



Claims *CMS-1500* Billing

2024 IHCP Works Annual Seminar

Agenda

- MHS Overview
- Claim Submission Process
- MHS Provider Claims Issue Resolution Process
- Additional Claims Assistance
- Portal Functionality
- Professional Billing
- Web Portal Claim Payment and Review
- Online Claim Reconsiderations on the MHS Secure Provider Portal
- Prior Authorization
- MHS Team
- Summary
- Questions

MHS Overview

Who is MHS?

- Managed Health Services (MHS) is a health insurance provider that has been proudly serving Indiana residents for more than twenty-five years through Hoosier Healthwise, the Healthy Indiana Plan (HIP) and Hoosier Care Connect.
- **MHS is your choice for better healthcare.**

MHS Products



Claim Submission Process

Medical Claims Submission

- Electronic Data Interchange (EDI) Submission:
 - Preferred method of claims submission
 - Faster and less expensive than paper submission
 - MHS Electronic Payor ID **68069**
- Online Portal
 - Provides immediate confirmation of received claims and acceptance
 - Institutional and Professional
 - Batch Claims
 - Claim Adjustments/Corrections
 - Claim review/Adjustments request
- Paper Claims:
 - Managed Health Services
 - P.O. Box 3002
 - Farmington, MO 63640-3802

Behavioral Health Claims Submission

- **Electronic Submission:**
 - Payor ID **68068**
 - MHS accepts Third Party Liability (TPL) information via Electronic Data Interchange
 - It is the responsibility of the provider to review the error reports received from the Clearinghouse (Payor Reject Report)
- **Online Portal**
 - Provides immediate confirmation of received claims and acceptance
 - Institutional and Professional
 - Batch Claims
 - Claim Adjustments/Corrections
 - Claim review/Adjustments request
- **Paper Claims:**

MHS Behavioral Health
P.O. Box 6800
Farmington, MO 63640-3818

Claims Billing with Ease

- National Provider Identification (NPI), Tax ID, Zip +4
- This information is necessary for the system to make a one-to-one match based on the information provided on the claim and the information on file with Indiana Medicaid.
 - Member Information
 - Newborn's Member ID (MID) is required for payment
- Attachment Forms:
 - Required forms need to accompany the claim form
- Secondary Claims Third Party Liability (TPL):
 - Accepted electronically from vendors or via the MHS Secure Provider Portal

Claim Submission

- Medicaid Timely Filing is:
 - In-Network providers: 90 calendar days from the date of service or discharge date.
 - Out-of-Network providers: 180 calendar days from the date of service or discharge date.
- Exceptions:
 - Newborns (30 days of life or less) – Claims must be received within 365 calendar days from the date of service. Claim must be filed with the newborn's Member ID (MID).
 - TPL – Claims with primary insurance must be received within 365 calendar days of the date of service with a copy of the primary insurance Explanation of Payment (EOP).
 - If primary insurance EOP is received after the 365 calendar days, providers have 60 calendar days from date of primary insurance EOP to file claim to MHS.
 - If the third party does not respond within 90 calendar days, claims may be submitted to MHS for consideration. Claims submitted must be accompanied by proof of filing with the patient's primary insurance.

Paper Claim Corrections

- A corrected claim can be submitted following Indiana Health Coverage Programs (IHCP) claim adjustment processes.
- A claim adjustment code is required on all claims, based on the type of claim submitted.
 - Example: Frequency 7 entered in Box 22 of the *CMS-1500* form.
- The original claim number must also be listed on the corrected claim.
 - Box 22 on the *CMS-1500*.
 - Remember: A rejection must be submitted as a first-time claim, not as a corrected claim.
- Handwriting or stamping on a claim will not be accepted as submission of a corrected claim, and will be rejected with rejection code RE.

Paper Claim Corrections CMS-1500 Example

- If you must submit via paper – never handwrite “corrected claim” on the claim form.
- Complete box 22 (Resubmission Code) to include a 7 (the "Replace" billing code) to notify us of a corrected or replacement claim.

The image shows a CMS-1500 claim form with several fields filled in. Key annotations include:

- Box 22 (Resubmission Code):** Contains the value '7'. A blue arrow points to this field with the text "Resubmission code is '7'".
- Box 16 (Dates Patient Unable to Work in Current Occupation):** Contains the original claim number. A red arrow points to this field with the text "Original claim number".
- Box 23 (Outside Lab?):** The "NO" option is checked with an 'X'.
- Box 24 (A):** Contains the date of service, with the month '1' filled in.
- Box 24 (J):** Contains the rendering provider ID, with 'NP' filled in.
- Box 24 (L):** Contains the provider's name, with 'NP' filled in.
- Box 24 (M):** Contains the provider's address, with 'NP' filled in.
- Box 24 (N):** Contains the provider's phone number, with 'NP' filled in.
- Box 24 (O):** Contains the provider's fax number, with 'NP' filled in.
- Box 24 (P):** Contains the provider's email address, with 'NP' filled in.
- Box 24 (Q):** Contains the provider's website, with 'NP' filled in.
- Box 24 (R):** Contains the provider's NPI, with 'NP' filled in.
- Box 24 (S):** Contains the provider's TIN, with 'NP' filled in.
- Box 24 (T):** Contains the provider's state, with 'NP' filled in.
- Box 24 (U):** Contains the provider's zip code, with 'NP' filled in.
- Box 24 (V):** Contains the provider's city, with 'NP' filled in.
- Box 24 (W):** Contains the provider's county, with 'NP' filled in.
- Box 24 (X):** Contains the provider's country, with 'NP' filled in.
- Box 24 (Y):** Contains the provider's postal code, with 'NP' filled in.
- Box 24 (Z):** Contains the provider's country code, with 'NP' filled in.

Laboratory Billing

- All providers that bill laboratory services on a *CMS-1500* form must have Clinical Laboratory Improvement Amendments (CLIA) certification or a CLIA waiver certification equal to the procedure code being billed and included on the *CMS-1500* form.
- **EXc1 DENIED: INVALID CLIA NUMBER:**
This denial code will appear on the provider's EOP. This verification will ensure that MHS is compliant with the Centers for Medicare & Medicaid Services (CMS) guidelines. Provider's will have to submit a corrected claim timely with proper CLIA certificate number entered on their claim submission.

Laboratory Billing Cont.

Physician's Office Lab Testing (POLT)

MHS Policy CC.PP.055: To ensure laboratory tests are performed in the correct setting, the health plan will limit the performance of in-office laboratory testing to the Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes listed in the Short Turnaround Time (STAT) laboratory (lab) code list included in this [policy](#).

Laboratory Billing Cont.

- These tests on the POLT list are those needed immediately, in order to manage medical emergencies or urgent conditions. Therefore, specific clinical laboratory tests have been designated as appropriate to be performed in the office setting.
- The health plan's automated claims adjudication system will deny in-office (place of service 11) laboratory procedures that are not included on the STAT lab list found on the MHS Indiana website.
- Policy and list can be found at:

<https://www.mhsindiana.com/content/dam/centene/mhsindiana/policies/payment-policies/CC.PP.055.pdf>

Transportation Claims

- MHS will process all Medicaid emergent and non-emergent ambulance claims, including air ambulance, which would have previously been processed by LCP Transportation.
- Claims for the following services should be sent to MHS:
 - 911 Transports.
 - Medically necessary non-emergent hospital transports requiring an ambulance with advanced life support (ALS) or basic life support (BLS).
 - Air ambulance.
- Only providers enrolled with the IHCP are eligible for reimbursement. Claims must be filed within:
 - 90 calendar days of the Date of Service (DOS) for contracted providers.
 - 180 calendar days of the DOS for non-contracted providers.
- Claims should be submitted to MHS via a CMS-1500 professional claim form. Claims may be submitted via EDI (preferred), [MHS web portal](#), or paper.

Managed Health Services

P.O. Box 531097

Indianapolis, IN 46253

Transportation Claims Cont.

- MHS will follow IHCP billing guidelines for coding and reimbursement.

For more information on Medicaid ambulance billing guidelines, please visit [Transportation Module](#).

- **Claim Inquiries:**
 - Check status online via the MHS Secure Web Portal.
 - Call Provider Services at 1-877-647-4848.

Claim Rejections

- A rejection is an unclean claim that contains invalid or missing data elements required for acceptance of the claim in the claim process system.
- Timely filing is not substantiated.
- Rejected claims must be corrected and submitted as a first-time new claim.
- EDI rejections require the provider to contact their clearinghouse and obtain a payer rejection report.

Common Claim Rejections

Medical

- **07** Invalid Subscriber/Member ID
- **02** Invalid Provider ID-Rendering Physician (Provider State Crosswalk File)
- **09** Member Invalid on Date of Service
- **01** Invalid Provider ID Billing Physician (Provider State Crosswalk File)
- **08** Invalid Member Date of Birth
- **76** Original claim number required
- **90** Invalid or Missing Modifier
- **40** Diagnosis code is missing
- **B5** Missing/incomplete/Invalid CLIA

Behavioral Health

- **02** Invalid Provider ID-Rendering Physician (Provider State Crosswalk File)
- **09** Member Invalid on Date of Service
- **07** Invalid Subscriber/Member ID
- **01** Invalid Provider ID Billing Physician (Provider State Crosswalk File)
- **08** Invalid Member Date of Birth
- **76** Original claim number required
- **40** Diagnosis code is missing
- **31** Invalid Service Procedure code

MHS Provider Claims Issue Resolution Process

Provider Claims Issue Resolution

PROCESS

- Level 1: Informal Claims Dispute Online or with Medical Claim Dispute/Appeal form
- Level 2: Formal Claim Dispute – Administrative Claim Appeal Online or with Medical Claim Dispute/Appeal form
- Level 3: Arbitration

Please note, this is different than an Authorization appeal. A claim appeal cannot change a denied authorization status. To change authorization status, you must appeal the denied authorization

Claim Dispute/Appeal Form- Medical and Behavioral Health

- Medical Claims Address:
Managed Health Services
Attn: Appeals Department
P.O. Box 3002
Farmington, MO 63640-3802
- Behavioral Health Claims Address:
Managed Health Services BH Appeals
Attn: Appeals Department
P.O. Box 6800
Farmington, MO 63640

Informal Claims Dispute or Objection Form

- Submit all documentation supporting your dispute:
 - Copies of original MHS EOP showing how the claims in question were processed.
 - Any subsequent MHS EOPs or other determinations on the claim(s) in question.
 - Documentation of any previous attempt you have made to resolve the issue with MHS.
 - Other documentation that supports your request for reprocessing or reconsideration of the claim(s).
 - Can be submitted via the Secure Web Portal within 60 calendar days of receipt of the MHS EOP.
 - Requests received after the 60 calendar days will not be considered.

Informal Dispute or Objection Form

- Level 1: Informal Dispute: MHS will make all reasonable efforts to review your documentation and respond to your request within 30 calendar days.
- At that time (or upon receipt of our response if sooner), providers will have up to 60 calendar days from date of dispute response to initiate a formal claim appeal which is (Level 2).

Informal Claims Dispute Objection Form

Helpful Tips

- Disputing multiple claim denials:
 - Submit separate Informal Claims Dispute Forms for each member/patient experiencing the denial.
 - Provide additional information such as:
 - The MHS denial code and description found on the EOP/remit.
 - Briefly describe why you are disputing this denial.
 - For multiple claims please either list all claim numbers or in the “Reason for Dispute” section state that “member is experiencing denial reason ___ for all claims DOS _____ to _____; Please review all associated claims”.

Save copies of all submitted Informal Claims Dispute Forms.

Provider Services Phone Requests and Web Portal Inquiries

- After the informal claims dispute (Level 1) has been submitted, the provider can access the Provider Service Phone line or Web Portal for assistance or questions. The inquiries will be logged and assigned a ticket number. Please keep this ticket number for your reference.
- Phone:
1-877-647-4848; Provider Services
8 a.m. to 8 p.m. Eastern time zone.
- [Provider Web Portal](#)
 - Use the Messaging Tool.

Provider Services Phone Requests and Web Inquiries

Disputing multiple claim denials:

Provide the provider services rep or web portal team member with one claim number as an example of the specific denial.

- Communication is key! Inform the rep you have a “claims research request” to review all claims for the specific denial reason.
- State if this denial is happening for one or multiple practitioners within your group or clinic; (if multiple, provide your TIN).
- Provide the MHS denial code and description found on the EOP.
- Briefly describe why you are disputing this denial or seeking research.

Formal Claims Dispute- Administrative Claim Appeal

- Level 2 is a Formal Claim Appeal, Administrative Claim Appeal.
- In the event the provider is not satisfied with the informal claim dispute/objection resolution, the provider may file an administrative claim appeal. The appeal must be filed within 60 calendar days from receipt of the Informal Dispute Resolution notice.
- An administrative claim appeal must be submitted via the Secure Portal or in writing by using the Medical Claim Dispute/Appeal Form with an explanation including any specific details which may justify reconsideration of the disputed claim. The appeal should be clearly marked on the form as Level 2.
- See the [MHS Provider Manual Chapter 5](#) Claims Administrative Reviews and Appeals for more information.

Arbitration

Level 3 is a part of the formal MHS Provider Claims dispute process.

In the event a provider is not satisfied with the outcome of the administrative claim appeal process (Level 2), the provider may request arbitration. Claims with similar issues from the same provider may be grouped together for the purpose of requesting arbitration.

To initiate arbitration, the provider should submit a written request to MHS on company letterhead. The request must be postmarked no later than 60 calendar days after the date the provider received MHS' decision on the administrative claim appeal.

Arbitration Requests must be mailed to:

MHS Arbitration

550 N. Meridian Street, Suite 101

Indianapolis, IN 46204

See the MHS [Provider Manual Chapter 5 Claims Administrative](#) Reviews and Appeals for more information.

Additional Claim Assistance

Provider Relations Regional Mailboxes

- If claim denials are upheld after following the informal dispute processes and the provider has not received resolution by calling Provider Services or utilizing the secure messaging on the portal, please contact the Internal Provider Relations team through the claim issues mailbox assigned to your region.
- Issues will be logged by the Internal Provider Relations team and providers will receive a response email with next steps and any assigned reference numbers.
- Please do not email your Provider Representative directly as this may delay the time in getting a response due to their travel.

Provider Relations Regional Mailboxes Cont.

Helpful Tips:

- Please submit the following information to the provider relations regional mailbox (attach spreadsheet if multiple claims but below fields must be included)
 - Issue Reference Number(s)
 - TIN
 - Group/Facility Name
 - Practitioner Name and NPI
 - Member Name and MID Number
 - Product (Medicaid/Ambetter/Wellcare by Allwell)
 - Claim Number(s)
 - DOS or DOS Range if multiple denials
 - Related Prior Authorization Numbers (this is key if issue involves claims denied for no authorization)
 - Provider reason for dispute

Provider Relations Regional Mailboxes Cont.

- Regional Mailboxes
 - Northeast Region: MHS_ProviderRelations_NE@mhsindiana.com
 - North Central Region: MHS_ProviderRelations_NC@mhsindiana.com
 - Central Region: MHS_ProviderRelations_C@mhsindiana.com
 - Northwest Region: MHS_ProviderRelations_NW@mhsindiana.com
 - Southwest Region: MHS_ProviderRelations_SW@mhsindiana.com
 - Southeast Region: MHS_ProviderRelations_SE@mhsindiana.com
 - South Central Region: MHS_ProviderRelations_SC@mhsindiana.com
 - Tier 1 Providers: IndyProvRelations@mhsindiana.com

Portal Functionality

Secure Web Portal Login or Registration



For Members ▼ For Providers ▼ Get Insured

For Providers
Login
Behavioral Health Providers ▼
Clinical & Payment Policies
Dental Providers
Email Sign Up
Enrollment and Updates ▼
Pharmacy ▼
Prior Authorization ▼
Provider Education & Training ▼
Provider Resources ▼
QI Program ▼
Provider News

Portal Login

Create your own online account today!

MHS offers you many convenient and secure tools to assist you. To enter our secure portal, click on the login/register button. A new window will open. You can login or register for a new account.

Creating an account is free and easy.

By creating a MHS account, you can:

- Verify member eligibility
- Submit and check claims
- Submit and confirm authorizations
- View detailed patient list

Portal Training Guides ⊖

- [Account Manager User Guide \(PDF\)](#)
- [Provider Secure Portal Brochure \(PDF\)](#)
- [Submit a Claim CMS 1500 \(PDF\)](#)
- [Submit a Claim CMS UB-04 \(PDF\)](#)
- [Update Portal Account Details \(PDF\)](#)
- [Utilize Member Management Forms \(PDF\)](#)

Secure Provider Portal

This login does not include Wellcare Complete.

Login/Register

Wellcare Complete Provider Portal

Wellcare Complete requires a distinct password and login.

Login/Register

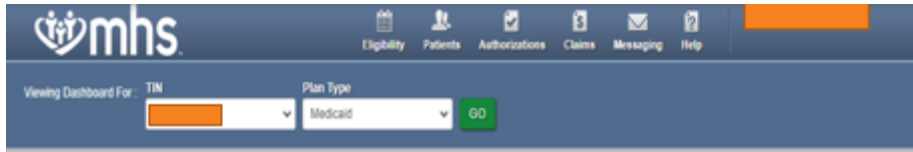
Provider Email Sign Up

Sign Up

Please note that Clear Claim Connection does not provide an all inclusive listing of claim edits. MHS does utilize additional



Homepage - MHS (Medicaid)



Eligibility Patients Authorizations Claims Messaging Help

Viewing Dashboard For: TIN [Redacted] Plan Type Medicaid [GO]

Notification of Pregnancy (NOP)
NOP must be accessed through the IHCP Provider Healthcare Portal and electronically submitted. NOP option is only for Medicaid members. You must create a login and password in order to access the NOP form through the Provider Healthcare Portal.

Please Note
Claims information is updated every 24 hours.

Welcome, [Redacted]

Get summaries of claims data at a glance and easy access to the options you use most.

Admin Settings

Add and manage user access and information.

[Add User](#) [Edit User Access](#) [Add a TIN](#)

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 *

[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.

Claims Audit Tool

- The Clear Claim Connection screen appears, allowing you to enter the Procedure Code, Quantity, Modifiers, Date and Place of Service, and Diagnosis for a claim proactively before you submit or retroactively after you submit to resolve question can this code be billed with another code.

Claims Individual Saved Submitted 11 Batch Payment History My Downloads Claims Audit Tool Filter

CLAIM NO. ↑	CLAIM TYPE ↓	MEMBER NAME ↓	SERVICE DATE(S) ↓	BILLED/PAID ↓	CLAIM STATUS ↓
1	CMS-1500	F	08/22/2017 - 08/22/2017	\$73.00 / \$0.00	⌚

McKesson Empowering Healthcare **Clear Claim Connection™**

Claim Entry

Gender: Male Female

Date of Birth: / / (mm/dd/yyyy)

ICD Code Set:

Click grid to enter information.
 * For quick entry, use your Down Arrow key after you enter a Procedure Code. Date of Service will default to today's date, and Place of Service will default to 11 (Office). Tabbing through Date of Service and Place of Service will give you the same defaults.

Line	Procedure	Mod 1	Mod 2	Mod 3	Mod 4	Qty.	Date of Service	Place of Service	Line Diag. 1	Line Diag. 2	Line Diag. 3	Line Diag. 4
1	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	-- select --	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
2	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	-- select --	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
3	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	-- select --	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
4	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	-- select --	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
5	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	-- select --	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Add More Procedures >>

Review Claim Audit Results Clear

Claims

- **Web Portal Claims Functionalities:**
 - **Submit** new claim.
 - **Review** claims information on file for a patient.
 - **Correct** claims.
 - **View** payment history.
- **Submit a New Claim:**
 - Click **Create Claim** and enter **Member ID** and **Birthdate**.

The screenshot displays the mhs web portal interface. At the top, there is a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, Messaging (with a notification badge of 98), and Help. Below the navigation bar, there is a section for 'Viewing Claims For' with a dropdown menu showing '3/13' and a 'Medicaid' filter, followed by a green 'GO' button. To the right of this section are buttons for 'Upload EDI' and 'Create Claim'. Below this, there is a 'Claims' section with a menu icon and tabs for 'Individual', 'Saved', 'Submitted', 'Batch', 'Payment History', 'My Downloads', and 'Claims Audit Tool'. A 'Filter' button is also present. The bottom section shows a search form with fields for 'Member ID or Last Name' (containing '123456789 or Smith') and 'Birthdate' (containing 'mm/dd/yyyy'), with a 'Find' button.

Claims Submission

- Choose the **Claim Type**
 - **Professional** or **Institutional** claim submission

The screenshot displays the mhs Claims Submission interface. At the top, there is a navigation bar with the mhs logo and icons for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. A dropdown menu for 'Provider Name' is also visible. Below the navigation bar, there is a section for 'Viewing Claims For:' with dropdown menus for 'Tax ID Number' and 'Medicaid', and a 'GO' button. To the right of this section are buttons for 'Upload EDI' and 'Create Claim'. The main content area features a 'Choose Claim for' dropdown menu. Below this, the heading 'Choose a Claim Type' is followed by two large green buttons: 'CMS 1500 Professional Claim →' and 'CMS UB-04 Institutional Claim →'. At the bottom of the main content area, there is an 'UPDATE' notice: 'UPDATE: In order to be compliant with ICD-10 regulations, we will require claims with discharge dates or service dates on or after October 1, 2015, be coded with ICD-10 codes. This change applies to the date of service on the claim, not the submission date.'

Professional Billing

Professional Claims Submission Cont.

- Add the **Diagnosis Codes** for the patient in Box 21. There are some situations that a specific diagnosis is required in position 1, and will deny the claim if it is not listed in primary location.
- Click the **Add** button to save.

The screenshot displays the 'Professional Claim for [L]' interface. At the top, there is a progress bar labeled 'Your Progress' with four steps, the first of which is highlighted in green. Below this, the section is titled 'THIS SECTION: Diagnosis Codes' with the subtitle 'Diagnosis Code and Additional Insurance information.' The interface includes 'Back' and 'Next' buttons at the top and bottom. A pink arrow points to the 'Diagnosis Codes*' input field, which contains 'XXXX e.g. V87:' and an 'Add' button. A red arrow points to the 'Add' button. A note states: 'Please note that for the claim statement dates entered, valid ICD-10 codes only are accepted.' Below the input field, a list of codes is shown, including 'V837 - PERS OUTSD INDUST VEH INJ NT ACC' with a 'Remove X' button. A button labeled 'Add Coordination of Benefits' is also visible. A page number '21.' is shown in the bottom right corner of the form area.

Professional Claims Submission Cont.

Click **Add Coordination of Benefits** to include any payments made by another insurance carrier (if applicable).

Primary Insurance x Remove

Notice: If the Member has more than one primary insurance (Medicaid would be the 3rd payer), the claim cannot be submitted through the Web.

Carrier Type* C50M -- Commercial

Policy Number* 1154451344 X

← Back Next →

Professional Claims Submission Cont.

- **Add** Service Lines, and any applicable COB information at bottom of each line.

The screenshot displays a web interface for submitting a professional claim. At the top, it says "Professional Claim for [redacted]" and "Your Progress" with a progress bar. The main section is titled "THIS SECTION: Service Lines" with the instruction "Enter maximum of 50 service lines." There are "Back" and "Next" buttons. A sidebar on the left shows a "Total: \$500.00" and a "New Service Line" button, which is highlighted by a large pink arrow. Below this, a list of "PROCEDURE / CHARGES" shows one entry: "1: 99213 / \$500.00". The main area shows the details for "Now Viewing Line 1: 99213 / \$500.00". Fields include: "Dates of Service" (From: 02/01/2016, To: 02/01/2016), "Place of Service" (11 - PROVIDER'S OFFICE), "Procedure Code" (99213), "Modifiers" (XX), "Diagnosis Code(s)" (W537 - PERS OUTSD INDUST VEH INJ NT ACC), "Charge" (500.00), "Units / Minutes / Days" (1), "Type" (UN - UT), "Family Planning" (Yes/No), "NDC" (NDC), and "Supplemental Information" (Supplemental information). Buttons for "Delete" and "Save / Update" are also visible.

Professional Claims Submission cont.

- Enter **Referring, Rendering,** and **Billing provider information.**
- **Service Facility Location.**
- Click **Next.**

Professional Claim for [TX] Your Progress [Progress Bar]

THIS SECTION: **Providers**
Providers on this claim.

Back Next

* Required

Referring Provider

NPI: [1 73] Find Provider

Last Name or Organizational Name: [Redacted] First Name: [Redacted]

Rendering Provider Only enter rendering provider information if not the same as Billing Provider information.

NPI: [Redacted] Tax ID: [Redacted] Find Provider

Taxonomy #: [2 3X] Last Name or Organizational Name: [Redacted] First Name: [Redacted] Clear X

Billing Provider

Tax ID: [2 34]

Name: [Redacted] NPI: [11 073] Taxonomy #: [2 3X]

Address: [Redacted] City: [Redacted] State: [Redacted] Zip: [40510]

Service Facility Location Save As Billing Provider

Name: [Redacted] NPI: [Redacted]

Address: [Redacted] City: [Redacted] State: [Indiana] Zip: [40510]

Back Next

Professional Claims Submission Cont.

- In the Attachments section you can **Browse** and **Attach** any documents to the claim as desired. (Note: If you have no attachments, skip this section.)
- Click **Next**.

Professional Claim for L Y Your Progress

THIS SECTION:
Attachments
Add attachments to the claim (5MB limit). Supported types are .jpg, .tif, .pdf and .tiff

If there are no attachments, click Next.

Attachments

*Do NOT send password protected files. You must click ATTACH for each file being submitted.

File* No file chosen Attachment Type*

There are no attached files.

If there are no attachments, click Next.

Professional Claims Submission Cont.

Professional Claim for L [] Your Progress []

THIS SECTION: **Review**
Please review your claim and submit.

← Back Validate →

This claim is eligible for Real Time Editing and Pricing.
Please click on the Validate button to proceed to the next step.

Almost done!
You can go back to review your claim or submit now.

Claim Id: 8 []
Member Record Number: 2 []
Member Claim Amount Paid: []
Patient's Account Number: []

General Info [Edit](#)
Statement From Date: 03/16/2017
Statement To Date: 03/16/2017
Date of current illness, injury, pregnancy (LMP): []
Other Date: []
Hospitalized From: []
Hospitalized To: []
Additional Claim Information:
Outside Lab?: No
Outside Lab Amount: []
Prior Authorization Number: []
CLIA Number: []

Diagnosis Codes and Primary Insurance [Edit](#)
Diagnosis Codes:
R011 - CARDIAC MURMUR UNSPECIFIED

Service Lines [Edit](#)

Line	From	To	Place	Proc	Diagnosis	Amount	Units/Minutes/Days	Family Plan	EPSDT	NDC	Supplemental Info
1	03/16/2017	03/16/2017	22	93010	R011	\$55.00	1.0	No			

Providers [Edit](#)

Provider Type	Name	Tax ID	NPI	Taxonomy	Address
Referring Provider	<input type="text"/>		<input type="text"/>		
Rendering Provider	<input type="text"/>	<input type="text"/>	<input type="text"/>		
Billing Provider	<input type="text"/>			248W03000X	<input type="text"/>
Service Facility Location	<input type="text"/>				<input type="text"/>

Attachments

← Back Validate →

This claim is eligible for Real Time Editing and Pricing.
Please click on the Validate button to proceed to the next step.

- In the **Review** section, you can see if the claim is eligible for Real Time Editing and Pricing (RTEP).
- Click **Validate** for RTEP claims and click **Submit** for regular processed claims.

RTEP Claim Pricing View

COMPLETE!
You have successfully submitted your claim. [Print](#)

Web Reference No. 8
Claim No.

RefAcct No: 002851 DOS Range:
Member ID: Billed Amount: \$90.00
Member Name: Payment Amount: \$46.75
Servicing Provider: Status: APPROVED

Line	DOS	Proc	Dx	Modifiers	Place of Service	Charged	Payment Amount	Status	Status Description
1	09/21/2015 - 09/21/2015	99212	285.9		11	\$65.00	\$31.75	Approved	92: PAID ACCORDING TO CONTRACT STATE PROCESSING GUIDELINES
2	09/21/2015 - 09/21/2015	99050	285.9		11	\$25.00	\$15.00	Approved	92: PAID ACCORDING TO CONTRACT STATE PROCESSING GUIDELINES

The system has provided a response back to the you indicating amount to be paid on the claim. Any post adjudication processes can change the amount paid.

[Close](#)

Real Time Edit Processing (RTEP) Overview:

- On the final screen, each procedure code will receive a reimbursement estimate, pending claim explanation, or denial reason.
- Claims with a reimbursement estimate or pending explanation may be impacted by final adjudication, including a change to the reimbursement amount or a denial.
- Adjudication status may be affected by code editing or other payment rules.

Web Portal Claim and Payment Review

Submitted Claims

- The **Submitted** tab will only display claims created via the MHS portal:
 - Accepted** is a **green** thumbs up.
 - Denied** is an **orange** thumbs down.
 - Pending** is a clock.
- RTEP** indicators on the right claims also show if eligible (i.e., line 3 was submitted but was not eligible for RTEP).

SUBMITTED STATUS ↑	DATE SUBMITTED ↑	WEB #/ REF # ↑	CLAIM NUMBER ↑	CLAIM TYPE ↑	MEMBER NAME ↑	MEMBER ID ↑	ORIGINAL CLAIM # ↑	TOTAL CHARGES ↑	
🕒	08/16/2017	8/16/17	C-1500	CMS-1500	S. J.	1-1500	C-1500-6	\$150.00	
👍	08/10/2017	8/10/17	C-1500	CMS-1500	C. H.	1-1500		\$150.00	RTEP 👍
👍	08/02/2017	8/2/17	C-1500	CMS-1500	S. M.	1-1500		\$150.00	RTEP 🗑️
👍	07/24/2017	7/24/17	C-1500	CMS-1500	S.	1-1500		\$150.00	RTEP 👍

4 items found, displaying all items. Page 1/1 1

Individual Claims

On the **Individual** tab, claims can be reviewed that had been submitted and accepted using paper, portal, or EDI clearing house methods.

View the Claim Number, Claim Type, Member Name, Service Date(s), Billed/Paid, and Claim Status.

The screenshot shows the mhs Claims portal interface. At the top, there are navigation tabs: Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below this, there are filters for 'Viewing Claims For' (set to 3) and 'Medicaid'. A 'GO' button and 'Upload EDI' and 'Create Claim' buttons are also present. The main content area shows a 'Claims' section with a sub-tab 'Individual' highlighted in red. Below this are buttons for 'Saved', 'Submitted', 'Batch', 'Payment History', 'My Downloads', and 'Claims Audit Tool', along with a 'Filter' button. A table lists individual claims with columns for CLAIM NO., CLAIM TYPE, MEMBER NAME, SERVICE DATE(S), BILLED/PAID, and CLAIM STATUS. The CLAIM STATUS column contains green thumbs up (Paid) and orange thumbs down (Denied) icons. A red arrow points to the CLAIM STATUS column. A red box highlights the text: 'Paid is a green thumbs up, Denied is an orange thumbs down and a clock is Pending.'

CLAIM NO. ↑	CLAIM TYPE ↓	MEMBER NAME ↓	SERVICE DATE(S) ↓	BILLED/PAID ↓	CLAIM STATUS ↓
Q 5	CMS-1500	K R	07/24/2017 - 07/24/2017	\$65.00 / \$41.38	👍
C 11	CMS-1500	JE EN	07/24/2017 - 07/24/2017	\$171.00 / \$106.34	👍
C 36	CMS-1500	E R	07/24/2017 - 07/24/2017	\$253.00 / \$101.04	👍
C 1	CMS-1500	EI R	07/24/2017 - 07/24/2017	\$2,783.00 / \$118.86	👍
C 2	CMS-1500	E	07/24/2017 - 07/24/2017	\$2,783.00 / \$0.00	👎

Saved Claims

To view **Saved** claims: Drafts, Professional, or Institutional:

1. Select **Saved**.
2. Click **Edit** to view a claim.
3. Fix any errors or complete before submitting.
Or
4. Click **Delete** to delete saved claim that is no longer necessary.
5. Click **OK** to confirm the deletion.

Viewing Claims For : 3 Medicaid GO Upload EDI Create Claim

Claims Individual **Saved** Submitted 11 Batch Payment History My Downloads Claims Audit Tool

Claims listed below have missing information or contain errors. Click 'Edit' to view a claim, then fix any errors or complete it before submitting.

DATE CREATED ↑	CLAIM TYPE ↑	CLAIM ID ↑	MEMBER NAME ↑	MEMBER ID ↑	ORIGINAL CLAIM # ↑	TOTAL CHARGES ↑		
08/10/2017	Institutional	8000	R	109	Q03	\$54,159.07	Edit	Delete
08/07/2017	Institutional	8005	P	109	Q01	\$461.75	Edit	Delete
08/02/2017	CMS-1500	8000	AI	109	Q04	\$292.00	Edit	Delete
08/01/2017	Institutional	8007	J	109	Q06	\$461.75	Edit	Delete
08/01/2017	Institutional	8001	F	109	Q01	\$461.75	Edit	Delete
07/17/2017	Institutional	8003		109		\$507.00	Edit	Delete

Payment History

- Click on **Payment History** to view Check Date, Check Number, Check Clear Date, Mailing Address, and Payment Amount.
- Click on **Check Date** to view Explanation of Payment.

Viewing Claims For : TIN [] Plan Type Medicaid [] GO [] Upload EDI [] Create Claim []

Claims [] Individual [] Saved [] Submitted [] Batch [] Recurring [] **Payment History** [] Claims Audit Tool [] Filter []

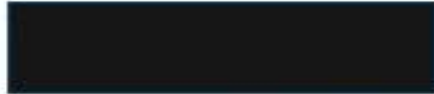
Transactions
All activity posted to your account between 06/20/2021 and 07/20/2021 .

Instructions: Click on the Check Date to view the PDF of payment details from your payment provider. The PDF will open in a new window where you can save or print it. If there are any discrepancies on your payment details, please contact Provider Services.

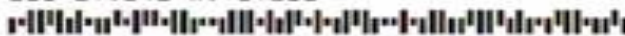
CHECK DATE ↑	CHECK NUMBER ↑	CHECK CLEAR DATE ↓	MAILING ADDRESS ↓	PAYMENT AMOUNT ↓
06/24/2021 (PDF)	[REDACTED]	06/23/2021	[REDACTED]	\$100.64
06/24/2021 (PDF)	[REDACTED]	06/23/2021	[REDACTED]	\$145.73
06/24/2021 (PDF)	[REDACTED]	06/23/2021	[REDACTED]	\$72.01
06/24/2021 (PDF)	[REDACTED]	EFT	[REDACTED]	\$0.00
06/24/2021 (PDF)	[REDACTED]	EFT	[REDACTED]	\$208.65
06/24/2021 (PDF)	[REDACTED]	EFT	[REDACTED]	\$578.92

Provider EOP

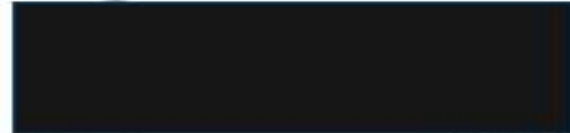
FORMALITY



Electronic Service Requested

606 D.7648 AV D.386 S-DIGIT 30374


3000706111



RUN DATE: 07/09/20
 CHECK #: [REDACTED]
 PAYEE ID: [REDACTED]
 IRS#: [REDACTED]

STATEMENT TOTAL

Beginning Negative Services Balance: .00
 Beginning Prepayment Balance: .00
 Total Beginning Balance: .00
 Claims Paid This Run: [REDACTED]
 Check Amount: [REDACTED]

Remittance Advice and Explanation of Payment

Insured Name: [REDACTED] Member ID: [REDACTED] Claim No: [REDACTED]
 Patient Name: [REDACTED] PCN: [REDACTED] Carrier: DE Provider ID: [REDACTED]
 Service Provider: [REDACTED] LNPI: [REDACTED] Group: [REDACTED]


Serv	Dates	Procedure	Modifiers	Days Ct/Qty	Charged	Allowed	Deduct / Copay	Coinsur/ Discount	Interest	Med Allow/ Med Paid	TPP	Denied	Payment Codes	Payment
0100	[REDACTED]	[REDACTED]	G5	1.00	6388.16	263.75	.00	.00	.00	.00	.00	.00	A0 SR 30	258.47
								5.28						
0200	[REDACTED]	[REDACTED]	G5	1.00	6388.16	263.75	.00	.00	.00	.00	.00	.00	A0 SR 30	258.47
								5.28						
0300	[REDACTED]	[REDACTED]	G5	1.00	6388.16	263.75	.00	.00	.00	.00	.00	.00	A0 SR 30	258.47
								5.28						
0400	[REDACTED]	[REDACTED]	G5	1.00	6388.16	263.75	.00	.00	.00	.00	.00	.00	A0 SR 30	258.47
								5.28						
0500	[REDACTED]	[REDACTED]	G5	1.00	6388.16	263.75	.00	.00	.00	.00	.00	.00	A0 SR 30	258.47
								5.28						
0600	[REDACTED]	[REDACTED]	G5	1.00	6388.16	263.75	.00	.00	.00	.00	.00	.00	A0 SR 30	258.47
								5.28						
0700	[REDACTED]	[REDACTED]	G5	1.00	6388.16	263.75	.00	.00	.00	.00	.00	.00	A0 SR 30	258.47
								5.28						

EFT and ERAs

PaySpan Health

- Web based solution for:
 - Electronic Funds Transfers (EFTs).
 - Electronic Remittance Advices (ERAs).
- One year retrieval of remittance advice.
- Provided at no cost to providers and allows online enrollment.
- Register at: [Payspan](https://payspan.com)
- For questions call Payspan at: 1-877-331-7154.

PaySpan® Health



FOLLOW THESE INSTRUCTIONS TO GET STARTED WITH PAYSAN® HEALTH, AN EFT AND ERA WEB BASED SOLUTION:

- 1 Call 1-877-331-7154 for your unique registration code. Then, visit payspanhealth.com and click **Register**.
- 2 Enter your registration code and click **Submit**.
- 3 Enter your PIN, TIN or EIN, and NPI. Then, click **Start Registration**.
- 4 Populate the requested Personal Information. Click **Next**.
- 5 Designate an account for fund transfers by completing the required fields. Click **Next**.
- 6 Verify your information and check the box to agree to the service agreement. Then, click **Confirm**.
- 7 Within a few business days, you will receive a deposit of less than \$1 from PaySpan. Then, follow these steps to complete registration:
 - ▶ Contact your financial institution to obtain the amount deposited by PaySpan.
 - ▶ Log into PaySpan, and click **Payments**.
 - ▶ Click the **Account Verification** link on the left side of the screen.
 - ▶ Enter the amount of the deposit in this format: 0.00.
(The deposit does not need to be returned.)

For PaySpan registration assistance, call: 1-877-331-7154
Email: providersupport@payspanhealth.com

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0221.PR.P.FL 2/21

Tips to Remember

- Clicking on items (claim numbers, check numbers, or dates) that are highlighted **blue** will reveal additional information.
- When **filtering** to find a claim or payment history, only a **30 calendar day** span within the same month can be used.
- Click on the **Saved Claims** tab to view claims that have been created but not Submitted. Claims in this queue can be edited for submission or deleted from this tab.
- In order to utilize the **Correct Claim** feature, the claim needs to be in a **Paid** or **Denied** status.

Online Claim Reconsiderations on the MHS Secure Provider Portal

Summary of Online Reconsiderations

- **Skip the phone call.**
 - Providers can make their case directly on the portal.
- **Make the case.**
 - Providers can submit informal dispute/reconsideration comments using expanded text fields.
- **Add context.**
 - Providers can easily attach supporting documentation when filing an informal dispute/reconsideration.
- **Stay current.**
 - Providers may opt in/out for informal dispute/reconsideration status change emails.
 - Providers may also view the status online.

Online Reconsiderations

Providers are able to:

- Submit informal disputes/reconsiderations on the secure portal.
- Submit corrected claims.
- Upload/view supporting documents.
- View acknowledgement letters.
- Track real time updates.
- View denial code information.

Online Reconsiderations Cont.


- It is important to note that all requests submitted via the online Portal for Level 1 will be considered an **informal dispute**. Secure messages are not considered reconsiderations/appeals.
- Calling Provider Services **will not** pause the time frame for timely submissions for informal disputes.
- Providers **do not** need to call prior to submitting an online claim reconsideration/information dispute.
- Providers may include a dispute form, but it is not required, as they may include comments directly into the portal.

Level 1 Informal Claim Dispute and Level 2 Claim Appeals on the Secure Provider Portal

Back to Claims
Claim Details

Claim # : Denied

COPY
DISPUTE



Claim Accepted In Process Denied

Participant

Participant Name
[REDACTED]

Member ID
ID123459

Member DOB
[REDACTED]

Provider

Ref./Acct No.
1234567890

Servicing Provider
[REDACTED]

Servicing NPI
[REDACTED]

Claim

DOS Range
08/12/2020 - 08/15/2020

Received Date
09/12/2020

Billed Amount
\$6,1234.12

Most Recent Payment

Payment Date	Paid Claim Amount
---	50.00
Check/EFT No.	Total Check Amount
---	---
Check Dated	

Service Lines

Label	Label	Label	Label	Label	Label	Label	Label
-------	-------	-------	-------	-------	-------	-------	-------

Level 1 Informal Claim Dispute and Level 2 Claim Appeals on the Secure Provider Portal cont.

The screenshot displays a web interface for a Secure Provider Portal. At the top, a dark blue navigation bar contains icons and labels for 'Eligibility', 'Patients', 'Authorizations', 'Claims', and 'Messaging', along with a 'User Name' dropdown menu. Below this, a light blue header bar features a 'Back to Claims' button, a search input field, and the text ': Claim #'. The main content area is white and lists three options, each with a 'SELECT' button:

- Option 1: Correct the claim**
Most providers use this option when there is a mistake on the submitted claim.
- Option 2: Informally dispute the claim**
A dispute is a informal review performed by the Claims Department.
 - A response will be issued within **30 calendar days** of submission.
 - You will still have the opportunity to select **Option 3: Appeal the claim**, if the decision is upheld.
 - You should **NOT** use this option if an authorization is not obtained and/or need to review for medical necessity.
 - Please refer to the [MHS Provider Manual](#) on filing a medical necessity appeal.
- Option 3: Appeal the claim**
An appeal is a formal review of your claim.
 - Appeal responses will be issued in writing within **45 calendar days** of submission, in accordance with 405 IAC 1-1.6.
 - Your appeal will be reviewed by a panel of one or more individuals who are **knowledgeable** in the policy, legal, and/or clinical issues in the matter subject to the appeal.
 - The panel was **not involved in any previous consideration** of the matter of the appeal.
 - Please refer to the [MHS Provider Manual](#) for more information.

Claim Reconsideration

- Enter your explanation for reconsideration and check email updates.

Reconsider Claim ×

Claim No:

For reconsiderations only. Not for appeals/Claim disputes
Example: If an authorization was not obtained and/or you need to review for medical necessity, submit an appeal.
Any submission on this form will be treated as a reconsideration.
Please refer to your Provider Manual.

Reconsideration Type
Denied for Untimely Filing ▼

Notes
Brief Explanation

500 Character Limit

Upload Documents
Proof of Timely Filing attachment Required

Uploaded Files

Email Updates
 Check here to receive email status updates for this reconsideration.
Please upload files less than 10MB each. Supported file formats are PDF, TIFF, TIF, JPEG, and JPG.

Level 1 Informal Claim Dispute and Level 2 Claim Appeals on the Secure Provider Portal cont.

Back to Claims
Claim Details

Claim # : Denied

COPY
DISPUTE

U026IA1234566

Dispute/Appeal Details

Created Date	Type	Current Status	Reference No.	Tools
1/26/2021	Dispute - Claim Paid at the Incorrect Amount	Resolved	U026IA1234566	

Member

Participant Name

Member ID
ID123459

Member DOB

Provider

Ref./Acct No.
1234567890

Servicing Provider

Servicing NPI
1234567890

Claim

DOS Range
08/12/2020 - 08/15/2020

Received Date
09/12/2020

Billed Amount
\$6,1234.12

Most Recent Payment

Payment Date	Paid Claim Amount
---	\$0.00
Check/EFT No.	Total Check Amount
---	---
Check Dated	

Service Lines

Label	Label	Label	Label	Label	Label	Label

Coordination of Benefits

Coordination of Benefits

- This screen is available if a member has other insurance, it is found on the Patient List tab.

[Back to Patient List](#) **Member Name**

Overview	Effective Date	Term Date	Policy Number	Group Number	Carrier Name	Coverage
Cost Sharing	06/01/2008	12/21/2013	V [REDACTED]		AETNA	MEDICAL AND HOSPITAL
Assessments						
Health Record						
Care Plan						
Authorizations						
Coordination of Benefits						
Claims						

Prior Authorization

Prior Authorization Considerations

Need to know what requires Authorization

- [Pre-Authorization tool](#)

How to obtain Authorization

- [Online](#) thru the Portal
- Phone: 1-877-647-4848 8am to 8pm Eastern
- Fax: 1-866-912-4245

Authorizations do not guarantee payment

Prior Authorization



For Members ▾

For Providers ▾

Get Insured

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?	<input type="radio"/>	<input checked="" type="radio"/>
Are anesthesia services being rendered for pain management?	<input type="radio"/>	<input checked="" type="radio"/>
Are services for infertility?	<input type="radio"/>	<input checked="" type="radio"/>

Enter the code of the service you would like to check:

58270

CHECK FOR PRE-AUTH

Y
Yes

58270 - VAG HYST UTRUS 250 GM<;REP ENTROCL
Pre-authorization required for all providers.

To submit a prior authorization [Login Here](#) [↗](#)



MHS Team

MHS Team

MHS Provider Network Territories

Indiana

NORTHEAST REGION

For claims issues, email:
 MHS_ProviderRelations_NE@mhsindiana.com
 joy.k.diarra@mhsindiana.com
 Joy Diarra, Provider Engagement Administrator
 1-317-864-2378

NORTHWEST REGION

For claims issues, email:
 MHS_ProviderRelations_NW@mhsindiana.com
 Candace.V.Ervin@mhsindiana.com
 Candace Ervin, Provider Engagement Administrator
 1-317-364-7635

NORTH CENTRAL REGION

For claims issues, email:
 MHS_ProviderRelations_NC@mhsindiana.com
 Natalie.Smith@mhsindiana.com
 Natalie Smith, Provider Engagement Administrator
 1-317-379-9035

CENTRAL REGION

For claims issues, email:
 MHS_ProviderRelations_C@mhsindiana.com
 ldavis@mhsindiana.com
 Latisha Davis, Provider Engagement Administrator
 1-317-601-5999

SOUTH CENTRAL REGION

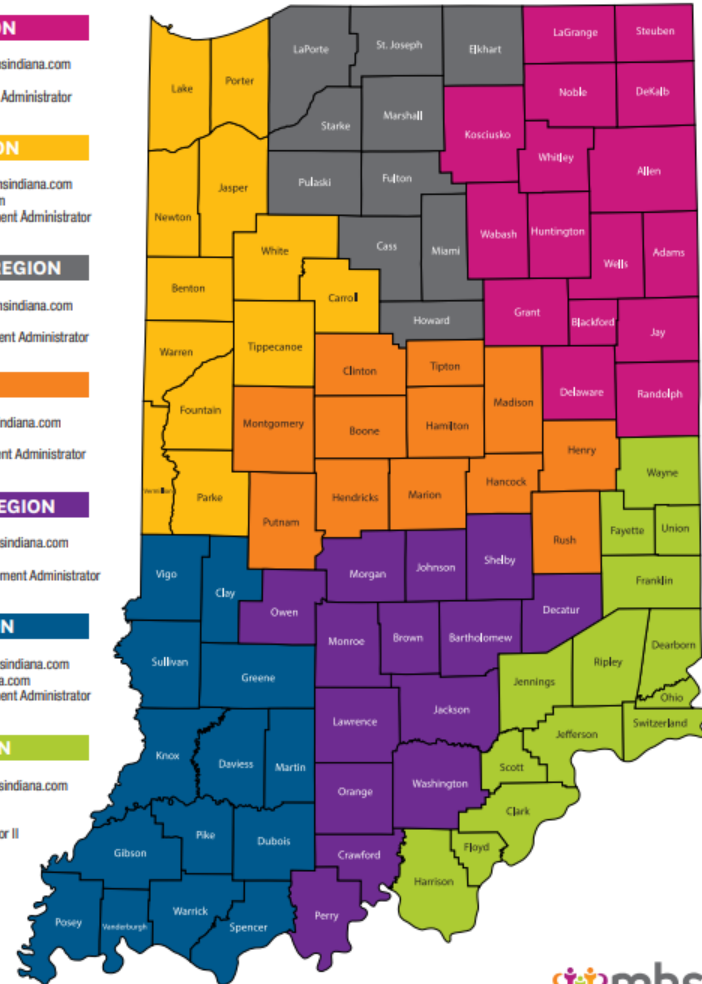
For claims issues, email:
 MHS_ProviderRelations_SO@mhsindiana.com
 DDENNING@mhsindiana.com
 Dalesia Denning, Provider Engagement Administrator
 1-317-951-3800

SOUTHWEST REGION

For claims issues, email:
 MHS_ProviderRelations_SW@mhsindiana.com
 Dawnalee.A.McCarty@mhsindiana.com
 Dawn McCarty, Provider Engagement Administrator
 1-317-556-6171

SOUTHEAST REGION

For claims issues, email:
 MHS_ProviderRelations_SE@mhsindiana.com
 CMONROE@mhsindiana.com
 Carolyn Valachovic Monroe
 Provider Engagement Administrator II
 1-317-443-8243



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 Allwell from MHS • Ambetter from MHS • Healthy Indiana Plan (HIP) • Hoosier Care Connect • Hoosier Healthwise

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



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ENVOLVE DENTAL, INC.

THOMAS "TONY" SMITH

Thomas.Smith@EnvolveHealth.com
Dental Provider Services: 1-855-609-5157
Questions: ProviderRelations@EnvolveHealth.com

CAROLYN VALACHOVIC MONROE

Provider Engagement Administrator II
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CMONROE@mhsindiana.com

PROVIDER GROUPS

Community Health Network
Indiana University Health
Wayspring Health
Reid Hospital
Norton Hospital
St. Elizabeth Hospital

MONA GREEN

Provider Engagement Administrator II
1-812-614-1003
mona.green@mhsindiana.com

PROVIDER GROUPS

St. Vincent/Ascension
Wellcare Complete
Lutheran Medical Group
Parkview Health System
Beacon Medical Group
American Senior Care
CarDon & Associates
OrthoIndy
Heart City Health
ONE
Franciscan Health



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AtWell from MHS - Ambetter from MHS - Healthy Indiana Plan (HIP) - Hoosier Care Connect - Hoosier Healthwise

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

Questions?
Thank you for being our
partner in care.
