UnitedHealthcare Dual Complete plans in Texas

2026 quick reference guide

WellMed Medical Management, an affiliate of UnitedHealthcare, manages certain administrative services for members enrolled in UnitedHealthcare Dual Complete health plans in Texas. 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 WellMed:

Contract number	PBP	Segment ID	Group Number	Group Medicaid eligibility type
H5322	025	000	TX99TXSNH2FW	Full Dual Group
H5322	025	000	TX99TXSNH2PW	Partial Dual Group
H5322	025	000	TX99TXSNH2QW	QMB
H5322	038	000	TX99TXSNPF6W	Full Dual Group
H5322	038	000	TX99TXSNPP6W	Partial Dual Group
H5322	038	000	TX99TXSNPQ6D	QMB
H5322	046	000	TX99TXDSNPP4	Partial Dual Group
H5322	046	000	TX99TXDSNPF4	Full Dual Group

As of Jan. 1, 2026, the following plans are no longer administratively managed by WellMed. These plans will be managed by UnitedHealthcare.

State	Contract number	PBP	Segment ID
Texas	H1278	005	000
Texas	H1278	013	000
Texas	H1278	014	000
Texas	H1278	021	000
Texas	H1278	025	000
Texas	H1278	026	000
Texas	H4514	015	000
Texas	R6801	008	000
Texas	R6801	009	000
Texas	R6801	011	000
Texas	R6801	012	000

For more information, including group numbers, see the **2026 Medicare Advantage, CSNP & DSNP Quick Reference Guide**.

Verifying member eligibility

You can verify member eligibility:

- **Online:** Sign in to the **UnitedHealthcare Provider Portal** and select Eligibility
- **EDI:** Use Transactions 270 (inquiry) and 271 (response) through your vendor or clearinghouse
- **By phone:** 866-944-4983

Referrals

The referral process is distinct from prior authorization.

- Referrals are for evaluation and/or treatment between physicians
- Prior authorization is required for specific procedures listed on the WellMed Prior Authorization List (PAL) and must be submitted via ePRG

Starting Jan. 1, 2026, specialists providing care to members enrolled in UnitedHealthcare Medicare Advantage HMO and HMO-POS plans are required to obtain a referral from the member's primary care physician (PCP) before rendering care in office or home settings.

United Healthcare®

PCPs:

- Must issue referrals for specialties prior to the patient receiving care for certain specialties
- Referrals should be directed to the **specialist physician's name**
  - Nurse practitioners and physician assistants are not listed in the referral tool

Specialists:

- Must have a valid referral from the patient's PCP **before rendering services**
- **Specialists** cannot refer to other specialists

A referral must be obtained for specialist visits for dates of service in 2026 even if the patient has an existing ongoing relationship with the specialist.

Referral requirements will NOT apply to services provided by a:

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

Additional specialty services not requiring a referral:

The following services do not require a referral. However, they **may require notification and/ or prior authorization.** For information on prior authorization requirements, refer to the prior authorization list.

- Urgent and emergency services billed with the applicable place of service
- PT/OT/ST
- Cardiac or pulmonary rehabilitation services
- Mental health/substance use services with behavioral health clinicians (follow health plan behavioral health guidelines)
- Any service from a hospital-based physician (anesthesiologist, emergency physician, radiologist and pathology)
- Any service provided in a hospital-based setting by a consulting physician, including hospitalists
- Routine, preventive and diagnostic, mammography, colonoscopies, and bone screening
- Dialysis services
- Routine vision or hearing services must follow benefit plan guidelines
- Any lab services or radiological or non-radiological testing services
- DME, home health, prosthetic/orthotic devices, medical supplies, diabetic testing supplies and Medicare Part B drugs (confirm the prior authorization list)

- Additional benefits that may be covered by some Medicare Advantage benefit plans but are not covered by Medicare, such as hearing aids, routine eyewear, fitness memberships or outpatient prescription drugs
  - Approvals for these services should follow members' benefit plan guidelines
- Services obtained while accessing the health plan Medicare National Network or other out of service area provider which allows for services while traveling. Please refer to members benefit plan regarding guidelines
- 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
- 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 WellMed Medical Management Inc., will not check for referrals for the above categories when paying claims.

Specialists' claims could be denied due to missing referrals. Any denied claims will be considered provider liability. Members must not be balanced billed for services rendered without a valid referral.

A claim may be denied even when a valid referral is on file for the reasons including, but not limited to:

- The services are not covered under the members' benefit plan
- Required prior authorization was not obtained
- Any denied claims will be considered provider liability. Members must not be balanced billed for services rendered without a valid referral.

For members on benefits plans administered through WellMed:

PCPs can issue referrals through the LeadingReach platform to the specialist or utilize their own referral systems for referral to specialists, including through their internal EMR system and/or alternative referral methods.

The PCP must provide a referral ID, which the specialist is required to submit on the claim. The referral ID must be a unique value (combination of number and/or letters) assigned to each specific patient/provider combination. Each referral should reflect a designated time period and number of visits. Generic or duplicate referral ID's are strictly prohibited and will not be accepted as a valid referral.

For additional information, go to the **Market Plan Reference Guide** under the referral section. For application assistance, contact LeadingReach at 866-656-4410.

Additional information about the upcoming referral requirement is posted at eprg.wellmed.net.

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.

- **Online (preferred):** **eprg.wellmed.net**
- **By phone:** 877-757-4440 or 877-299-7213

Requests for services that require prior authorization will be in the Prior Authorization List that is on **eprg.wellmed.net.** Submit your request at least 7 days before the planned date of service.

Services previously approved by UnitedHealthcare for dates of service starting Jan. 1, 2026, and after will be transitioned to WellMed no further action needed on previously approved services.

Hospital admission notifications

Please notify WellMed of hospital admissions no later than 1 business day after admission by:

- **Online (preferred):** **eprg.wellmed.net**
- **Phone:** 877-490-8982

Claims and reimbursement for Dual Special Needs Plans (D-SNPs)

Submit claims to WellMed. WellMed will reimburse you for the member's medical services. UnitedHealthcare will reimburse you for the applicable member cost-share.

- **Payer ID:** WELM2
- **Mailing address:**
  WellMed D-SNP Claims
  P.O. Box 30578
  Salt Lake City, UT 84130-0578

Check the status of your claim submission:

- **Online (preferred):** **eprg.wellmed.net**
- **276/277 Transactions**
  Payer Name: WellMed
  Payer ID: WELM2

Claims Customer Service Department hours of operation:

Monday–Friday (closed on federal holidays)
7 a.m.–5 p.m. CT
800-550-7691

Submit claim reconsiderations:

- **Online (preferred):** WellMed PHC Claims Portal at **americas.pch.global** (promo code WE0622)
- **By phone:** 800-550-7691
- **By mail:**
  WellMed D-SNP Claims
  P.O. Box 30578
  Salt Lake City, UT 84130-0578

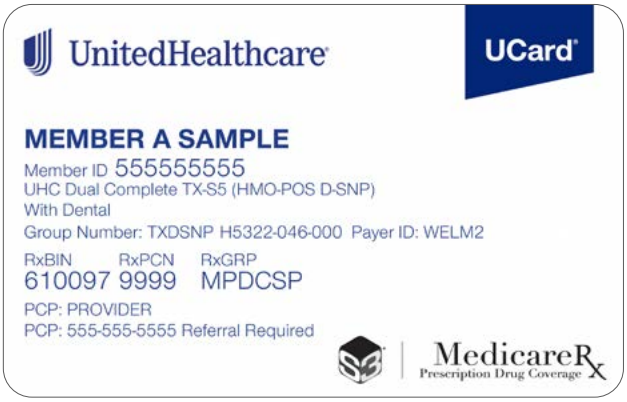
Member ID cards

Members in the affected plans will get new member ID cards that show the Payer ID WELM2 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.**

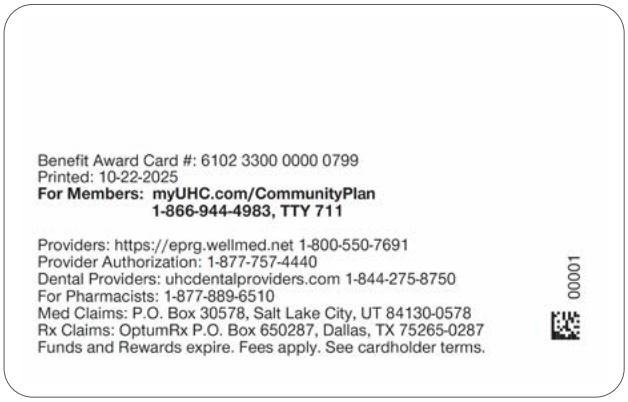
UnitedHealthcare UCard

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



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.

United Healthcare®

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.

Claims

Submit claims using the following electronic Payer ID or mailing address:

Payer ID:
WELM2
WellMed D-SNP Claims
P.O. BOX 30578
Salt Lake City, UT 84130-0578

Submit claim reconsiderations:

Online: WellMed PHC Claims Portal at **americas.pch.global** (promo code WE0622)

By phone: 800-550-7691

By mail:
WellMed D-SNP Claims
P.O. Box 30578
Salt Lake City, UT 84130-0578

Check the status of your claim submission:

Online: eprg.wellmed.net

- **276/277 Transactions**
  Payer Name: WellMed
  Payer ID: WELM2

Claims Customer Service Department hours of operation: Monday–Friday (closed on federal holidays) 7 a.m.–5 p.m. CT 800-550-7691

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**.

United Healthcare®