Administrative updates for UnitedHealthcare Medicare Advantage members in Tennessee

For dates of service beginning Jan. 1, 2026, Optum Health Networks, an affiliate of UnitedHealthcare, will manage certain administrative services for the following UnitedHealthcare Medicare Advantage benefit plans. This reference guide provides an overview of the administrative processes, including how to:

- Verify member eligibility
- Submit and check referral status
- Submit hospital admission notifications
- Submit prior authorization requests
- Check claim status, submit claims and claim reconsiderations

The following benefit plans will be administered by Optum Health Networks, effective Jan. 1, 2026:

Contract number	PBP	Segment ID	Group number
H2001	094	000	90384
H2001	094	000	90385
H2001	104	000	90386
H2001	104	000	90387
H5253	047	000	90639
H5253	048	000	90640
H5253	113	000	90641
H5253	121	000	90642
H5253	081	000	90445
H5253	082	000	90446
H5253	084	000	90448
H5253	047	000	90648
H5253	048	000	90649

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Contract number	PBP	Segment ID	Group number
H5253	113	000	90650
H5253	121	000	90651

Verifying member eligibility

You can verify member eligibility:

Online: Sign in to the **UnitedHealthcare Provider Portal** and select Eligibility

Referrals

For plans that require referrals, submit referral requests online at **optumproportal.com**

Specialist services referrals

Starting **Jan. 1, 2026,** most members enrolled in UnitedHealthcare Medicare Advantage HMO and HMO-POS plans will be required to obtain a referral from their primary care provider (PCP) before accessing certain specialist services in outpatient, office or home settings. Claims for specialist services without a referral will be denied beginning **May 1, 2026.**

Applicable markets

This requirement will apply to UnitedHealthcare Medicare Advantage HMO and HMO-POS plan members delegated to Optum networks in the following markets. To see if a UnitedHealthcare Medicare Advantage plan member is delegated to your Optum network, check their member ID card. It will list **LIFE1** as the payer ID.

- Arizona
- Colorado
- Connecticut
- Georgia
- Idaho
- Indiana
- Kansas-Missouri
- Nevada*
- New Jersey
- New Mexico**
- New York
- Ohio
- Oregon
- South Carolina
- Tennessee
- Utah
- Virginia
- Washington
- Wisconsin

*Nevada has referral requirements currently in place. Existing referral policies will not change, and referrals are required for all 2026 dates of service. For referral exclusions, requirements and details, please refer to the member's evidence of coverage.

**New Mexico has referral requirements currently in place. The existing referral requirements will be replaced with this new referral policy that includes claim denial. Please see Key dates below for details regarding this update.

What this change means

If you see patients covered by a UnitedHealthcare Medicare Advantage HMO or HMO-POS plan in one of the applicable markets, they must obtain a referral from their PCP before seeing a specialist. The PCP must submit the referral to Optum prior to the specialist visit.

Referral requirements **do not apply** to members enrolled in:

- Institutional SNP plans
- Erickson Advantage plans
- Michigan Integrated DSNP plan (H2247-005)

The new referral requirements will **not** apply to services provided by a:

- Audiologist
- Chiropractor
- Emergency medicine
- Hematologist
- Infectious disease specialist
- Mental health provider
- Neonatology
- Nuclear medicine
- Nutritionist
- Obstetrician/gynecologist
- Oncologist
- Ophthalmologist
- Optician
- Optometrist
- Podiatrist
- Primary care provider
- Radiologist
- Therapeutic radiologist

In addition, a PCP referral is **not required** for:

- PT/OT/ST, cardiac therapy or pulmonary therapy
- Provision of anesthesiology (pain management services rendered by an anesthesiologist do require a referral)
- Home health agency services
- Services performed in an observation setting
- Any services from a pathologist or inpatient consulting physician, including hospitalists
- Emergency room, ambulance or urgent care services
- Telehealth services
- Medicare-covered preventive services, kidney disease education or diabetes self-management training
- Routine annual physical exams, routine vision exams or hearing exams
- Dialysis services
- Any lab services, radiological or non-radiological testing services, or radiation therapy
- Durable medical equipment, home health, prosthetic/orthotic devices, medical supplies, diabetic testing supplies, Medicare Part B drugs or allergens
- Additional coverage that may be included by some Medicare Advantage plans but are not covered by Medicare, such as hearing aids, routine eyewear, dental care, fitness memberships or outpatient prescription drugs

Key dates

Claims will not be denied for lack of referral on plans with new referral requirements for dates of service through **April 30, 2026.** However, providers are encouraged to begin submitting referrals for services scheduled on or after **Jan. 1, 2026.** Claims for specialist services without a referral will be denied beginning **May 1, 2026.**

Claims denied due to missing referrals will be considered provider liability. Members must not be balance billed for services rendered without a valid referral.

For plans with new referral requirements, referrals for the 2026 plan year can't be submitted before Jan. 1, 2026.

Claims may still be denied even if a referral is on file if:

- The services are not covered under the member's benefit plan
- Required prior authorization was not obtained

Learn more

Additional information about the upcoming referral requirement is posted at **UHCprovider.com/news**.

We're here for you

If you have questions, please contact an Optum Health Networks team member. For technical assistance, contact the support team using the Contact us link in the portal.

Prior authorization

Prior authorization may be required for certain services based on the member's plan. Inpatient and outpatient services generally don't require prior authorization when members are referred to health care professionals who participate with UnitedHealthcare Medicare Advantage PPO.

Services that require prior authorization will be listed at **UHCprovider.com/priorauth** > Advance Notification and Plan Requirement Resources. Submit your request at least 7 days before the planned date of service:

Online: **optumproportal.com**

By phone: 888-598-7855

You don't need to submit another prior authorization request if a request was previously reviewed and approved by UnitedHealthcare for dates of service starting Jan. 1, 2026, and after. Optum Health Networks will reimburse services approved by UnitedHealthcare.

Hospital admission notifications

Please notify Optum Health Networks of hospital admissions no later than 1 business day after admission:

Online: **optumproportal.com**

By phone: 866-565-3468

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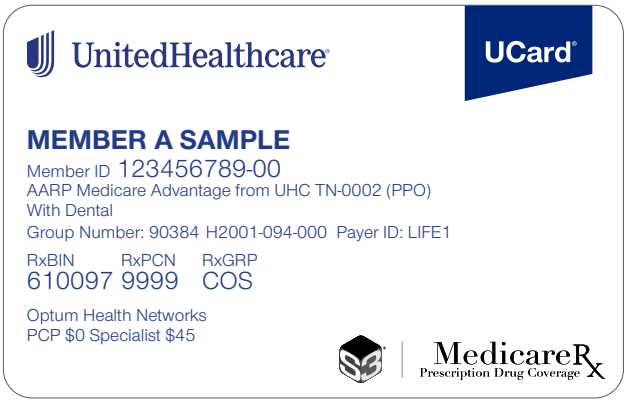
Member ID cards

Members in the affected plans will get new member ID cards that show the Payer ID LIFE1 and will have other applicable delegation-specific descriptors such as delegate name and delegate website listed as the care provider contact. You can download a copy of the member ID card when you verify eligibility and benefits in the **UnitedHealthcare Provider Portal.**

UnitedHealthcare UCard

You can download a copy of the member ID card when you verify eligibility and benefits in the **UnitedHealthcare Provider Portal**.

- UnitedHealthcare UCard makes it easier for members to access their benefits and programs so they can take advantage of their plan offerings
- UCard does not need to be activated for you to verify eligibility or provide care services to members and should be used in the same manner as any other UnitedHealthcare member ID card
- UCard cannot be used for member out-of-pocket expenses, including copays, coinsurance or deductibles
- Each UCard includes a Benefit Award Card Number, security numbers, expiration dates and a magnetic stripe for in-store purchases or spending rewards – providers do not need to scan the barcode to provide medical, dental, prescription, vision or hearing services to the member
- Payer ID is listed the front of the member ID card
- PCP name and phone number displays on some referral plan ID cards



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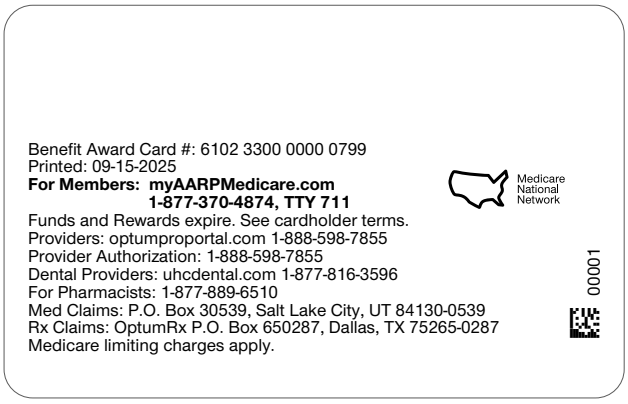

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Sample member ID cards for illustration only; actual information varies depending on payer, plan and other requirements.

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2026 plan names

Providers can refer to the **Medicare Advantage Benefit Plan Names** for the state-specific plan names.

Plan overviews

Plan overviews are available in the **2026 Medicare Advantage, CSNP & DSNP Plan Overview Course** > State > Interactive guide.

Summary of benefits

State-specific plan benefits are available at **UHC.com/medicare** > Shop Medicare plans > Enter ZIP code > Find plans > View 2026 plans Medicare Advantage plans > Find plan and select view plan details > Plan documents > Summary of benefits.

Questions?

For chat options and contact information, visit **UHCprovider.com/contactus**.

UnitedHealthcare Medicare National Network and UnitedHealth Passport®

Some HMO and HMO-POS plans with referral requirements have access to the UnitedHealthcare Medicare National Network. For services requiring a referral, referrals are required to any participating network specialist nationwide, including specialists both inside and outside the member's home plan service area.

For HMO and HMO-POS plans with referral requirements and the Passport benefit, a PCP referral is not required for Passport services. covered services using the National Network or their Passport benefit. For more information about National Network and Passport, visit **UHCprovider.com/plans** > Choose your state > Medicare > Choose plan > Tools & Resources.

Claims

Submit claims using the following electronic Payer ID or mailing address: **Payer ID:** LIFE1 **Mailing address:** Optum Care Claims P.O. Box 30539 Salt Lake City, UT 84130-0539	Submit claim reconsiderations: **Online:** optumproportal.com	Check the status of your claim submission: **Online:** optumproportal.com

The delegate owns all reconsiderations and appeals when they process claims for a delegated member.

Please don't submit duplicate claims unless you haven't received payment or an explanation of payment within 45 days of submission.

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