

Georgia Gold Card exemptions

Frequently asked questions

Overview

The UnitedHealthcare Georgia Gold Card Program launches on July 1, 2026. You may qualify for prior authorization exemptions for a specific set of services, based on your performance, that are entered and requested on or after this date.

Frequently asked questions

What does this mean for providers already eligible for the UnitedHealthcare National Gold Card Program?

- The dedicated Georgia Gold Card Program applies only to fully insured plans regulated by the state in accordance with **Georgia SB 5 (Act 299, 2025) Codified in O.C.G.A. Title 33**
- Contracted provider processes for plans not impacted by this Georgia legislation will remain unchanged. These include self-insured, ERISA and federally funded plans such as Medicare and Medicaid.

How do I qualify for Georgia Gold Card exemption?

We determine eligibility for our Gold Card program by analyzing approval rates and submission volumes at the provider TIN level for the codes on the Gold Card list.

- You must have at least 10 prior authorization submissions per year for each of the previous 2 years and a 92% approval rate in each year
 - The 10 prior authorizations may include any combination of codes on the Gold Card List, such as:
 - 10 submissions for one code per year
 - 10 submissions across different codes per year
 - The 92% approval rate is averaged across all Gold Card List codes for which prior authorizations were received and decisioned, and the threshold must be met for each individual year
- If an in-network provider meets both criteria, the provider qualifies for the applicable program for the plan types for which they are contracted.

You can check your Gold Card status starting July 1, 2026, in the UnitedHealthcare Provider Portal.

Is there a review process for provider groups who feel they should have been included in the Gold Card program?

Yes. Provider group administrators, defined by a single TIN, have one opportunity to submit a Gold Card status review request within 30 calendar days after the status determination is made available in the [UnitedHealthcare Provider Portal](#).

We'll communicate any Gold Card status change resulting from a review request, including the effective date. Provider groups must submit review requests with all required information as outlined in our Gold Card resources.

How do I find information specific to the Georgia Behavioral Health Gold Card program?

Access our [Georgia Gold Card quick reference guide](#) for the correct processes related to answering questions and provider status related to Behavioral Healthcare Gold Card programs for Georgia.

To avoid delays, behavioral health care providers and providers Gold Carded for behavioral health services who have any questions related to Behavioral Health Gold Carding, please email Optum Behavioral Health at bh_gold_card@optum.com.

How do I view other TINs for my account?

To see other TINs, click on the Provider dropdown within the [UnitedHealthcare Provider Portal](#) and select a different corporate tax ID.

When will provider groups have another opportunity to qualify?

We'll evaluate provider groups that don't qualify for Gold Card status during the next annual evaluation cycle.

How often will you reevaluate provider eligibility and participation in the Gold Card program?

We evaluate health care professional eligibility and participation annually.

How are prior authorizations attributed to providers?

To determine which prior authorization requests are counted toward Gold Card qualification status, we review all available health care professional information for each authorization request submitted during the evaluation period.

The authorization is attributed to a single health care professional, known as the attributed provider, based on the combination of health care professional role type and the quality of provider information available on the authorization request. When possible, we attribute an authorization request to a professional rather than a facility.

We may not consider requests that have missing, incomplete or invalid information in key fields in the determination of Gold Card status.



How do I submit a voluntary advance notification?

A voluntary advance notification can be started the same way as a prior authorization request: through the UnitedHealthcare Provider Portal, Point of Care Assist, Electronic Data Interchange (EDI), phone or fax.

If the TIN, CPT® code and member all qualify for the Gold Card program, provider groups will receive notice that no additional information is needed and will receive an advance notification number.

- Please note that Gold Carded health care professionals don't need to include the notification number on their claims. Claims for Gold Card-eligible CPT codes will automatically find the advance notification number and process the claim.

What if the services we are requesting include both Gold Carded and non-Gold Carded codes?

You can continue to submit those services together. Our systems will identify which codes qualify for Gold Card and which codes require additional clinical information for review.

Could UnitedHealthcare still require medical documentation?

We may require medical records for other non-medical necessity reviews we conduct.

Which National Provider Identifier is eligible for Gold Card?

The ordering provider National Provider Identifier (NPI) that is associated with a Gold Card TIN is eligible for Gold Card status.

How does this work for providers with multiple TINs?

Each TIN is independently evaluated for Gold Card qualification.

What if a provider practices under multiple TINs?

Providers practicing under multiple TINs may qualify for the program under some TINs but not others.

How do I submit claims if an exempted provider requests my services, but I don't have an exemption?

If a provider with an exemption requests your services and you don't have an exemption for that service, include the requesting provider's name and NPI on the claim:

- In fields 17 and 17B of CMS Form 1500
- In fields 76-79 or another appropriate field in Form UB-04
- In the corresponding fields for electronic claims using the ASC X12N 837 format

If this information is not included, we will require prior authorization for the claim.

How do I tell if my patient is fully insured?

You have 2 ways to determine if a member is fully insured:

- The member ID card has the letters “DOI” in the lower left corner if the member is in a fully insured plan



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

- Search for your patient in the Eligibility and Benefits section of UHCprovider.com. Funding type, “Fully insured,” displays, letting you know your patient’s eligibility.

Policies

Policies Medical (Liberty Network) Active: 05/01/2022 - Present

Oxford Health Insurance, Inc.

Medical Active: 05/01/2022 - Present | Subscriber | Member ID Selected Payer Status: Primary

Member ID	Plan Name Liberty Network	Payer Oxford Health Insurance, Inc. (06111)	Prior Authorizations Yes, Required Go to Prior Authorizations
Group	Plan Type Commercial	Claims Address P.O. Box 29130 Hot Springs, AR 71903	Referral No, Not Required
Funding Type Fully Insured-Small Group	Product —	Care Opportunities —	Prior Authorizations by Code Services Requiring Prior Authorization

Coordination of Benefits Status
Cannot determine update status

View ID Card Find a Provider Find a Claim

If I am exempt, can I still submit a prior authorization request anyway?

No. Submitting a prior authorization request for an exempted service triggers a rejection message that reminds you about the exemption.

If I am exempt, do I need prior authorization for services for which I am not gold carded?

Yes. For services for which you are not exempt and prior authorization is required, you will need to submit a prior authorization request.

How do I know if the service is covered under the member's benefit plan?

Regardless of the exemption, to obtain reimbursement for this service, a member must meet their plan's eligibility requirements and the service must be a covered benefit under the plan.

We strongly encourage you to check the member's eligibility and covered benefit status for exempted services through the through our [EDI transactions and code sets resource](#).

How long are these exemptions in place?

Exemptions are open-ended if you comply with the medical policy and remain contracted with an eligible UnitedHealthcare plan.

How and when will I know if my exemption is rescinded?

We will send you a notice if you no longer qualify for an exemption.

When can I qualify for an exemption?

Each year, provider TINs that are not currently qualified will be evaluated for Gold Card exemption qualification.

How does the UnitedHealthcare Gold Card program align with state Gold Card legislation?

State criteria will be applied first, as required, for the applicable line of business, then the Gold Card program will take effect for qualifying care provider groups and codes where it does not conflict with state requirements.



Questions? We're here to help.

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

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