5197

Fax – (800)262-2567 or (970)255-5681



Submitting a Prior Authorization: Appropriate Auth Class & Auth Sub-Class Selections

Please do not use any other Auth Class other than what is outlined here. An incorrect Auth Class may result in a voided/cancelled preauth and/or a denial for claims payment.

DO NOT USE AUTH CLASS AMBULATORY SURGICAL CENTER

DO NOT USE the following Sub-Classes:

- **MENTAL HEALTH (47)**
- **AMBULATORY SURGICAL CENTER (49)**
- **HOME ACC DME (53)**
- **INPATIENT REQUESTS** (Acute Hospital, Residential, Hospice, Observation, Skilled Nursing, Inpatient Rehabilitation, and Long-Term Acute Care auth classes)
- Inpatient cases should **NEVER** be submitted through the portal. If you have a surgery that will require an inpatient stay, submit your request as outlined using the “**Outpatient Facility**” auth class. The hospital will call and notify us when the member is admitted for their surgery, and an inpatient auth will be created at that time.
ALL INPATIENT REQUESTS ARE TAKEN OVER THE PHONE or FAX.
 - Phone – (800)416-2157 or (970)248-5197
 - Fax – (800)262-2567 or (970)255-5681



Submitting a Prior Authorization: Appropriate Auth Class & Auth Sub-Class Selections Cont'd

- **Auth Class: Home** = Used for DME, PT, ST, OT, Pharmacy, Orthotics/Prosthetics, Wound Vac, Enteral Nutrition, Incontinence
 - **Sub Class: Durable Medical Equipment**
 - Equipment
 - Pharmacy
 - Wound Vac
 - Enteral Nutrition
 - Incontinence
 - Orthotics
 - Prosthetics
 - **Sub Class: Home Services**
 - PT/ST/OT (No preauth required for Medicaid Only)
 - J codes & Q codes (Pharmacy)
- **Auth Class: Office** = Services provided in an office setting (generally used for Out of Network office visits). The “**Requesting**” and “**Servicing**” providers **MUST** be physician. A provider group can be listed for the “**Servicing Provider**” on these auth types.
 - **Sub Class: Medical**
 - Office visits that are not done in a facility for basic needs
 - Diagnostic Testing
- **Auth Class: Outpatient** = Services provided in a non-facility outpatient setting such as allied/ancillary providers. The physician asking for service should be listed as the “**Requesting Provider**” and the facility or provider group where service is performed should be listed as the “**Servicing Provider**”
 - **Sub Class: Medical**
 - Dental requests for 41899 and 00170
 - All other office/outpatient procedures that ARE NOT SURGERY



Submitting a Prior Authorization: Appropriate Auth Class & Auth Sub-Class Selections Cont'd

- **Auth Class: Outpatient Facility** = **ALL SURGERIES MUST BE ENTERED WITH THIS AUTH CLASS AND SUB CLASS**. The provider requesting the service should be listed as the “**Requesting Provider**”, the surgeon should be listed as the “**Attending Provider**”, and the facility surgery is taking place is listed as the “**Servicing Provider**”. The “**Requesting**” and the “**Attending**” providers can be the same provider.
 - **Sub Class: Surgical** – All surgeries are going to be listed as “**Surgical**”. There may be other options that seem available to choose. These options are not valid for surgical pre auths in order to get into the claims systems appropriately.
 - **NOTE:** If there is a co-surgeon, this will need to be noted in the “**Additional Information**” box in Step 2 (the screen where the providers/diagnoses/services/date of service are entered). Please be sure to include NPI/TIN for that co-surgeon.



Authorization Details: Searching for a Provider

- Search for the providers by typing the provider/facility name and clicking on “**Search**” or click on “**Search**” to open additional search fields or to search for Out of Network providers.
- Search for facilities using the last name field. Use first and last name fields to search for physicians. Keep the search terms simple for best results.
- If unable to find providers, use “**Dummy Test Provider 4**” for Requesting/Attending providers, and “**Facility 003 – Dummy**” for Facility/Servicing providers. Make sure to **uncheck** the box titled: “**Only Contracted Providers**” to allow out of network search.

> Authorization Details

Primary Care Physician:

Requesting Provider: ⚠️ Dr. Pepper, 123 ABC Street, Bora Bora ✎

Attending Provider is required.
Servicing Provider is required.

Attending Provider: 🔍 SEARCH

Servicing Provider: 🔍 SEARCH

Submitting provider will populate this field.

Click here to search for the correct provider

Click on check mark to search for Non-Contracted (Out of Network) providers

Search for Providers

☒ Only Contracted Providers

Attending Provider: ⓘ Dummy Test Provider 4, 2775 ✎
Crossroads Blvd, Grand Junction

Servicing Provider: ⓘ FACILITY 003- DUMMY, 2775 ✎
Crossroads Blvd, Grand Junction

Provider Identifier

Provider First Name

City

🔍 SEARCH ✕ CLEAR

NPI #

Provider Last Name

Select Gender

Provider Group

Select State

Zip Code



Authorization Details: Searching for a Provider Cont'd

- Provider ID's are the UHC assigned provider ID's based on the lines of business (LOB) and claims platform.
- If the Member is Medicare Advantage, select the Provider ID that begins with "MPC".
- If the Member is all other LOB's use the Provider ID that starts with leading 0's.
- Clicking on the double arrow button will select the provider and populate it into the prior auth details page.

Select Provider MPC for all Medicare Advantage Members

Provider ID	Provider	Facility	NPI #
» MPC0082	Provider Name	Address DELTA	123456789
» MPC0082	Provider Name	Address , MONTROSE	123456789

All other LOBs use ID with leading 0's

Provider ID	Provider	Facility	NPI #
» 000042	Provider Name	Address DELTA	123456789
» 00004	Provider Name	Address MONTROSE	123456789

Click double arrow to select option



Authorization Details: Entering/Selecting a Diagnosis

Diagnoses
Search Diagnoses

I509

SELECT COMMON DIAGNOSIS ☐ Show Inactive Diagnoses

Diagnosis Description	Flags
display.	
Displaying 0 records.	

I50 - HEART FAILURE

I501 - Left ventricular failure, unspecified

I502 - SYSTOLIC CONGESTIVE HEART FAILURE

I5020 - UNSPECIFIED SYSTOLIC CONGESTIVE HEART FAILURE

I5021 - ACUTE SYSTOLIC CONGESTIVE HEART FAILURE

I5022 - CHRONIC SYSTOLIC CONGESTIVE HEART FAILURE

I5023 - ACUTE CHRON SYSTOLIC HEART FAILURE

I503 - DIASTOLIC CONGESTIVE HEART FAILURE

I5030 - UNSPECIFIED DIASTOLIC CONGESTIVE HEART FAILURE

- The diagnosis code must be entered without the character (.). *For example, J44.9 will be entered as J449*
 - If you are unable to find a diagnosis code, enter the code that is closest to what the request pertains to, and enter what the diagnosis code should be in the “Additional Information” box at the bottom of the screen. The reviewers will make sure it gets added to the system and the request.
- If an incorrect code is entered, it can be removed by clicking the trash can icon (shown below) and clicking “OK” when asked to confirm removal.

Primary Dx	Diagnosis Code	Diagnosis Description
	I50	HEART FAILURE



Authorization Details: Entering/Selecting a Service

92943 - Percutaneous transluminal revascularization of c

9294322 - Percutaneous transluminal revascularization of c

9294323 - Percutaneous transluminal revascularization of c

9294324 - Percutaneous transluminal revascularization of c

9294325 - Percutaneous transluminal revascularization of c

9294326 - Percutaneous transluminal revascularization of c

9294332 - Percutaneous transluminal revascularization of c

9294333 - Percutaneous transluminal revascularization of c

9294347 - Percutaneous transluminal revascularization of c

92943

SELECT COMMON SERVICE

Show Inactive Services

Primary Svc. Qty Req'd Qty Approved Service Code Service Description

There are no rows to display.

Displaying 0 records.

Start typing service code and select the appropriate option available. The blue highlight shows what option is being selected.

Type code or description here

- Type code or service description and select the appropriate code being requested.
- To remove a code, select the trash can button (shown below) and confirm removal by clicking on “Ok”.

Services

Search Services

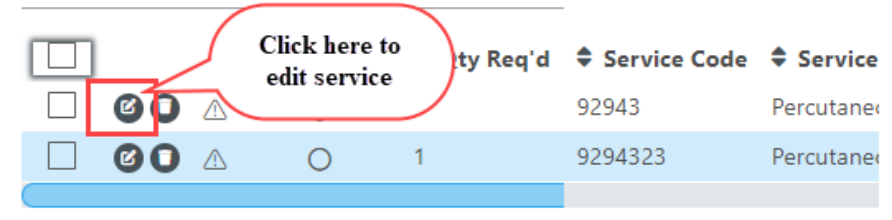
Show Inactive

		Primary Svc.	Qty Req'd	Service Code
☐			1	92943
☐			1	9294323



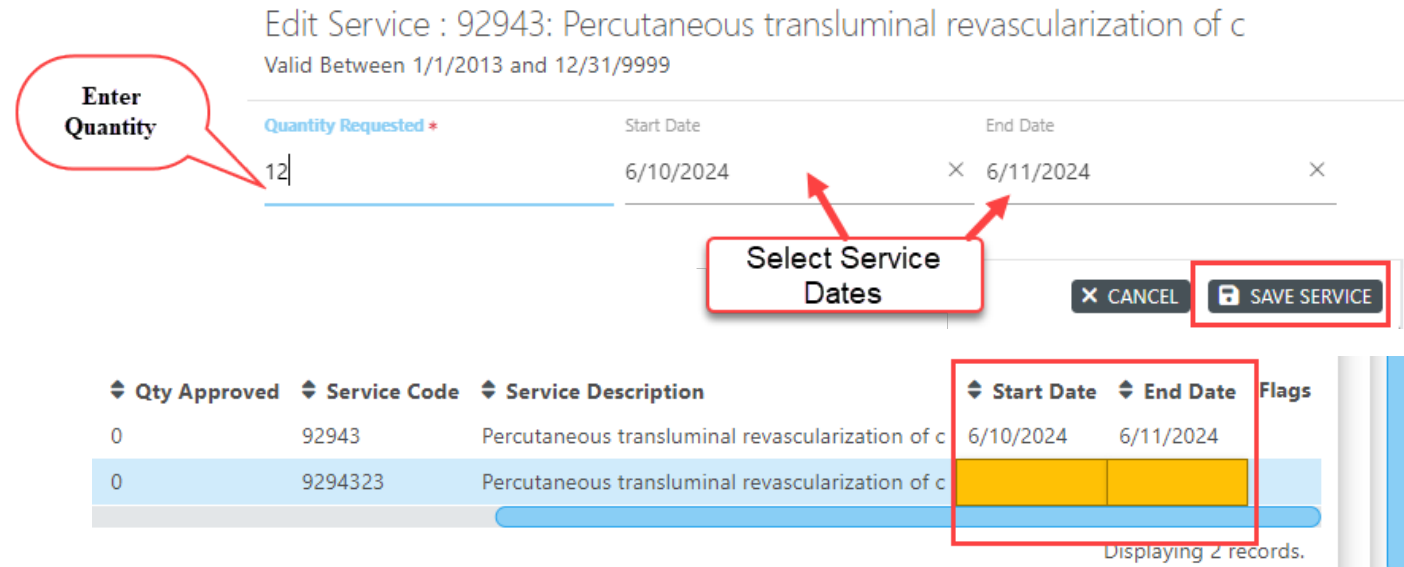
Authorization Details: Editing Service/Adding Dates of Service

- The quantity will always populate with a default of '1'. To edit a service line to correct the quantity, click on the edit button (box with a pencil) for that line item.
- Enter quantity and select dates of service. Once complete, click on **"Save Service"**.
- Yellow/orange boxes are a warning that this requirement is missing. See next page for instructions on how to add multiple dates of service at one time.



A callout bubble with the text "Click here to edit service" points to a pencil icon in the first column of a table. The table has columns: "Qty Req'd", "Service Code", and "Service". The second row is highlighted in blue and contains the value "1" under "Qty Req'd", "9294323" under "Service Code", and "Percutane" under "Service".

Qty Req'd	Service Code	Service
1	9294323	Percutane



The "Edit Service" form for service code 92943, "Percutaneous transluminal revascularization of c", is shown. A callout "Enter Quantity" points to the "Quantity Requested" field, which contains the value "12". Another callout "Select Service Dates" points to the "Start Date" and "End Date" fields, which contain "6/10/2024" and "6/11/2024" respectively. Below the form is a table with columns: "Qty Approved", "Service Code", "Service Description", "Start Date", "End Date", and "Flags". The first row shows "0" for "Qty Approved", "92943" for "Service Code", and "Percutaneous transluminal revascularization of c" for "Service Description". The second row shows "0" for "Qty Approved", "9294323" for "Service Code", and "Percutaneous transluminal revascularization of c" for "Service Description". The "Start Date" and "End Date" fields in the second row are highlighted in yellow. At the bottom right, there are "CANCEL" and "SAVE SERVICE" buttons. The text "Displaying 2 records." is at the bottom right.

Enter Quantity

Select Service Dates

Qty Approved	Service Code	Service Description	Start Date	End Date	Flags
0	92943	Percutaneous transluminal revascularization of c	6/10/2024	6/11/2024	
0	9294323	Percutaneous transluminal revascularization of c			

Displaying 2 records.



Authorization Details: Editing Service/Adding Dates of Service

- To add multiple dates of service, select the box at the top of all service lines and make sure all boxes get checked.
- Enter the dates of service below as shown in example to the right, then click on “**Apply Dates to Selected Services**”.
- Once added, you should see all service lines populated with the dates selected.

☒

Check the top box to select all lines of service

	Qty Req'd	Determination	Reason	Qty Approv
☒	12			0
☒	1			0

Start Date

6/5/2024

×

End Date

6/30/2024

×

APPLY DATES TO SELECTED SERVICES

Service Date is required.

Service Code	Service Description	Start Date	End Date	Flags
92943	Percutaneous transluminal revascularization of c	6/5/2024	6/30/2024	
9294323	Percutaneous transluminal revascularization of c	6/5/2024	6/30/2024	



Authorization Details: Additional Info

- The “**Additional Info**” at the bottom of this section is for provider information, such as out-of-network provider name, address, phone, and fax when unable to find the right provider.
- Any contact information that is needed must be entered here, such as a direct line to the provider for nurse to communicate determination, or to obtain additional clinical information.
- Once note is added, click on “**Save Additional Info**”.

Additional Info 

Additional Info

Out of Network Provider:

Barb Wireless
123 Easy Pea St
Funky Town, CO 81506

NPI:123456789
TIN: 987654321
Contact: Sarah
Contact #: 970-555-1212
Fax#: 800-555-1212

 SAVE ADDITIONAL INFO

165 / 2000



Document Medical Necessity: Selecting Appropriate Code

- Click on the CPT or ICD10 code to populate the appropriate clinical guidelines for the procedure/equipment being requested.
- Click on “+Add Documentation” to move forward with selecting clinical options.

Choose one option

> Document Medical Necessity

Diagnoses or Services to Document

Primary	Type	Code	Description	Determination from Rules
☐	ICD10	I50	HEART FAILURE	
☒	CPT	92943	Percutaneous transluminal revascularization of c	
☐	CPT	9294323	Percutaneous transluminal revascularization of c	

+ ADD DOCUMENTATION



Document Medical Necessity: Selecting Criteria for Member

CWQWindowLoading

Authorization Request

Request Form → 2 Document Clinical → 3 Submit Request

mcb

Patient: Member ID Name Member Name DOB: Gender: [show more](#)

Authorization: 397373 Type: Procedure Outpatient Facility Status: NoDecisionYet [show more](#)

Diagnosis Codes: R69(ICD-10 Diagnosis) primary

Procedure Codes: 58558(CPT/HCPCS) primary, 58661(CPT/HCPCS)

Disclaimers

58558 - CPT/HCPCS

- Click the Document button to proceed.

58661 - CPT/HCPCS

- Click the Document button to proceed.

Procedure Code: 58558 (CPT/HCPCS) [Document Clinical](#)

Procedure Code: 58661 (CPT/HCPCS) [Document Clinical](#)

- This screen will show Member name and ID, the authorization type, diagnosis, and procedure codes.
- The “**Disclaimers**” box shows what is needed for next steps.
 - If this states “**Click the Document button to proceed**”, this means it is required to move forward.
- Click on the “**Document Clinical**” button to move forward with selection.
- **NOTE: If this window does not open, and an error occurs, exit prior auth, and fax in the clinical information to 800-262-2567. The request was created once Step 2 was completed.**



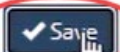
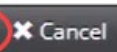
Document Medical Necessity: Selecting Criteria for Member Cont'd

Procedure Code: 58558 (CPT/HCPCS)

A-0286 - Hysteroscopy, with or without Endometrial Ablation, or Myomectomy - (AC)

The procedure is/was needed for approval because of ...

- ☐ Abnormal bleeding evaluation or management directed by ...
- ☒ Cervical cytology demonstrating AGC or AIS in patient 35 years or older 
- ☐ Chronic pelvic pain evaluation needed, as indicated by ...
- ☒ Endometrial evaluation previously performed, and ablation needed, as indicated by ...
 - ☐ No evidence of endometrial hyperplasia or uterine cancer on endometrial sampling 
 - ☐ Patient no longer desires childbearing. 
 - ☐ Premenopausal bleeding and ...
- ☐ Infertility or recurrent pregnancy loss related to ...
- ☐ Intrauterine synechiae (Asherman's syndrome), known or suspected (eg, amenorrhea or oligomenorrhea and history of uterine ...)
- ☐ Myomectomy needed, as indicated by ...
- ☐ Resection of vaginal or uterine septum
- ☐ Retrieval of retained intrauterine device, intrauterine device fragment, or intrauterine device fragment after removal 

- The guideline for the code selected will open with check boxes.
 - Some boxes will have subset boxes to select. These must be checked in order to continue. If they do not apply to the Member's case, select an option and use note on that line to let the reviewer know it does not actually apply to case.
- Select the appropriate boxes for Members case and click on “Save” when done.
- If more than one code, repeat this step for each code that includes a guideline.
- The blue box with a pencil at the end of the sentences is an additional option that will allow the submitter to type a note if clicked on.



Document Medical Necessity: Selecting Criteria for Member Cont'd

Procedure Code: 58661 (CPT/HCPCS)		
Guideline Title	Product Code	
Pelvic Surgery	HC	S-2450
Laparoscopic Gynecologic Surgery, Including Myomectomy, Oophorectomy, and Salpingectomy	ISC	S-775
No Guideline Applies		

✓

Procedure Code: 58558 (CPT/HCPCS)

show more

✓

Procedure Code: 58661 (CPT/HCPCS)

show more

Submit Request

Cancel Request

Back

This system provides access to MCG evidence-based guidelines; however the determinations made using this system are directed by the health plan, based on a number of factors.

- If a code has more than one guideline that could apply, select the appropriate one by clicking “**Add**” under ‘**Action**’ on the right.
- If none apply, select “**Add**” for the line that states ‘**No Guideline Applies**’.
- Once these steps are complete, there will be a green check mark to the left of the ‘**Procedure Code**’.
- Click on “**Submit Request**” to continue to the next step.
- NOTE: A selection may be required. Click what is necessary and note in the guideline “**NO CGs APPLY**”



Attach Supporting Documentation: Paper Documents (Fax)

- All requests require clinical documentation
- Clinical documentation can be faxed or attached through this section.
- Selecting “**Paper Documents**” will open a “**Fax Paper Documentation**” menu. This menu will provide a printable cover page to fax clinicals into RMHP with.
- Save the cover page as a PDF by selecting “**Adobe PDF**” and click on “**Print**”.
- Select where to save your file, and “**Continue**” at the bottom of the screen.

Do you have supporting documentation to accompany this request?

☐ None ☒ Paper Documents ☐ Electronic Files ☐ Both

Fax Paper Documentation

Click below to print a fax cover sheet to use when sending in supporting documentation.

 PRINT COVER SHEET

 CANCEL REQUEST  CONTINUE

 **ROCKY MOUNTAIN**
HEALTH PLANS®

Print (?)

Total: 1 sheet of paper

Printer

Adobe PDF ▼

 Print  Cancel

Grand Junction Office

FAX

To: UM Department Company: RMHP

Fax #: 800-262-2567 or 970-255-5681



Attach Supporting Documentation: Electronic Files

- Selecting “**Electronic Files**” will allow multiple uploads to this authorization.
- Click on “**+Add Documentation**” to open the upload file window.
- Once window opens, click on “**Upload File**” and select the files needing uploaded.
- Select an appropriate category (required).
- The “Title” and “Summary” boxes are to allow the option to provide a title and/or additional info information (not required).
- Click “**Save**” to go back to the authorization page and click “Continue” to move on to the next section.
- Selecting “**Both**” will allow both options (fax and upload).

The screenshot shows a two-step process for uploading electronic documentation. The top section, titled 'Do you have supporting documentation to accompany this request?', has three radio buttons: 'None', 'Paper Documents', and 'Electronic Files' (which is selected and highlighted with a red box). Below this is the 'Upload Electronic Documentation' section. It features a '+ ADD DOCUMENT' button (highlighted with a red box) and a table with columns 'Title', 'Attached', 'By', and 'Category'. The table is empty, with the text 'There are no rows to display.' and 'Displaying 0 records.' at the bottom. A red dashed arrow points from the '+ ADD DOCUMENT' button to the 'Upload/Attach Document' window below. This window has a title bar 'Upload/Attach Document' and a file upload area with an 'UPLOAD FILE' button (highlighted with a red box) and a note 'File is limited to 40 MB'. A red callout bubble points to the 'UPLOAD FILE' button with the text 'Click here to upload the clinical documentation'. Below the file upload area are two text input fields: 'Category *' (with a dropdown menu and a red callout bubble pointing to it saying 'Select appropriate option') and 'Title' (with a red callout bubble pointing to it saying 'Title of document'). A red callout bubble points to the 'Category' field with the text 'Category is required.' Below these fields is a 'Summary' text area (with a red callout bubble pointing to it saying 'Additional info up to 500 characters') and a character count '0 / 500'. At the bottom right of the window are 'CANCEL' and 'SAVE' buttons (both highlighted with red boxes). A red callout bubble points to the 'CONTINUE' button in the top right of the first section with the text 'Click Continue AFTER uploading clinicals'.



Authorization Confirmation: Authorization Summary

- This is the end of the prior authorization submission process.
- All standard requests can take from 5 to 10 calendar days based on the line of business and/or policy.
- This page provides the authorization number that should always start with an ‘O’ as in outpatient.
- Clicking on the hyperlinked authorization number will open a summary page to show what was submitted on this request. This page can be downloaded/printed for the provider’s records.
- Click on “**Submit Another Request**” to begin another submission.
- **If any errors or issues occur during submission, please email RMHPPreAuthSupport@uhc.com.**

Thank you for submitting your DME request. It has been assigned Reference #**O11000000** with a status of "Pended".

Reimbursement for services rendered is subject to:

- Member eligibility must be verified for date(s) of service
- Service(s) rendered is a covered benefit
- Member is not eligible for other health care coverage
- Service(s) rendered do not require authorization
- Service(s) rendered are performed within effective date range of referral

Authorization Number (O11000000) **Status of Authorization** (Pended)

OPEN AUTH SUMMARY **SUBMIT ANOTHER REQUEST**

Opens the below window (points to OPEN AUTH SUMMARY)

Click here to start another authorization (points to SUBMIT ANOTHER REQUEST)

Click here to save or print your confirmation page (points to print icon)

Authorization # **O11000000** • Summary

Auth Number:	O11000000	Other Reference #:	
Request Date:	6/6/2024 11:03:05 PM	Initial Service Date:	6/6/2024
Service Date Range:	6/6/2024 - 6/30/2024	Class:	DME
Sub Class:	DME	Priority:	Standard
Status:	In Process	Line of Business:	Medicaid
Type:	Concurrent Review		

Member

Member Name:	John Smith	Member ID:	7050510810
Date of Birth:	01/01/2000	Gender:	Male
Spoken Language:	English	Written Language:	English
Home Phone Number:		Mailing Address:	
PCP Name:	Stephen Smith, Oklahoma City Medical Clinic	PCP Phone Number:	
Primary Plan:	Medicaid		



Troubleshooting: Tips & Tricks

- Please make sure the correct provider is shown that is requesting or providing service for the request
- **DO NOT Select an Inpatient auth class type. This will result in an immediate cancellation of the request.**
A new request will need to be submitted by the provider correctly.
- All procedures requiring an inpatient stay are requested as an Outpatient or Outpatient Facility Auth Class. Once the Member is admitted, the facility will call RMHP to start the inpatient auth. These are reviewed separately.
- Need to add a provider to your submission access? Send an email to RMHPPreAuthSupport@uhc.com and include the provider's name, Tax ID, NPI, and address/location submitting for.
- The provider submitting the authorization will automatically populate in the “**Requesting Provider**” field. Most submitters requesting a prior auth are the “**Servicing Provider**”. Make sure to list the correct provider/physician/facility information for these fields. An incorrect selection may result in a denial.
- If any diagnosis or service codes are not working, please add them in the “**Additional Information**” box.
- **PLEASE ENTER A CONTACT NAME and PHONE NUMBER** in the “**Additional Information**” box. If documentation is skewed, unreadable, or missing the clinical reviewers will need a contact to reach out directly to obtain the information needed.



Troubleshooting: Tips & Tricks

- When the guidelines populate in this step, make sure the appropriate guidelines are added for the service requested.
- If there are not any guidelines, click on “**Submit Request**” to move forward.
- If this step is not allowing the option to click on “**Submit Request**” that means something is required that has not been done. Look at the clinical selections to make sure there is not a missing box section needing a selection.
- If there is an RMHP guideline available, select to add that guideline for the review.
- When you encounter an error while uploading documents, close out of the error page/prior auth window, and fax in the clinical documentation to **800-262-2567 or 970-255-5681**.
- **DO NOT** submit more than one request when receiving an error past the section where diagnosis and service codes were entered. The request was created and received to the team after completing this step.
- If you would like confirmation that we received your request and obtain the auth number, please click on “**My Authorizations**” and it will show a status.
- If experiencing any issues not outlined within this training manual, please email RMHPPreAuthSupport@uhc.com. **Make sure to include screenshots and a brief explanation of what steps were taken that lead to the error.**



Questions?





Thank You!