How to Make Prior Authorizations Work for You

2024 IHCP Works Annual Seminar

Agenda

- Medical Prior Authorization (PA)
- Need to Know
- Web Portal
- Telephonic Requests
- Fax Requests
- Appeals Process
- Behavioral Health Prior Authorization
- MHS Team
- Questions and Answers

Medical Prior Authorization

Medical Prior Authorization (PA) is an approval from MHS to provide services designated as needing authorization before treatment and/or payment.

- ER services do not require PA. Admission must be called into MHS Prior Authorization Department within two business days.

- Urgent concurrent = Emergent inpatient admission. Determination timeline within 24 hours of receipt of request.

Medical Prior Authorization continued

- MHS has up to five business days to render standard PA decisions and 48 hours to render urgent PA decisions.
- Reasons for a delayed decision may include:
  - Lack of information or incomplete request.
  - Request requiring Medical Director review.

- Medical Management does not verify eligibility or benefit limitations:
  - Provider is responsible for eligibility and benefit verification.

Medical Prior Authorization continued

MHS Medical Management will review state guidelines and clinical documentation.

- If the provider requests an inpatient level of care for a covered/eligible condition, but procedure and documentation supports an outpatient/observation level of care, MHS will send the case for Medical Director review.

- Elective procedures that require PA must be submitted to MHS at least two business days prior to the date of service.

Authorizations do not guarantee payment.

Transfer Prior Authorization Requests

- MHS requires notification and approval for all transfers from one facility to another at least two business days in advance.

- MHS requires notification within two business days following all emergent transfers.

- Transfers include, but are not limited to:
  - Facility-to-facility.

Higher level of care changes require PA, and it is the responsibility of the transferring facility to obtain.

MCE's and Indiana Health Coverage Programs

- MCE's must follow Indiana Health Coverage Programs (IHCP) Policy (fee-for-service criteria) exactly for the following items:
  - ABA Therapy
  - Drug Testing
  - EndoPredict-Breast Cancer Test
  - Hysterectomies
  - ReliZorb (in-line cartridge containing digestive enzymes for enteral feeding)
  - Speech-Generating Devices
  - Spinal Stenosis
  - Transplants
  - Bariatric Procedures
  - Oxygen Usage

  For additional details please see IHCP Bulletin BT2022117

How to Obtain a Prior Authorization

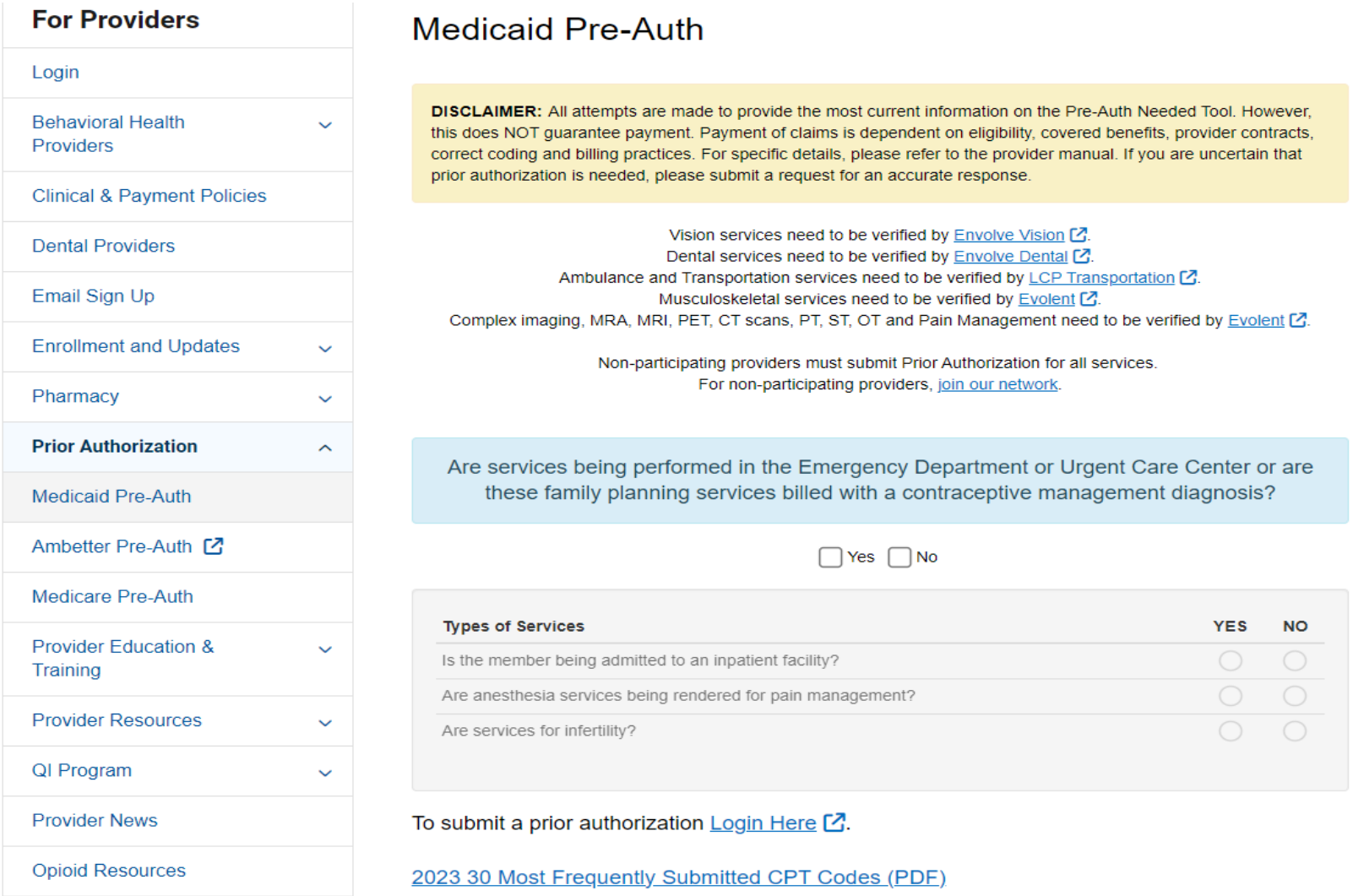
Check to see if a pre-authorization is necessary by using our online tool located on the sidebar. It's quick and easy. If an authorization is needed, you can access our Provider Portal to submit online.

- Preauthorization Tool: www.mhsindiana.com/providers/prior-authorization/medicaid-pre-auth.html. This link will take you to the create an authorization page.

- For imaging, outpatient surgeries and testing, requests for services may be obtained via:

  Phone: 1-877-647-4848
  Fax: 1-866-912-4245
  Online: www.mhsindiana.com

How to Obtain a Prior Authorization continued



For Providers

- Login
- Behavioral Health Providers
- Clinical & Payment Policies
- Dental Providers
- Email Sign Up
- Enrollment and Updates
- Pharmacy
- **Prior Authorization**
  - Medicaid Pre-Auth
  - Ambetter Pre-Auth
  - Medicare Pre-Auth
- Provider Education & Training
- Provider Resources
- QI Program
- Provider News
- Opioid Resources

Medicaid Pre-Auth

DISCLAIMER: All attempts are made to provide the most current information on the Pre-Auth Needed Tool. However, this does NOT guarantee payment. Payment of claims is dependent on eligibility, covered benefits, provider contracts, correct coding and billing practices. For specific details, please refer to the provider manual. If you are uncertain that prior authorization is needed, please submit a request for an accurate response.

Vision services need to be verified by Envolve Vision.
Dental services need to be verified by Envolve Dental.
Ambulance and Transportation services need to be verified by LCP Transportation.
Musculoskeletal services need to be verified by Evolent.
Complex imaging, MRA, MRI, PET, CT scans, PT, ST, OT and Pain Management need to be verified by Evolent.

Non-participating providers must submit Prior Authorization for all services.
For non-participating providers, join our network.

Are services being performed in the Emergency Department or Urgent Care Center or are these family planning services billed with a contraceptive management diagnosis?

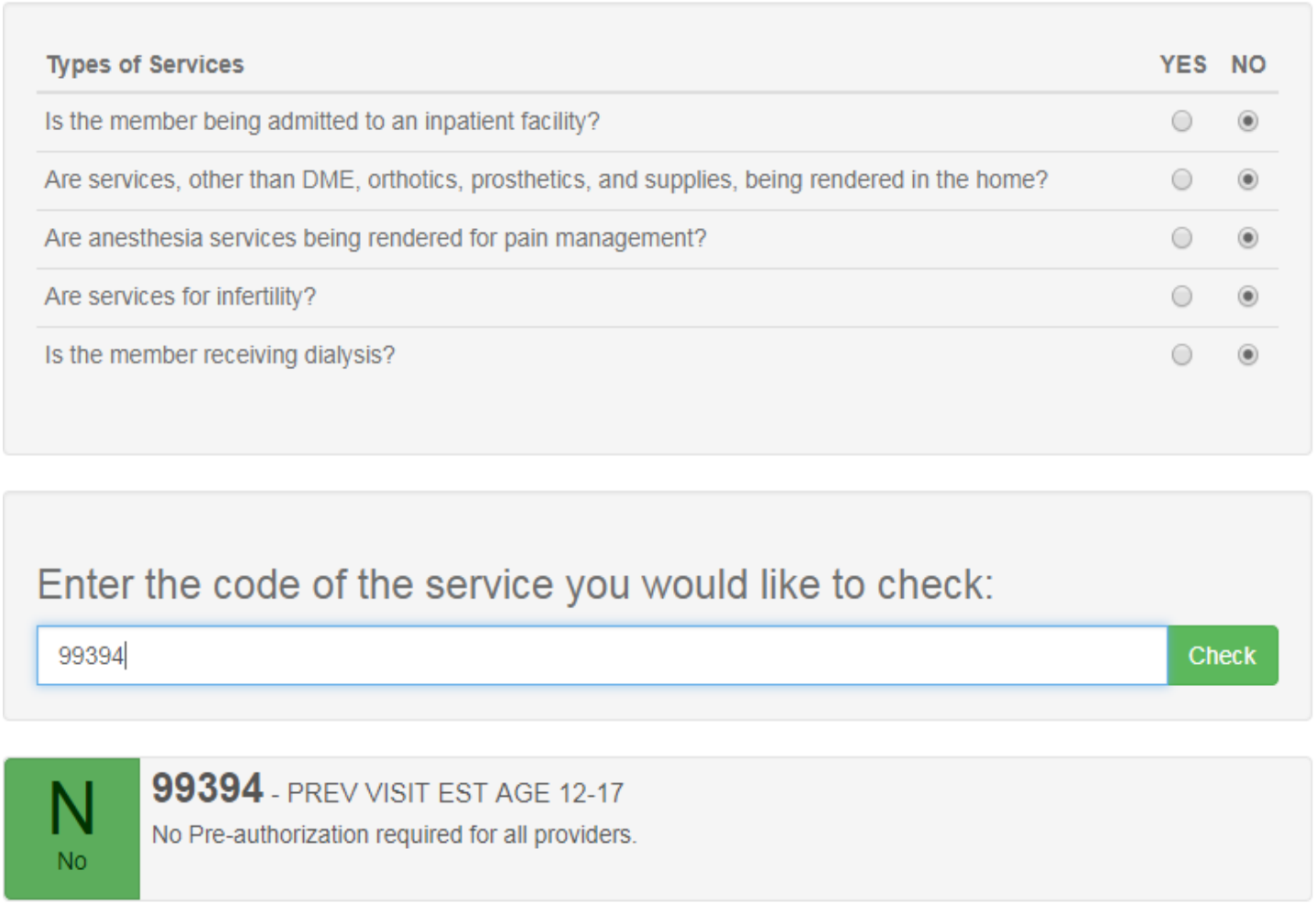
☐ Yes ☐ No

Types of Services	YES	NO
Is the member being admitted to an inpatient facility?	○	○
Are anesthesia services being rendered for pain management?	○	○
Are services for infertility?	○	○

To submit a prior authorization Login Here.

2023 30 Most Frequently Submitted CPT Codes (PDF)

How to Obtain a Prior Authorization continued



How to Obtain a Prior Authorization continued

Information Needed to Complete All Prior Authorizations:

- Member's Name, Medicaid ID, and Date of Birth.
- Type of service needed.
- Date(s) of service.
- Ordering Physician with NPI number.
- Servicing/Rendering Physician with Rendering NPI number.
- Healthcare Common Procedure Coding System (HCPCS)and Current Procedural Terminology (CPT) codes requested for approval.
- Diagnosis code.
- Contact person, including phone and fax numbers.
- Clinical information to support medical necessity
- Home care requires a signed Plan of Care (POC).

Prior Authorization Update Requests

- Providers can update previously approved PAs within 30 business days of the original date of service prior to claim denial for changes to:
  - Dates of service.
  - CPT/HCPCS codes.
  - Provider demographic changes.

Providers are encouraged to make corrections to the existing PA prior to submitting the claim.

Continuity of Care PA Requests

- MHS will honor pre-existing authorizations from any other Indiana Medicaid payor following the below mentioned guidelines:
  - During the first 30 calendar days during enrollment, or up to the expiration date of the previous authorization, whichever occurs first, and upon notification of transition to MHS.
  - Providers must include the approval from the prior Payor and FFS, once the member transfers to MHS.

***Reference: MHS Provider Manual Chapter 7**

MHS - Provider Manual 2023 (mhsindiana.com)

Sub-Acute Care PA Requests

- MHS conducts clinical review for ongoing authorization and coordination of discharge needs for our members in subacute facilities at least every 3-5 calendar days.
- One day sub-acute care request turnaround time.
- Indiana Administrative Code (IAC) requires that individuals requesting a nursing facility admission to a Medicaid-certified nursing facility (NF) meet a nursing facility level of care (*405 IAC 1-3-1* and *405 IAC 1-3-2*.).
- A Preadmission Screening and Resident Review (PASRR) is required before admission and must be submitted with the admission request and when updated according to IAC requirements.

Sub-Acute Care Cont.

The PASRR is submitted to MHS with the admission request and should include complete current information regarding:

- Member's condition.
- Level of functioning (prior to admission).
- Medications.
- Therapies provided.
- Participation in therapies.
- Progress toward goals.
- New or amended goals.
- Updates from care conferences.
- Updates to the member's plan of care.
- Discharge plans and needs identified (Home Health/DME, etc.).
- Anticipated discharge date.

Inpatient Prior Authorization Requests

- To ensure timely and accurate medical necessity review of a physical health inpatient admission.

- Notification of an inpatient admission and any clinical information may be submitted for medical necessity review by:
  - MHS Provider web tool, using the IHCP universal PA form
  - Via fax 1-866-912-4245

- Phone notifications of admission and submission of clinical information for members enrolled in Hoosier Healthwise, the Healthy Indiana Plan (HIP), or Hoosier Care Connect will not be accepted.

Need to Know

Outpatient Radiology PA Requests

- MHS partners with Evolent for outpatient radiology PA process:
- PA requests must be submitted via:
  - Evolent Website at RadMD.com.
  - Evolent phone number 1-866-904-5096.

**Not applicable for ER, Observation or Inpatient.*

EVOLENT
Physical, Occupational and Speech Therapy

Utilization management of these services is managed by EVOLENT for Medicaid and Ambetter.

Prior authorization for Physical (PT), Occupational (OT) and Speech Therapy (ST) services are required to determine whether services are medically necessary and appropriate; determination is made by MHS not EVOLENT.

All Health Plan approved training/education materials are posted on the EVOLENT website, www.RadMD.com under the Resources tab. For new users to access these web-based documents, a RadMD account ID and password must be created.

Chiropractors rendering therapy services are exempt from the EVOLENT program.

EVOLENT

Cardiac Services

Evolent manages prior authorizations for the Cardiac Services below

- Automated Implantable Cardioverter Defibrillator
- Leadless Pacemaker
- Pacemaker
- Revision or Replacement of Implanted Cardiac Device
- Coronary Artery Bypass Grafting (Non-Emergent)
- Coronary Angioplasty and Stenting
- Non-Coronary Angioplasty and Stenting

Telephonic Intake: Direct:1-574-784-1005 | Toll Free:1-855-415-7482

Facsimile Intake: 1-463-207-5864

This is not an all-inclusive list

Durable & Home Medical Equipment (DME)

- Non-Participating DME providers require prior authorization on all services. Prior Authorization requests must be submitted by the ordering physician. All requests should be faxed directly to MHS at 866-912-4245.
- Orders are sent directly to and coordinated by MHS and delivered to the member.
- Does not apply to items provided by and billed by physician office.
- To initiate a prior authorization:
  Log into the Secure Provider Portal, click on “Create Authorization.” Choose DME and the provider will be directed to the DME portal for order entry.
- **Fax Number:**1-866-912-4245 **Phone Number:**1-844-218-4932.

Ambulance Coverage

Clarification of Authorization Requirements

Prior authorization is required to ensure medical necessity for the following non- emergent ambulance services:

Ambulance:
A0426 - Ambulance service, adv. life support, non-emergency transport, level 1
A0428 - Ambulance service, basic life support, non-emergent transport.
A0999 - Unlisted ambulance service
T2003 - Non-emergency transportation encounter/trip
T2004 - Non-emergency transportation commercial carrier

Air Transport:
A0140 - Non-emergency transportation and air travel
A0430 - Air Ambulance, conventional air services, one way (fixed wing)
A0999 - Unlisted Ambulance service

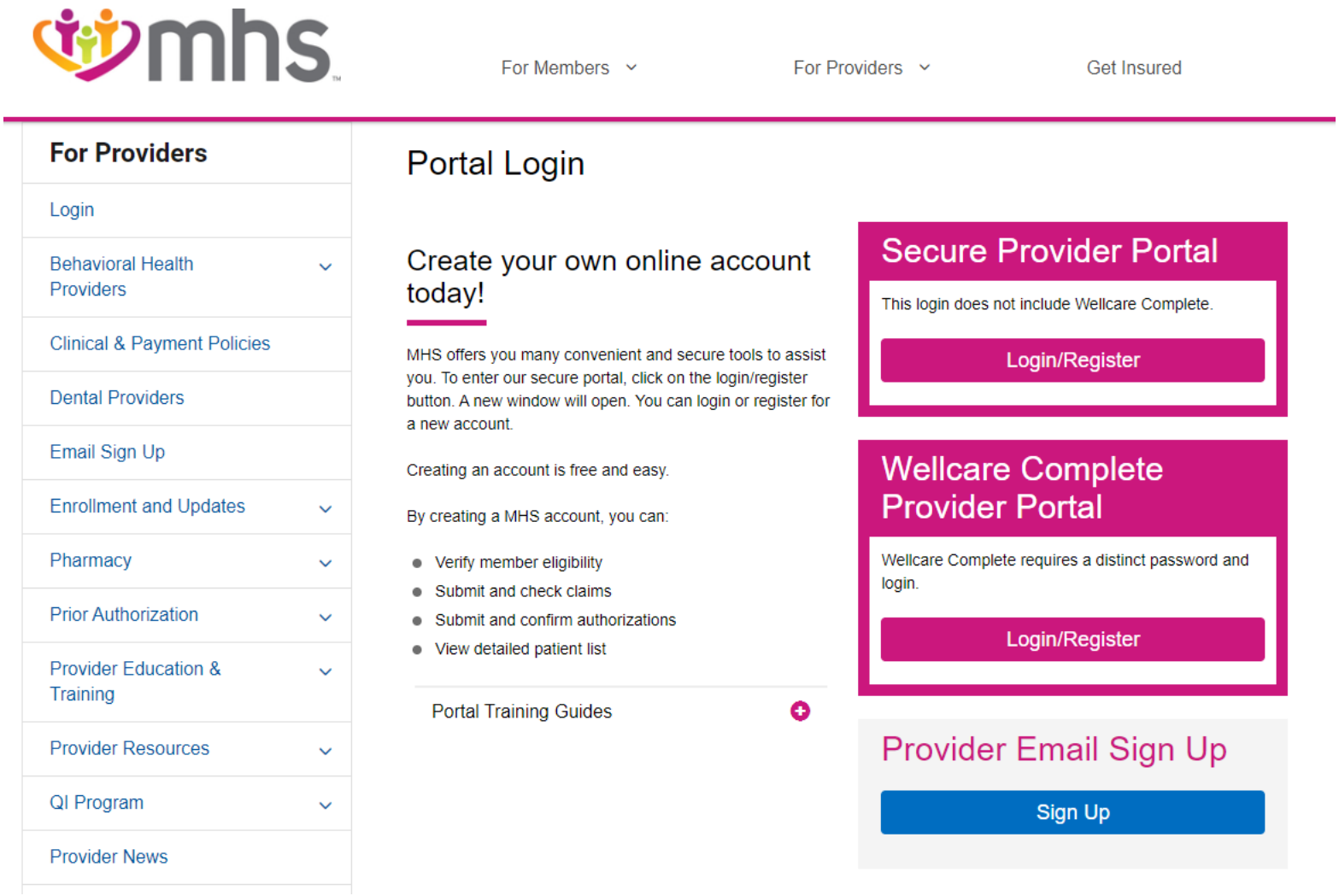
Pharmacy Requests

MHS Pharmacy Benefit Manager is Express Scripts, Inc. (ESI)

- Preferred Drug Lists and authorization forms are available on our MHS website
- PA requests:
  Phone: 1-866-399-0928
  Fax non-specialty drugs: 1-866-399-0929
  Fax Specialty drugs: 1-833-645-2742
- Formulary integrated into many Electronic Health Records (EHR) solutions
- Online PA submission available through CoverMyMeds:
  - covermymeds.com/main/
- Specialty Drugs
  AcariaHealth General Customer Care
  Phone: 1-800-511-5144 Fax: 1-877-541-1503

Web Portal

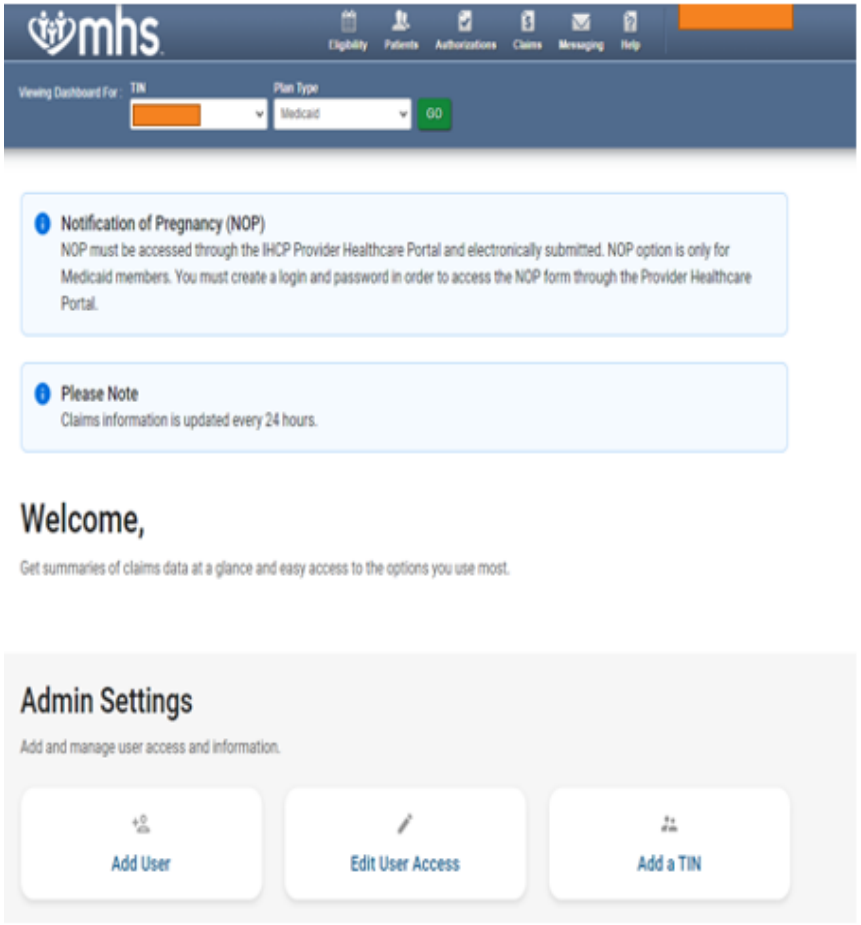
Secure Portal Registration or Login



Web Authorization

- Providers can submit PAs online via the MHS Secure Provider Portal.
- When using the portal, providers can upload supporting documentation directly.
- **Exceptions**: Must submit hospice, home health, and biopharmacy PA requests via fax 1-866-912-4245.
- Providers can check the authorization status on the portal.

Homepage - MHS (Medicaid)



Quick Actions

Do a quick eligibility check, find patient benefits information, create a new claim or recurring claim or an authorization.

Member ID or Last Name *

Member Date of Birth

MM/DD/YYYY

Select Action Type *

Select

SUBMIT

Authorization Overview

Inpatient Authorizations

View All

Outpatient Authorizations

View All

Useful Links

Reports

This repository contains reports that are uploaded and maintained by the health plan.

Patient Analytics

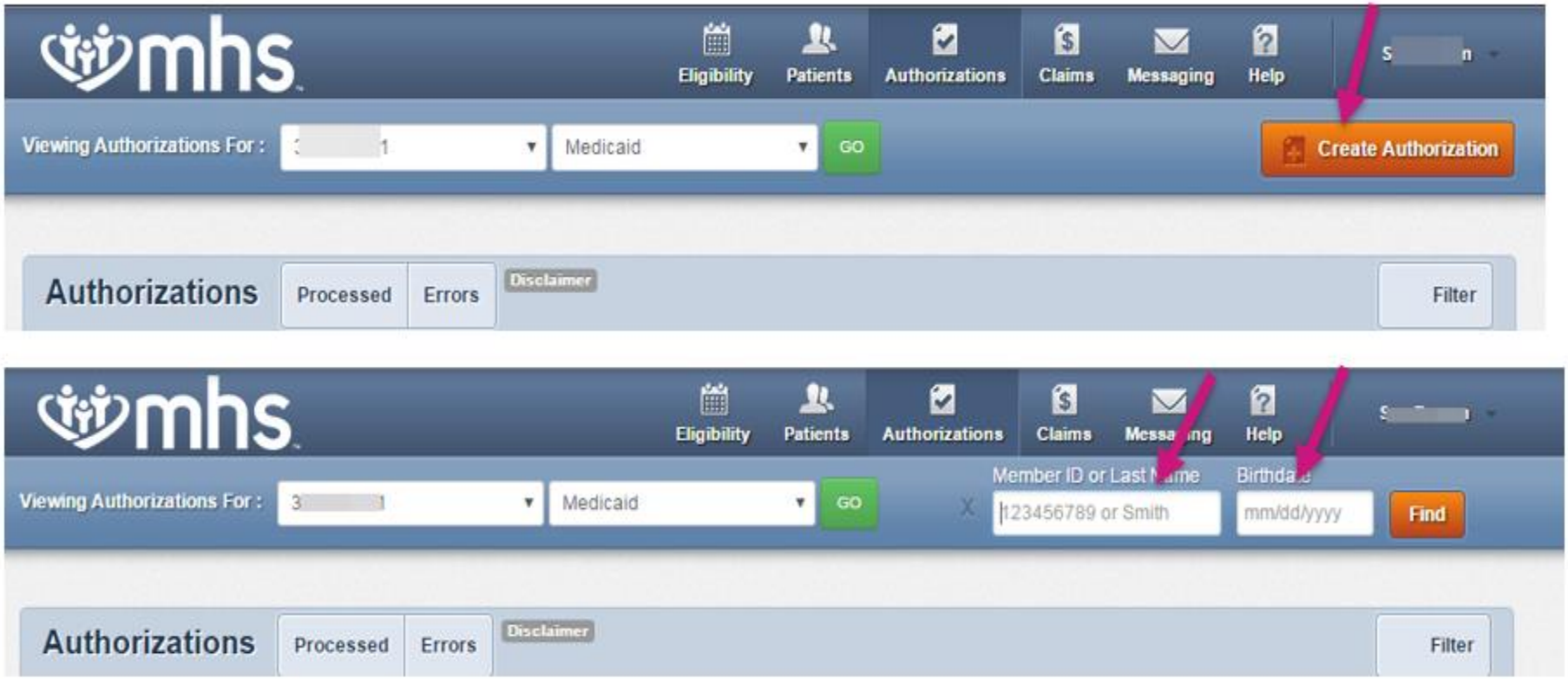
This is a PHM tool that supports providers in the delivery of timely, efficient, and evidence-based care to our members.

Provider Analytics

Used by PCP groups to access data/reports/dashboard that assist in providing better health outcomes and lower cost.

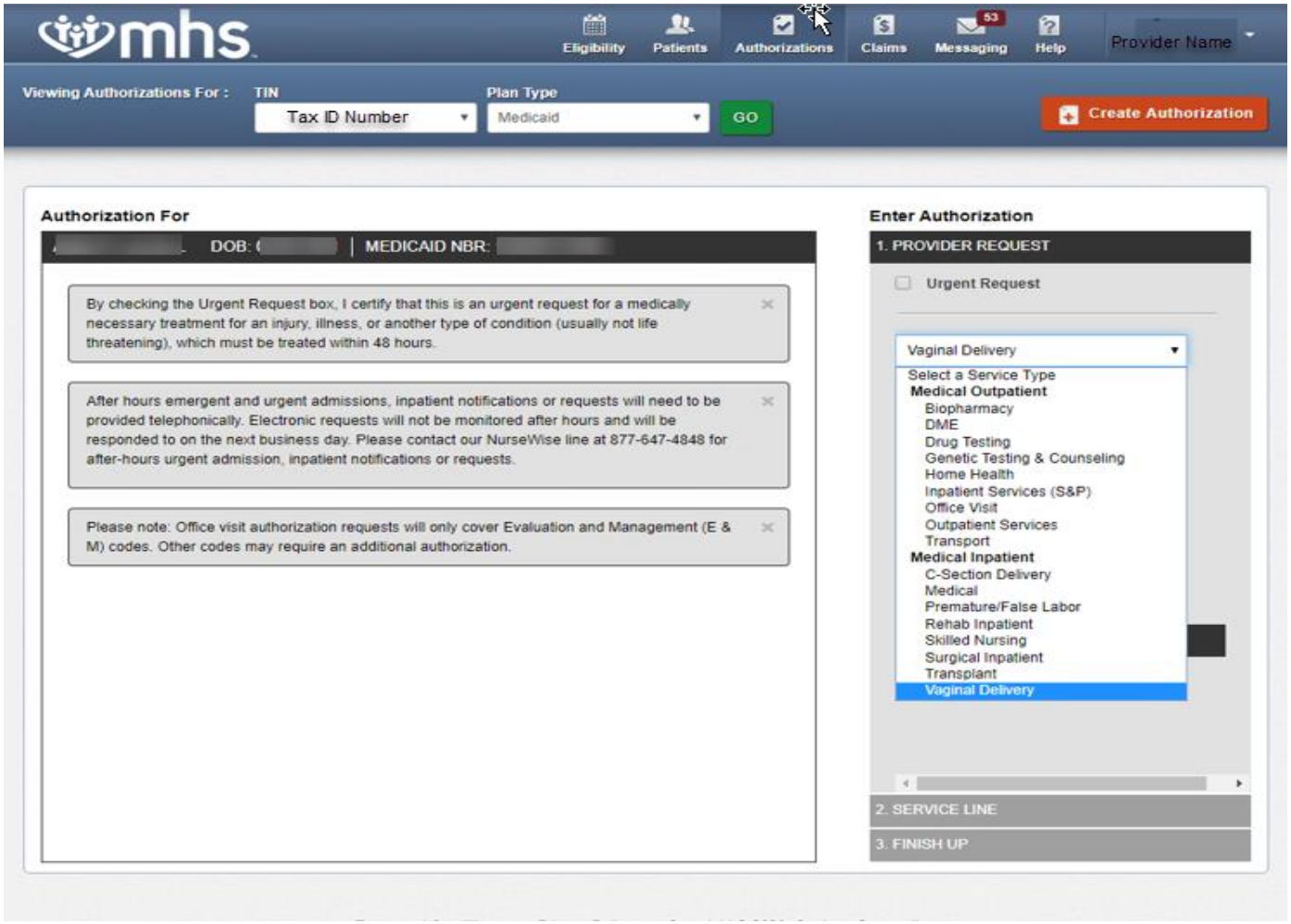
Creating a New Authorization

- Click **Create Authorization.**
- Enter **Member ID** or **Last Name** and **Birthdate.**



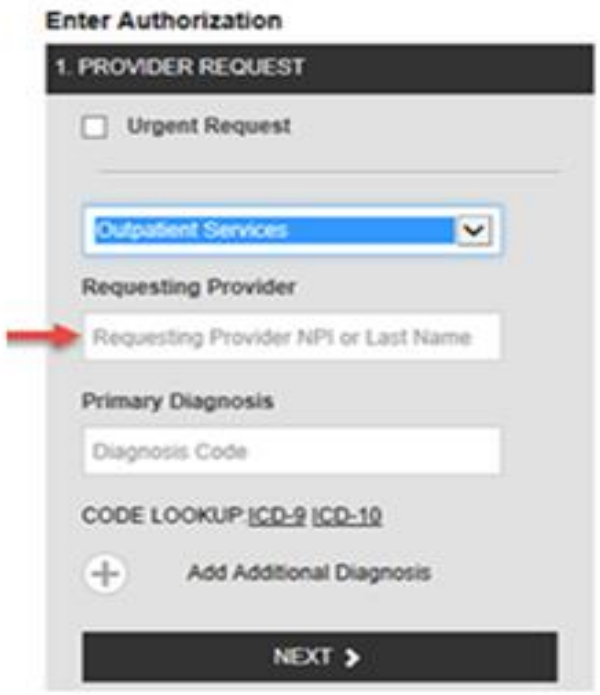
Creating a New Authorization continued

- Select a Service Type.



Creating a New Authorization continued

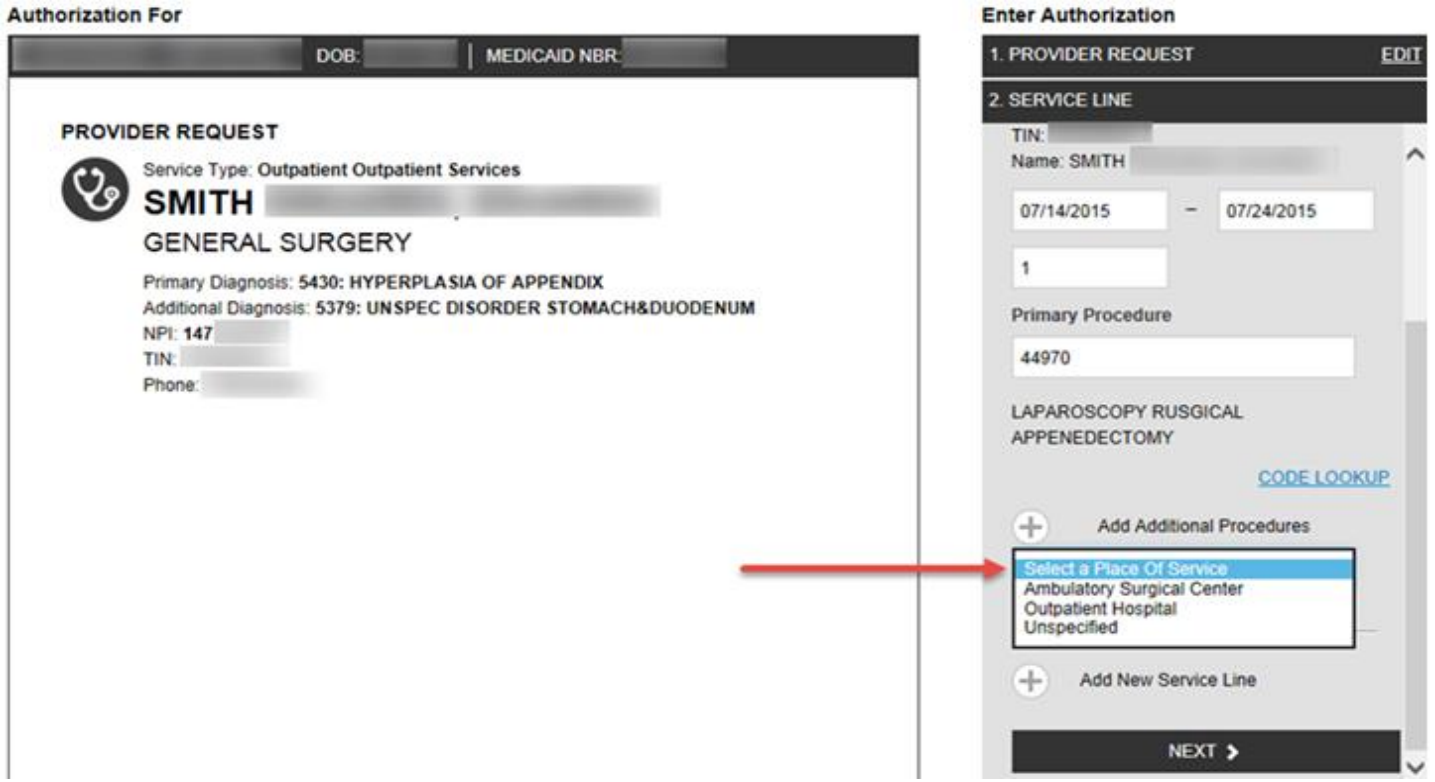
Select Provider NPI



Add Primary Diagnosis

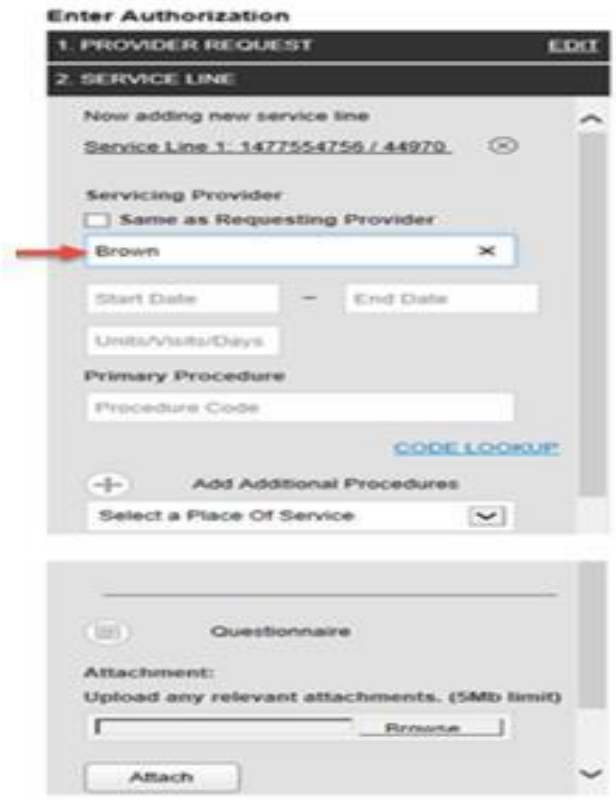
Creating a New Authorization continued

Add Additional Procedures (if applicable)



Creating a New Authorization continued

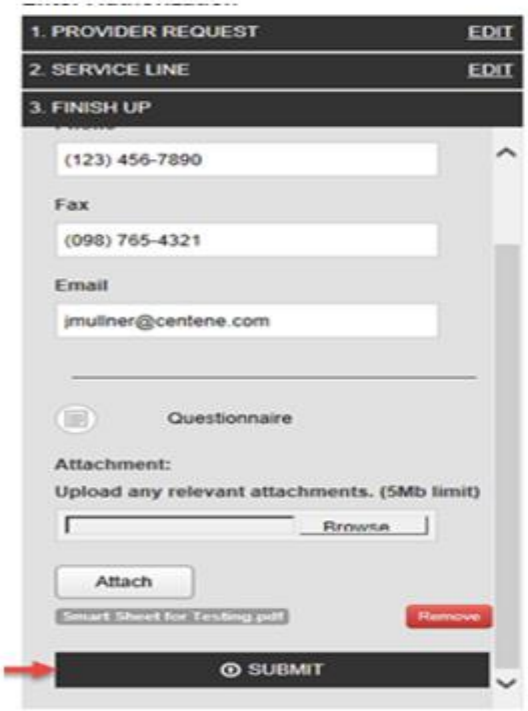
Service Line Details:



- Provider request will appear on the left side of the screen.
- Update Servicing Provider. Check box if same as Requesting Provider.
- Update Servicing Provider if not the same.
- Update Start Date and End Date.
- Update Total Units/Visits/Days.
- Update Primary Procedure.
- Add any additional procedures.
- Add additional Service Line if applicable: All Service Lines added will appear on the left side of the screen.

Creating a New Authorization continued

- Submit a new Authorization:
  - **Confirmation number**



Telephone Authorizations

Telephone Authorizations

- Providers can initiate PA via the MHS referral line by calling 1-877-647-4848:
  - Monday - Friday 8 a.m. to 5 p.m. EST (Closed for lunch from noon to 1 p.m.).
  - After hours, MHS 24-Hour Nurse Advice Line is available to take emergent requests by selecting nurse when prompted by calling 1-877-647-4848.
- The PA process begins at MHS by speaking with the MHS non-clinical referral staff.
- For procedures requiring additional review, we will transfer providers to a live nurse line to facilitate the PA process.

Fax Authorizations

Fax Authorizations continued

MHS Medical Management Department

https://www.mhsindiana.com/providers/prior-authorization.html

Fax:1-866-912-4245

Patient Information					
IHCP Member ID (RID):					
Date of Birth:					
Patient Name:					
Address:					
City/State/ZIP Code:					
Patient/Guardian Phone:					
PMP Name:					
PMP NPI:					
PMP Phone:					
Ordering, Prescribing, or Referring (OPR) Provider Information					
OPR Physician NPI:					
Medical Diagnosis (Use of ICD Diagnostic Code Is Required)					
Dx1		Dx2		Dx3	

Please check the requested assignment category below:

☐ DME	☐ Inpatient	☐ Physical Therapy
☐ *Purchased*	☐ Observation	☐ Speech Therapy
☐ *Rented*	☐ Office Visit	☐ Transportation
☐ Home Health	☐ Occupational Therapy	☐ Other

Member ID, DOB, Patient name required

Medical Diagnosis code(s) required

Check Service category

https://www.mhsindiana.com/providers/resources/forms-resources.html

Fax Authorizations continued

Requesting Provider Information
Requesting Provider NPI/Provider ID:
Taxonomy:
Taxpayer Identification Number (TIN):
Provider Name:
Rendering Provider Information
Rendering Provider NPI/Provider ID:
TIN:
Name:
Address:
City/State/ZIP Code:
Phone:
Fax:

Enter the **Requesting** provider's information

Enter the **Rendering** provider's individual NPI#

https://www.mhsindiana.com/providers/resources/forms-resources.html

Fax Authorizations continued

Dates of Service Start	Stop	Procedure/ Service Codes	Modifiers		Service Description	Taxonomy	Place of Service (POS)	Units	Dollars

Prior Authorization/Medical Necessity Appeals

Prior Authorization/Medical Necessity Appeals

- Appeals must be initiated within 60 calendar days of the denial to be considered.
- Members may continue to receive benefits while the appeal is pending but may be liable for the costs if the decision is unfavorable. Determination will be communicated to the provider within 30 calendar days of the receipt.
- Before billing the patient, the provider must notify the patient or the patient's healthcare representative in writing that the patient will be responsible for the cost of services provided after the date of the notice.
- Decisions regarding expedited appeals are made no later than forty-eight (48) hours after the receipt.
- Peer-to-Peer requests must be within 10 business days of the adverse determination.

Prior Authorization/Medical Necessity Appeals continued

- Prior Authorization/Medical Necessity Appeals may be submitted to MHS in the following ways:
  - Web: Secure Provider Portal
  - Call: Medicaid: 1-877-647-4848
  - Email: Appeals@mhsindiana.com
  - Fax: Medicaid: 1-866-714-7993
  - Mail: MHS Grievance & Appeals
    P.O. Box 441567
    Indianapolis, IN 46244

Prior Authorization Denial and Appeal Process

PA Denial and Appeal Process

- **If MHS denies the requested service:**
  - And the member is still receiving services, the provider has the right to an expedited appeal. The attending physician must request the expedited appeal.
  - Or if the member already has been discharged, the attending physician must submit an appeal in writing within 60 calendar days of the denial.
  - The attending physician has the right to a peer-to-peer discussion with a MHS physician:
    - Providers initiate peer-to-peer discussions and expedited appeals by calling an MHS appeals coordinator at 1-877-647-4848.

***PA appeals are also known as medical necessity appeals.**

PA Denial and Appeal Process continued

Peer-to-Peer Discussion

- Effective June 24, 2024, the Indiana MHS Medicaid Peer-to-Peer Schedulers will report to Dr. Richard Cox, Senior Medical Director of Medical Affairs.

- They must request peer-to-peer within 10 calendar days of the adverse determination.

A PA appeal is different than a claim appeal request.

PA Denial and Appeal Process continued

- PA and Appeals can be completed through our Secure Web Portal. https://www.mhsindiana.com/

- Appeals can also be mailed to:

  Authorization/Medical Necessity
  Managed Health Services
  Attn: Appeals Coordinator
  P.O. Box 441567
  Indianapolis, IN 46244

- To check status of an Appeal or Grievance email.

  Appeal status inquiries should be sent to MHS Indy Appeals: appeals@mhsindiana.com

  Grievance status inquiries should be sent to MHS Indy Compliance Outreach: compliance_outreach_in@centene.com

P2P phone line (855-696-2613), extension 87058 will transfer to the P2P Schedulers

Behavioral Health Prior Authorizations

Behavioral Health Prior Authorizations

- Outpatient Treatment Request (OTR) Intensive Outpatient/Day Treatment Form Mental Health Chemical Dependency; Applied Behavioral Analysis Treatment Psychological & Neuropsych Testing Authorization Request Form.

- Fax IHCP Fax Forms to:
  1-866-694-3649

- Residential/Inpatient Substance Use Disorder (SUD) Treatment Prior Authorization Form:

  Fax Inpatient: 1-844-288-2591
  Fax Outpatient: 1-866-694-3649

Behavioral Health Prior Authorizations continued

- If MHS determines that additional information is needed, MHS will call the provider, using the contact information provided on the OTR form, and providers are given 24-48 hours to call us back.
- Medical necessity appeals must be received by MHS within 60 calendar days of the date listed on the denial determination letter. The monitoring of the appeal timeline will begin the day MHS receives, and date stamps the appeal.
- Medical necessity behavioral health appeals should be mailed or faxed to:

MHS Behavioral Health
ATTN: Appeals Coordinator
12515 Research Blvd, Suite 400
Austin, TX 78701
FAX: 1-866-714-7991

Behavioral Health Prior Authorizations continued

- Facility Services:
  - Inpatient Admissions (approved per diem).
  - Intensive Outpatient Treatment (IOT):
    - Outpatient (may be different timeframes depending on codes billed).
  - Partial Hospitalization (approved per diem).
  - SUD Residential Treatment.
  - ABA Services (approved by units).

Behavioral Health Prior Authorizations
continued

Professional Services

- Psychiatric Diagnostic Evaluation.
- Behavioral Health Outpatient Therapy (BHOP Therapy) Electroconvulsive Therapy.
- Psychological testing:
  - Unless for autism, then no auth is required.
- Developmental testing, with interpretation and report (non-EPSDT).
- Neurobehavioral status exam, with interpretation and report.
- Neuropsych testing per hour, face-to-face:
  - Unless for autism, then no auth is required.
  - Non-participating providers only.
- ABA Services – are approved by units.

Behavioral Health

Limitations on Outpatient Mental Health Services:

MHS follows the IHCP Mental Health and Addiction limitation policy 20 BHOP units per member, per practitioner, per calendar year limitation for the following CPT codes.

- This changed from rolling 12 - month period.
- Do not request authorizations to span after 12/31 of the current year.
  - HHW Package C members receive 30 BHOP units:

Code	Description
90832 – 90834	Individual Psychotherapy
90837 – 90840	Psychotherapy, with patient and/or family member & Crisis Psychotherapy
90845 – 90847 90849 – 90853	Psychoanalysis & Family/Group Psychotherapy with or without patient

Behavioral Health continued

Limitations on Outpatient Mental Health Services

Claims exceeding the benefit limit will deny

- Maximum Benefit Reached, EX Mb:
- If the member requires additional services beyond the 20 - unit limitation, providers may request prior authorization for additional units.
- Approval will be given based on the necessity of the services as determined by the review of medical records.
- Providers will need to determine if they have provided 20 units to the member in the calendar year to determine if a prior authorization request is needed.
- “Per Provider” is defined by MHS as per individual rendering practitioner NPI being billed on the *CMS-1500* claim form (Box 24J).

Behavioral Health Prior Authorizations continued

Limitations on BHOP Therapy (Continued):

- For submission of PA:
  - BH prior authorization outpatient treatment request (OTR) forms located: https://www.mhsindiana.com/providers/behavioral-health/bh-provider-forms.html
  - Fax number for submission at the top: 1-866-694-3649.
  - It is best to include all service codes, duration/units/frequency requests on one OTR form per member.
  - MHS typically approves of authorizations in 3-6 months depending on medical necessity determination.
  - MHS turnaround time on OTR request is 5 business days.
  - A decision letter, referred to either as a Notice of Coverage or Denial Letter, is sent as a response to every request.

Prior Authorization Form Submissions

- **Previously approved PAs can be updated, within 30 calendar days of the original request submission, for changes to:**
  - Practitioner, and/or;
  - Dates of Service;
    - Unless the DOS overlaps a previous adverse determination (denial or partial approval), OR;
    - The DOS includes retro days (dates more than 1 business day. Prior to the initial request).
- Updates/corrections to PAs must be requested prior to related claim denials.

Prior Authorization Form Submissions continued

Outpatient Treatment Request (OTR) Form:

- Use to submit for professional BH services that require PA, including BHOP Therapy services (Exception of ABA services which has its own separate authorization form).
- Form found at the following link: mhsindiana.com/content/dam/centene/mhsindiana/medicaid/pdfs/508-Medicaid-OTR.pdf
- The NPI entered on the OTR form needs to match the NPI of the billing supervising MD, Psychologist, HSPP, or Advanced Practice Registered Nurse (independently practicing):
  - Advance Practice Providers (APP) NPI should not be entered here.
  - This is not the Group NPI.
- Complete Provider Information: Use Rendering Practitioner that is billing for the service in box 24J of the *CMS-1500* form.
- Indicate yes, under the Individual Provider option for whom the authorization should be made to.

Prior Authorization Form Submission continued

Intensive Outpatient Treatment Form Mental Health/Chemical Dependency:

- Use to submit PA of IOT services with this form found here: mhsindiana.com/content/dam/centene/mhsindiana/medicaid/pdfs/508-Medicaid-IOP-P-Form.pdf
- IOT services can either be billed on a UB-04 form *CMS-1500* form.
- PA submission must match the combination in which the provider intends to bill:
  - UB-04: Must submit the authorization form under the facility NPI and checking the applicable Revenue code.
  - Professional Billing: Must submit the IOT Authorization form under the billing practitioner (Psych MD, Psychology HSPP, or APRN) that will be billed within box 24J of the *CMS-1500* form. Select the applicable HCPCS code for billing.

Prior Authorization Form Submission continued

ABA AUTHORIZATION FORM:

- Submit for PA of ABA services with this form found here: https://www.mhsindiana.com/providers/behavioral-health/bh-provider-forms.html
- Reimbursement of ABA services will be made only to enrolled school corporations.
    - Enroll as a mental health provider with an ABA therapist specialty (provider type 11/provider specialty 615) to obtain an IHCP Provider ID for billing purposes.
    - Providers already enrolled as a licensed HSPP (provider type 11/provider specialty 114) must add the ABA specialty to their enrollment profile.
- Enter the enrolled IHCP/MHS ABA therapist (BCBA-D, BCBA, HSPP) under the Billing Provider Information for Provider Name and Provider NPI fields. Do not use Group NPI in this field.

Prior Authorization Form Submission continued

Residential/Inpatient Substance Use Disorder (SUD) Treatment Prior Authorization Request Form:

- Submit PA of SUD services with this form: mhsindiana.com/content/dam/centene/mhsindiana/medicaid/pdfs/508-IHCPSUD-Universal-PA-2021.pdf
- SUD services are facility-based services reimbursed to IHCP enrolled SUD residential addiction treatment facilities.
  - Provider type 35 – *Addiction Services;* and
  - Provider specialty 836 – SUD Residential Addiction Treatment Facility.
- Rendering practitioners are not allowed to be tied to Provider type 35/Specialty 836.

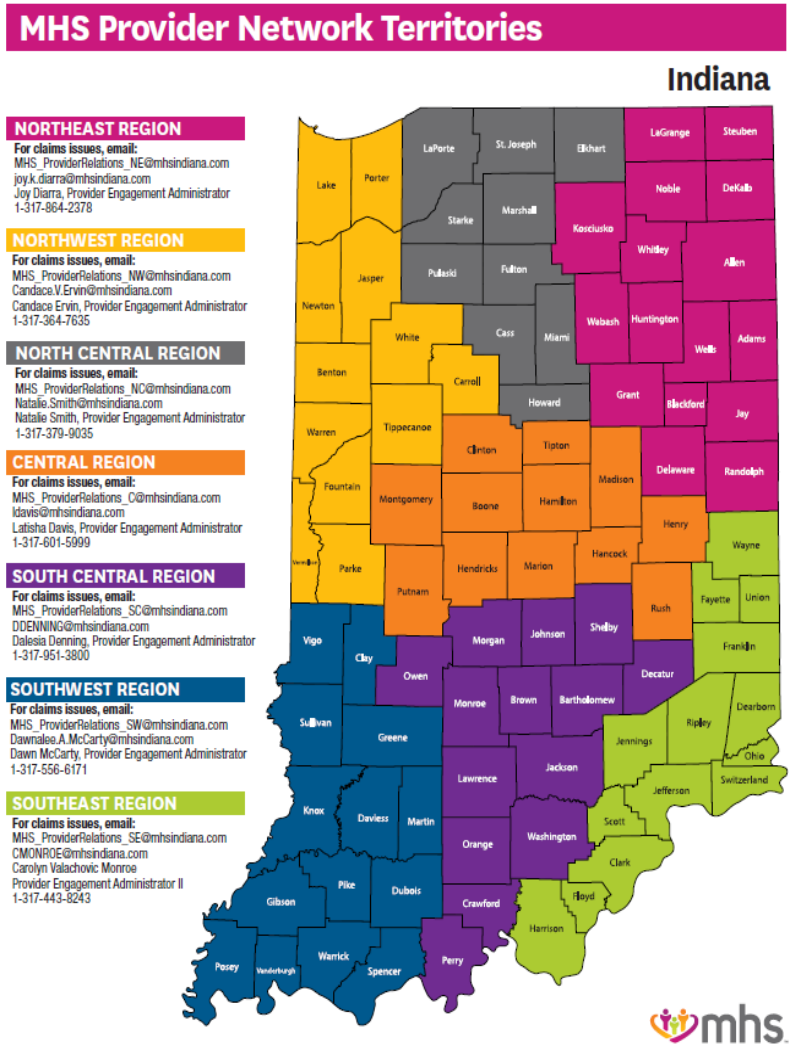
Prior Authorization Form Submission continued

- Under the “Rendering Provider Information” fields of the authorization form, please enter the IHCP/MHS enrolled SUD facility NPI under the Rendering Provider NPI field.
- Providers should bill using a *CMS-1500* claim form.
- When billing SUD services on *CMS-1500*, box 24J cannot contain the NPI of a practitioner. You must input the facility NPI in box 24J or leave blank.

Rendering Provider Information
Rendering Provider NPI:
TIN:
Name:
Address:
City/State/ZIP Code:
Phone:
Fax:

Provider Relations Team

MHS Team



https://www.mhsindiana.com/providers/resources/guides-and-manuals.html

MHS Team continued

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Parkview Health System
Beacon Medical Group
American Senior Care
CarDon & Associates
OrthoIndy
Heart City Health
ONE
Franciscan Health

Questions?

Thank you for being our partner in care.