Remember to call ahead

Make sure you're covered before receiving care

Any time you or a family member is admitted to the hospital or receives certain outpatient services, it is important to let UMR know. We want to make sure you receive the appropriate care and that you understand whether your benefit plan will pay for any portion of the treatment cost.

You or your health care provider can call the number on the back of your medical ID card to verify the level of benefits available. Our decisions are for payment purposes only. All decisions about the types of care you receive remain between you and your providers.

There are two reasons you or your provider should call UMR before a medical service or procedure:

Prior authorization of care

Some types of care require a review to determine if they are medically necessary. This means they meet generally accepted standards of care and are considered effective in treating your illness or injury. We also review if the length of your inpatient stay and type of facility is clinically appropriate.

Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs.

Pre-determination of benefits

We recommend you and your health care provider also call ahead regarding treatments that do not require a review. This is to verify the amount, if any, your medical plan will pay toward the cost of care you plan to receive.

Any payment for an expense that is not covered under the plan is the patient's responsibility.

We will send a letter to you and your provider, notifying you whether the treatment is covered.

Procedures we commonly review: [1]

- *Inpatient stays in Hospitals, Extended Care Facilities or residential treatment facilities*
- *Partial hospitalizations*
- *Organ and tissue transplants*
- *Home Health Care*
- *Durable Medical Equipment, excluding braces and orthotics, over $1,500 or Durable Medical Equipment rentals over $500 per month.*
- *Prosthetics over $1000*
- *Qualifying Clinical Trials*
- *Outpatient surgical procedures not performed in a Physician's office*

1- This list is not all-inclusive. Please refer to your summary plan description (SPD) for a full list of services requiring prior authorization. UMR pays providers according to the coverage terms, benefits, limitations and exclusions of your benefit plan documents.

2- Except stays of 48 hours or less following a normal vaginal delivery or 96 hours or less following a Cesarean section.

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