

Administrative updates for UnitedHealthcare Medicare Advantage members in Arizona



For dates of service beginning Jan. 1, 2026, Banner Health Network 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 Banner Health Network, effective Jan. 1, 2026:

Contract number	PBP	Segment ID	Group number
H0609	026	000	91037
H0609	026	000	91040
H0609	044	000	00333
H0609	046	000	00328
H0609	807	000	Any employer groups associated with these H/PBPs
H0609	808	000	Any employer groups associated with these H/PBPs

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. Sign in to the [UnitedHealthcare Provider Portal](#) and select Referrals.

Specialist services referrals

Starting Jan. 1, 2026, most members enrolled in UnitedHealthcare Medicare Advantage HMO and HMO-POS plans are required to obtain a referral from their PCP before accessing certain specialist services in outpatient, office or home settings. Referrals must be submitted by the PCP to UnitedHealthcare prior to the specialist visit.

Before providing services that require a referral, specialists and other health care professionals should confirm a referral has been issued. Easily complete your registration and start using UnitedHealthcare's self-service tools. Our [Registration and Access Management guide](#) will walk you through the process step-by-step.

We offer several digital tools to help health care professionals manage eligibility and referral activity.

- [Digital Solutions Comparison Guide](#) can help health care professionals choose which tools are right for them
- [UnitedHealthcare Provider Portal](#): The secure place for accessing patient and practice-specific information including checking eligibility and referral requirements. Sign in to the Provider Portal to begin.
- [Application Programming Interface \(API\)](#) is a common interface that interacts between multiple applications in real-time. API solutions allow health care professionals to electronically receive detailed data on the status of claims, eligibility and benefits. The [API Marketplace](#) houses API technical guides.
- [Electronic Data Interchange \(EDI\)](#) is the automated transfer of data. This involves enabling seamless and faster information transfers by allowing health care professionals or facilities to check eligibility and benefits. The [EDI Overview](#) highlights the benefits of this technology.

Use the UnitedHealthcare Provider Portal to check referral requirements, submit requests and see the status of referrals. [Referrals Interactive User Guide](#) will get you started using our Referrals solution.

You may securely view a member's referrals by signing into the UnitedHealthcare Provider Portal. Go to [UHCprovider.com](#) > Sign In > Referrals.

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 UnitedHealthcare prior to the specialist visit.

Members with an active referral may see providers of the same specialty billing under the same TIN – including physicians, nurse practitioners, physician assistants or other healthcare professionals – without a separate referral.

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

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

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

- PT/OT/ST
- Cardiac or pulmonary rehabilitation services
- 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
- Same-day or walk-in visits for evaluation and treatment for orthopedic urgent care with a diagnosis of acute fracture, sprain, strain, dislocation or other acute injury
- 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, including preventive and diagnostic mammograms and colonoscopies
- 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

What this change means (cont.)

Note, eligibility and benefit verification information and member materials, such as the Evidence of Coverage, may indicate referrals are required for additional benefit categories. However, PCPs are not required to submit referrals for the exclusions listed above, and Banner Health Network will not check for referrals for the above categories when paying claims.

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: [EviCore](#)

By phone: 800-827-2464

By fax: 888-693-3210

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. Banner Health Network will reimburse services approved by UnitedHealthcare.

Hospital admission notifications

Please notify Banner Health Network of hospital admissions no later than 1 business day after admission:

By fax: 520-874-3420

Member ID cards

Members in the affected plans will get new member ID cards that show the Payer ID 12X42 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](#).

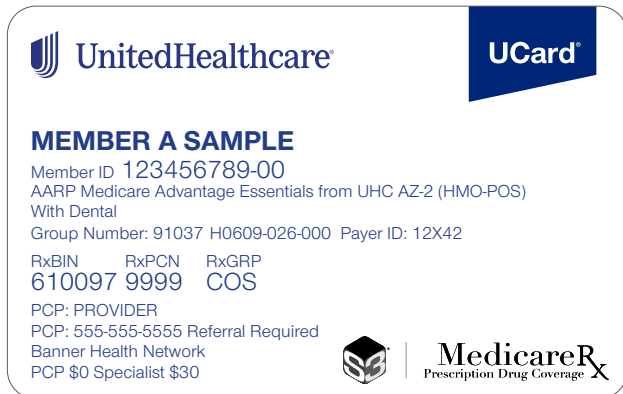
UnitedHealthcare UCard

You can download a copy of the member ID card when you verify eligibility and benefits in the [UnitedHealthcare Provider Portal](#).

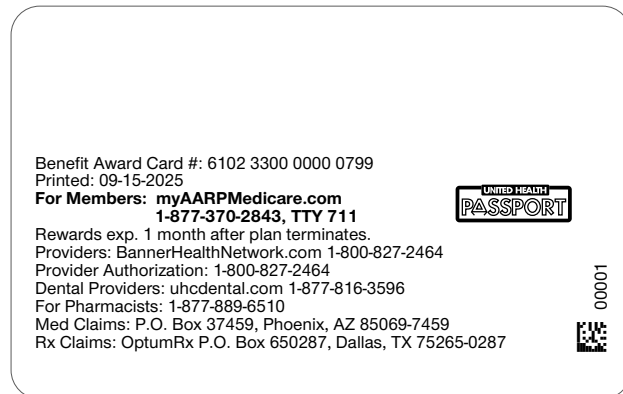
- UnitedHealthcare UCard makes it easier for members to access their benefits and programs so they can take advantage of their plan offerings
- UCard does not need to be activated for you to verify eligibility or provide care services to members and should be used in the same manner as any other UnitedHealthcare member ID card
- UCard cannot be used for member out-of-pocket expenses, including copays, coinsurance or deductibles

UnitedHealthcare UCard (cont.)

- 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



front



back

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

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.

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: 12X42

Mailing address:

Banner Health Network
P.O. Box 37459
Phoenix, AZ 85069-7459

Submit claim reconsiderations:

By phone: 800-827-2464

By mail:

Banner Health Network
P.O. Box 37459
Phoenix, AZ 85069-7459

Check the status of your claim submission:

Online: [bannerhealthnetwork.com](https://www.bannerhealthnetwork.com)

By phone: 800-827-2464



The delegate owns all reconsiderations when they process a claim 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.



Questions?

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