Provider Healthcare Portal
## Revision History

<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
<th>Reason for Revisions</th>
<th>Completed By</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0</td>
<td>Policies and procedures as of February 13, 2017 Published: February 16, 2017</td>
<td>New document</td>
<td>FSSA and HPE</td>
</tr>
<tr>
<td>2.0</td>
<td>Policies and procedures as of July 1, 2017 Published: February 15, 2018</td>
<td>Scheduled update</td>
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| 3.0     | Policies and procedures as of March 1, 2018 Published: May 24, 2018 | Scheduled update:  
- Reorganized and edited text as needed for clarity  
- Added the term *edit* for claim replacements (as shown in the Portal)  
- Updated information throughout the module to reflect that delegates can be authorized to add, modify, and deactivate delegate accounts  
- Updated the requirements in the *Website Requirements* section  
- Updated the roles and responsibilities in the *Provider Representative and Delegate Roles* section  
- Updated *Figure 17 – My Home Page Features* to show the Manage Accounts link  
- Updated the User Details and Provider section descriptions in *Table 1 – My Home Page Feature Descriptions*  
- Updated the responsibilities in the *Manage Accounts – Adding and Managing Delegates* section and subsections  
- Updated the steps to provide delegate permissions and to deactivate delegate account in the *Change Delegate Permissions or Deactivate Delegate Accounts* section  
- Added the *View Provider Profile Information* section  
- Updated the Provider Identification Changes description in *Table 2 – Provider Maintenance Change Types* | FSSA and DXC |
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<td>Updated the <strong>Presumptive Eligibility Changes</strong> section to reflect the new PE process and remove reference to the PEPW module</td>
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<td>Updated the note box under <strong>Figure 37 – Provider Maintenance: Other Information</strong> to clarify 340B information</td>
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<td>Added for users to retain their tracking numbers in the <strong>Check Status</strong> section</td>
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<td>Updated the <strong>Secure Correspondence</strong> section to clarify that the user sees previous messages they sent from the same service location</td>
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<td>Updated the steps in the <strong>Eligibility Verification Request</strong> section to reflect the new Portal process</td>
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<td>Updated <strong>Table 3 – Coverage Detail Panels</strong>:</td>
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<td>- Modified the Benefit Details, Managed Care Assignment Details, and Detail Information rows</td>
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<td>- Added a row for Other Insurance Details</td>
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<td>Removed the <strong>Other Insurance Details</strong> section (options now appear as a coverage detail panel)</td>
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<td>Updated the <strong>Presumptive Eligibility Application</strong> section and added note box regarding inmates</td>
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<td>In the <strong>Search Claims</strong> section, clarified information in the note box regarding adjustments shown in searches</td>
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<td>Added note box regarding required fields in the <strong>Submit Claim</strong> section</td>
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<td>Added instructions for indicating emergency services for the dental claim in the <strong>Claim Information Section</strong></td>
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<td>Updated the <strong>Claim Note Information</strong> sections to add that claim notes should be used if needed</td>
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<td>Clarified information in the <strong>Other Insurance Details</strong> and <strong>Other Insurance for Service Details</strong> sections for the institutional claim</td>
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<td>• Updated the <a href="#">Claim Information Section</a> regarding hospital date fields and how to indicate pregnancy on the professional claim</td>
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<tr>
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<td>• Updated the <a href="#">Service Details</a> section to include how to indicate emergency services on the professional claim</td>
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<td></td>
<td>• Clarified information in the <a href="#">Other Insurance for Service Details</a> section for the professional claim</td>
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Provider Healthcare Portal

Introduction

The Indiana Health Coverage Programs (IHCP) Provider Healthcare Portal (Portal) is an interactive, secure, and easy-to-use tool for providers to exchange information with the IHCP through the internet. Providers can access the Provider Healthcare Portal at portal.indianamedicaid.com.

This Provider Healthcare Portal module provides a user guide for the Portal functions. For additional assistance, Help information is available at the top of each Portal page, by clicking the “?” icon. For telephone-based assistance, contact the Electronic Data Interchange (EDI) technical assistance line toll-free at 1-800-457-4584 (press option 3 twice to reach a Portal representative). Questions can also be sent by email to INXIXElectronicSolution@dxc.com.

Website Requirements

Any web browser can be used to access the Portal and use its functions. However, for the best viewing experience, the following web browsers (with a screen resolution of 1024 × 768 pixels) are recommended:

- Microsoft Internet Explorer (two latest versions)
- Mozilla Firefox (two latest versions)

For viewing documents, the following software is required:

- Adobe Reader version 8.0 or higher
- Microsoft Office Suite 2000 or higher

The Portal will not function properly if special software is being used to block pop-up windows. Users are encouraged to disable pop-up blockers when accessing the Portal. See Website Requirements link at the bottom of the Portal home page.

Portal Features

Through the secure and easy-to-use internet Portal, healthcare providers can perform a number of critical tasks online, including the following:

- Apply for enrollment in the IHCP and update enrollment information:
  - Complete and submit a provider enrollment application.
  - Update enrollment information as needed, including address changes, specialty changes, adding or removing rendering providers, updating license information, and so on.

- Verify IHCP member eligibility:
  - Perform coverage verification by Member ID (also known as RID), Social Security number (SSN) and date of birth, or name and date of birth.
  - View information about a member’s managed care entity (MCE), benefit limits, and other insurance coverage.
  - Obtain more response information than is provided by telephone via the Interactive Voice Response (IVR) system.
• Send inquiries and requests using secure correspondence:
  – Update information about a member’s other insurance coverage/third-party liability (TPL).
  – Submit inquiries regarding provider enrollment status.
  – Request assistance with using the Portal.

The following Portal features are available only for fee-for-service, nonpharmacy services:

• Submit IHCP claims:
  – Electronically submit professional, dental, and institutional claims, including Medicare crossover claims, to the IHCP for immediate adjudication.
  – Reduce claim errors with the validity editing features that are built into certain fields of the Portal claim-entry process.
  – Copy, void, and edit (replace) claims.
  – Submit electronic attachments and notes.
  – Take advantage of extensive claim submission help.

• View claim status online:
  – View claims for a billing provider for as many as seven previous years.
  – View adjudicated claims in any status – paid, denied, or suspended.
  – Locate groups of claims by dates, claim type, claim status, Member ID, or Claim ID.
  – View paid amounts, explanation of benefits (EOB) messages, and other claim data.

• View current and historical Remittance Advices (RAs)

• Inquire about payments:
  – Inquire about previously received payments by searching on the check or electronic funds transfer (EFT) date or specific check number or payment ID.
  – View the list of claims associated with each payment.
  – View specific claim information associated with a payment by clicking on the Claim ID.

• Request prior authorization (PA):
  – Submit fee-for-service, nonpharmacy PA requests and attachments.
  – View PA status.
  – Update existing PA requests.

• Send inquiries and requests using secure correspondence:
  – Submit requests for claim-related administrative review or appeals.
  – Inquire about a claim or coverage issue.

Note: Claim submission and inquiry, RAs, payment inquiries, PA requests and inquiries, and some secure correspondence inquiries on the Portal are limited to fee-for-service, nonpharmacy services. These functions cannot be used for managed care services. In addition, the Portal cannot be used to submit or view HIP Employer Link claims.

For billing, reimbursement, and PA procedures related to managed care services, contact the member’s MCE. Billing, reimbursement, and PA for fee-for-service pharmacy services are handled by the IHCP pharmacy benefit manager, OptumRx. See the IHCP Quick Reference Guide at indiannamedicaid.com for MCE, pharmacy, and HIP Employer Link contact information.
Provider Representative and Delegate Roles

To use the Portal, providers must designate a representative, if they do not already have one. The following are the roles and responsibilities of the provider representative:

- Register a Provider account on the Portal. A separate Provider account must be created for each service location associated with the provider.
- Maintain compliance to Health Insurance Portability and Accountability Act (HIPAA) security and ensure that users do not share user IDs or passwords.
- Identify and manage Portal users, called delegates, who are authorized to work in the Provider account.
- Assign specific Portal access rights to delegates according to the user’s business need. Delegates have access only to the functions assigned to them by the provider representative (or by a delegate authorized to manage delegates).
- Deactivate delegate access for all accounts (service locations) to which the delegate has access when staff changes occur or the delegate is no longer employed by the organization.

The provider representative grants a delegate access to perform specific Portal functions on his or her behalf.

Portal Security and Password Regulations

The Portal is HIPAA-compliant for direct data entry (DDE). Encryption and secure sockets layer (SSL) connections protect the data in transit. HIPAA security regulations require that security information is not shared; therefore, each user must have a unique user ID and password. The Portal password regulations meet the qualifications for HIPAA security. All passwords are case-sensitive.

As needed, users have the capability of resetting their own passwords from the Portal. For security reasons, the reset password process requires users to answer one of the challenge questions that they defined during the registration process. The Portal will email a new temporary password to the user’s email address on file. The user will be prompted to change the temporary password the next time he or she logs on.

All user passwords expire after 60 days. The Portal notifies users when their password has expired and routes them to the Change Password page.

Registration Process

Note: You need to be an IHCP-enrolled provider before registering a secure account in the Portal. You can access the Portal’s online provider enrollment application from the public Provider Healthcare Portal home page at portal.indianamedicaid.com.

To start the registration process, access the Portal and complete the following steps:

1. From the Login window, click Register Now.
2. On the Registration page, you will be prompted to select the type of account you are registering:
   - To register as the provider representative for the service location, click Provider.
   - To register as a delegate authorized to perform functions on behalf of the service location, click Delegate.

3. After the registration type is selected, the Portal prompts you for the personal information that is required for the role selected. All fields in the Personal Information panel are required.
Figure 4 – Personal Information – Delegate

Note: The delegate code is provided by the provider representative or authorized delegate who added the user as a delegate.

4. After entering the personal information, click Continue, and the Portal displays the Security Information panel.

5. The Security Information panel allows you to configure all your security and contact information.
   - User IDs in the Portal are unique, so after entering a user ID, you need to confirm that the user ID is available by clicking Check Availability.
   - After establishing an available user ID, complete all required fields in the panel, including selecting a password, display name, email address, site key (an image used as a mutual authentication between the user and the Portal), and passphrase.
     - The display name for a Provider account should uniquely identify the provider service location.
     - The display name for a Delegate account should uniquely identify the person associated with the Delegate account.
6. As an added security feature, the Portal asks you to select three challenge questions that can be used to verify identity if the user logs on from a public or unregistered computer. These questions may also be used to help authenticate the user if a user gets locked out of the Portal or forgets his or her password.

7. Finally, you must read and accept the *User Agreement* by entering your full name and clicking **Submit**.
8. The Portal validates the submitted information and confirms the registration process.

9. A registration verification email message is sent to the email address specified during registration. The message includes a link that contains embedded random data that identifies the user.
10. Click the link in the email to access a page where the password (created during the application process) is required to verify the registration.

   ![Figure 10 – Registration Verification Window](image)

11. Upon successful verification, a *User Successfully Registered* message displays, and an email notification with credentials and login instructions is sent to the user’s email.

   ![Figure 11 – Registration Confirmation Message](image)

12. Click **OK** and check the email account provided during registration for the confirmation email.

   ![Figure 12 – Registration Confirmation Email](image)

**Logging in to the Portal**

To log in and access the Portal, go to the Provider Healthcare Portal home page at portal.indianamedicaid.com. From there, each user account has to follow a three-step process to log into the Portal:

1. Enter the user ID established during registration and click **Log In**.
Figure 13 – Portal Login

Note: If you forgot your user ID, you can request to have it sent to your email address using the Forgot User ID? link.

2. Answer the challenge question and click Continue.
   - If you are using a public computer, do not select the option to register the computer. If you are logging in to the Portal on a personal computer used only by authorized individuals, you may select the associated radio button to register the computer. When a computer is registered with the Portal, the Challenge Question window will be skipped for future logins from that computer.
   - If you have forgotten your challenge question answer, use the Forgot answer to challenge questions link to ask for assistance.

Figure 14 – Challenge Question Window

3. Verify that the site key and passphrase shown in the window are correct; these selections were made when your password was created during account registration. If the site key and passphrase are correct, enter your password and click Sign In.

Note: If you don’t remember your password, you can use the Forgot Password? link. You will then be required to answer one of the challenge questions you set up during the registration process. If you answer the challenge question correctly, a temporary password is sent to the email address on your profile. If you lock your account by entering the incorrect password too many times, the account will remain locked for 60 minutes before it becomes available again. To avoid delays, when you do not remember your password, it is always recommended to go directly to Forgot Password? link.
4. You will be required to read and accept the User Confidentiality Agreement the first time you log in to the Portal and annually thereafter. After reviewing the agreement, click Accept. User Confidentiality Agreement acceptance is a prerequisite to use the Portal.

5. After you log in, you see the Portal’s My Home page.
My Home – Features and Functions

The following figure shows the different features on the Portal’s My Home page, and the table describes these features and their functions.

Figure 17 – My Home Page Features

Table 1 – My Home Page Feature Descriptions

<table>
<thead>
<tr>
<th>Ref #</th>
<th>Description</th>
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<tbody>
<tr>
<td>1</td>
<td>The menu bar provides tabs for each page as well as quick drop-down navigation, to access the core functions of the Claims and Care Management pages.</td>
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<tr>
<td>2</td>
<td>Breadcrumbs indicate the page of the Portal you are working on and the path you took to get there. By clicking on a page listed on the breadcrumbs, you can return to that page.</td>
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<tr>
<td>3</td>
<td>Contact Us links to a page that provides several methods to contact the IHCP with questions. FAQs provide several resources for information related to the IHCP and Portal. Logout protects your information by logging out of the Portal.</td>
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<tr>
<td>4</td>
<td>The Broadcast Messages section displays information related to the Portal such as scheduled maintenance. This box is only visible when message information is available and being broadcast.</td>
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<tr>
<td>5</td>
<td>The content area contains specific information for the page you are currently viewing in the Portal.</td>
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<tr>
<td>6</td>
<td>The User Details section includes the options to manage your user account information (My Profile) and to manage the delegate assignments (Manage Accounts) if logged in as the provider representative or as a delegate who has been authorized to manage Delegate accounts.</td>
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<tr>
<td>Ref #</td>
<td>Description</td>
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<tr>
<td>7</td>
<td>The <strong>Provider</strong> section displays the provider’s name and National Provider Identifier (NPI) or Provider ID, and provides links to view provider profile, disenroll, change provider organization information (<strong>Provider Maintenance</strong>), revalidate (when applicable), and check status for enrollment/revalidation. (These options are available only to users with permission to perform these functions.)</td>
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<tr>
<td>8</td>
<td>The <strong>Provider Services</strong> section allows users to check member information, provider payment history, and Medical Assistance Provider Incentive Repository (<strong>MAPIR</strong>) information. (This option is available only to users with permission to perform this function.)</td>
</tr>
<tr>
<td>9</td>
<td>The <strong>Notify Me</strong> link gives subscribers access to all the email notifications.</td>
</tr>
<tr>
<td>10</td>
<td>The <strong>Secure Correspondence</strong> link allows users to send secure correspondence and attachments. (This option is available only to users with permission to perform this function.)</td>
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**My Profile – Portal User Information**

The **My Profile** link is available to all the Portal users from User Details section of the **My Home** page. From the **My Profile** page, you can update user information including telephone number, email address, and user-specific challenge questions and answers.

**Figure 18 – My Profile Information**

![My Profile Information](image)
**Manage Accounts – Adding and Managing Delegates**

The provider representative may add other Portal users as delegates, authorized to perform select functions on behalf of the provider. Delegates can also be authorized to create and manage Delegate accounts for that service location.

**Add New Delegate**

After logging in to the Portal as the provider representative (or as a delegate who has been authorized to manage delegate Accounts), follow these steps to add a new delegate:

1. Click the Manage Accounts link on the My Home page.
2. Select the Add New Delegate tab of the Delegate Assignment panel.
3. Enter the new delegate’s first name, last name, birth date, and the last four digits of his or her driver’s license number.

   **Note:** If the delegate does not have a driver’s license, any unique four-digit number can be used; however, delegates must remember the number, as it may be needed to validate their identity on the Portal.

4. Select all functions that the delegate will be authorized to perform on behalf of the provider.

5. Click Submit.

6. The Portal displays the information entered and requires you to confirm or edit any data as needed. If all information is correct, click Confirm. If information is incorrect, click Edit and correct the data as needed.
7. When information is confirmed, the Portal alerts you that the new delegate is added and provides the delegate code. Communicate the delegate code to the new delegate and instruct the delegate to use the code to register a Delegate account in the Portal to begin using Portal functions for the provider.

Add Registered Delegate

If the delegate being added is already a registered Portal user, follow this simplified process to add the delegate:

1. Click the Manage Accounts link on the Portal’s My Home page.
2. Select the Add Registered Delegate tab of the Delegate Assignment panel.
3. Enter the delegate’s last name and delegate code. The delegate code must be obtained from the delegate. The delegate code is not searchable by a provider within the Portal. If you do not know the user’s delegate code, the delegate may be added using the Add New Delegate tab, and the system will automatically locate and attach the user’s existing delegate code.
4. In the Functions area, select the functions that the delegate will be authorized to perform for the provider by clicking all applicable boxes.

5. Click **Submit** to receive confirmation that the delegate has been added to the provider’s delegate list.

6. Communicate to the registered delegate that he or she has been added to the provider’s delegate list.

**Figure 22 – Add Registered Delegate**

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**Change Delegate Permissions or Deactivate Delegate Accounts**

Follow these steps to change a delegate’s status or authorized functions:

1. Click the **Manage Accounts** link on the Portal’s **My Home** page.

2. In the Delegates panel, click on the name of the delegate whose authorized functions you want to modify.

**Figure 23 – Select Delegate Account**

3. In the Delegate Assignment panel (Figure 24), under the Edit Delegate tab, change the functions that the delegate will be granted to perform or change the delegate status to inactive:
   - Select or deselect items in the Functions list to change delegate permissions.
   - Select the Inactive radio button in the Status field to deactivate the delegate’s account.
Delegates who are assigned a status of inactive are not able to access Portal functions for the provider that assigned them the inactive status.

When a delegate leaves an organization, it is the provider representative's responsibility to ensure that the delegate's accounts for all service locations with that provider are made inactive. The delegate can continue to use his or her same delegate code for a different provider organization. A delegate cannot be deleted from a provider's delegate list.

4. Click Submit.

**Disenroll**

A provider can voluntarily disenroll from the IHCP through the Portal. An assigned delegate authorized for this function can also disenroll the provider using the Portal.

1. Click the **Disenroll Provider** link on the Portal’s **My Home** page.
2. Complete the required fields.
3. Click **Disenroll**.
4. After the Provider Enrollment Unit processes the disenrollment, a notification will be sent to the provider to verify disenrollment from the IHCP.
**View Provider Profile Information**

IHCP providers can view their profile information in the Portal:

- Rendering provider information, such as primary medical provider (PMP) information, and the start and end dates of current and historical rendering linkages, when viewing a group’s profile
- PMP information for individual rendering providers when viewing a group’s profile
- Current and historical group linkages for a rendering provider when viewing a rendering provider’s profile
- Current and historical NPI and IHCP Provider ID information
- All address information associated with an IHCP Provider ID
- Current and historical license information
- Current and historical CLIA information
- Current and historical contract and program information with start and end dates
- Current taxonomy codes
- Current Medicare participation information
- Recertification dates, when applicable
- Revalidation dates, when applicable

**Important:** To view the profile information in the Portal, registered delegates must have the appropriate permission assigned to their account.
The **Provider Maintenance** link in the Provider section of the Portal’s *My Home* page allows users to submit changes to the provider information reported to the IHCP. Most provider updates can be made through the Portal. Some changes may require users to submit or upload additional supporting documentation before the change is finalized in the system.

The Provider Maintenance function is available to any user within the provider’s organization who has been granted access to this function by his or her provider representative (or by an authorized delegate). To modify delegate access to these functions, see the *Change Delegate Permissions* section. It is the provider representative’s responsibility to grant Provider Maintenance access to only the appropriate delegates. By limiting personnel who have access to this function, providers can prevent unauthorized changes to provider information. Providers should ensure that users do not share their user IDs and passwords.

Click the **Provider Maintenance** link to view the Provider Maintenance Instructions panel. If there are no pending requests, the Current Maintenance Pending Requests section displays the message: *There are no Pending Maintenance Requests to show.* If there are pending requests, a message will appear indicating pending requests, and the section associated with the pending requests will appear grayed out and cannot be accessed until updates are finalized.
Table 2 – Provider Maintenance Change Types

<table>
<thead>
<tr>
<th>Change Types</th>
<th>Description</th>
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<tbody>
<tr>
<td>Change of Ownership (CHOW) Overview</td>
<td>Provides information about how to report a change of ownership.</td>
</tr>
<tr>
<td>Tax ID Changes</td>
<td>Allows federal tax ID/Social Security number information change. Requires submission of a W-9 when making the change.</td>
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</table>
| Contact and Delegated Administrator Information Changes | Allows maintenance of contact information and delegated administrators:  
  - Contact information corresponds to the individual to be contacted with questions about this location.  
  - Delegated administrators are the individuals entered (during initial IHCP enrollment) for paper submissions only. This option is not related to the task of registering delegates in the Portal.                                                                                                                                                              |
| Address Changes                                  | Allows users to modify registered addresses.  
  Legal address change requires submission of W-9.  
  Dental providers can also use this option to indicate whether they are accepting new patients or patients with special needs.                                                                                                                                                                                                                                 |
<p>| Specialty Changes                                | Allows users to add or remove provider specialties and change primary specialty assignment.                                                                                                                                                                                                                                                                                                                        |
| Presumptive Eligibility Changes                  | Allows appropriate provider types to begin the application process to enroll as a qualified provider (QP) for presumptive eligibility processes.                                                                                                                                                                                                                                                                  |
| EFT Changes                                      | Allows users to change electronic funds transfer (EFT) information. It takes approximately 18 days for the bank to process and completely establish an EFT account. If claims are paid before an EFT is active, paper checks will be mailed to the pay-to address on file.                                                                                                                                                     |
| Language Changes                                 | Allows users to add languages for which they are able to interpret. This field is not required.                                                                                                                                                                                                                                                                                                                      |</p>
<table>
<thead>
<tr>
<th>Change Types</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ERA Changes</td>
<td>Allows users to sign up to receive claim payment information using electronic remittance advance (ERA) 835 transactions. If ERA 835 transactions are to be electronically exchanged, an account should be established using this page within the maintenance application.</td>
</tr>
<tr>
<td>Other Information Changes</td>
<td>Provides access to update participation in the 590 Program, Preadmission Screening and Resident Review (PASRR), and Medical Review Team (MRT). The access to change or view these options will only appear to providers whose type and specialty are appropriate.</td>
</tr>
<tr>
<td>Rendering Provider Changes</td>
<td>Allows group users to add or remove rendering providers.</td>
</tr>
<tr>
<td>Provider Identification Changes</td>
<td>Allows users to change provider identification data, which includes legal name, doing business as (DBA) name, organizational structure, NPI, taxonomy information, licensure and certificate information including Clinical Laboratory Improvement Amendments (CLIA) certification, Medicare participation, patient population, and Drug Enforcement Agency (DEA) information. These changes are not intended to report the sale or transfer of ownership of the enrolled entity.</td>
</tr>
<tr>
<td>Disclosure Changes</td>
<td>Allows users to report any new or departing owners, board members or managers and maintain address information for all disclosed individuals (owners and managers, individuals, and corporations). Do not use the Disclosure Changes link to report CHOW information.</td>
</tr>
<tr>
<td>Check Status</td>
<td>Allows users to check the status of their change request using the tracking number assigned during the submission process and the provider’s federal tax identification number (TIN), employer identification number (EIN), or Social Security number (SSN).</td>
</tr>
</tbody>
</table>

**Change of Ownership (CHOW) Overview**

Clicking the Change of Ownership (CHOW) Overview link displays information about when to report a change of ownership and how to do it. CHOWs cannot be reported via the Provider Maintenance option. To report a CHOW, providers must submit a new enrollment application for each service location. To do so, log out of the Portal and select the Provider Enrollment link from the Portal home page. When completing the application, be sure to select Change of Ownership in the Enrollment Request Type drop-down menu.

**Note:** At this time, long-term care facilities cannot report a CHOW through the Portal; they must use the paper enrollment process.
Figure 28 – Provider Maintenance: Change of Ownership

**Change of Ownership Overview**

A change of ownership would include, but is not limited to, any of the following circumstances:

- For a sole proprietorship - When a provider of services is an entity owned by a single individual, and transfers title and property belonging to the enterprise to another person or firm, whether or not including a transfer of title to the real estate, or if the former sole proprietor becomes one of the members of a business entity succeeding him or her as the new owner.

- For a partnership - A new partnership, or the addition, admission, or substitution of an individual partner in an existing partnership, in the absence of an express statement in the partnership agreement that dissolves the old partnership and creates a new partnership.

- For a corporation - A new corporation, the merger of the applicant or provider corporation into another corporation, the consolidation of two or more corporations, or any change resulting in the creation of a new corporation. In an incorporated provider entity, the corporation is the owner. The governing body of the corporation is the group having direct legal responsibility under state law for operation of the corporation of the corporation’s entity, whether that body is a board of trustees, a board of directors, the entire membership of the corporation, or known by some other name.

Notes: A change of ownership can result in the assignment of a new provider number. Long-term facilities (provider type 03) with provider specialties 030 (Nursing Facilities), 021 (ICF/MR), 022 (Pediatric Nursing Facility), and 032 (Residential Care Facility) retain their provider number and service location when a change of ownership occurs. When these provider specialties change ownership, the new owner shall accept the responsibilities of the previous owner as listed in the previous owner’s provider agreement, and as required by 45 CFR 444.24.

All providers under new ownership, including LTC facilities are required to submit an entire HIP Provider Enrollment. An entire Enrollment must be completed for each service location, including the submission of all insurance and other supporting documentation and payment or proof of payment of an application fee. The new owner must also submit a copy of the purchase agreement, bill of sale, or other documentation to verify the change of ownership.

Please log out of the Portal and choose the Provider Enrollment link from the HealthCare Portal Home page to begin the change of ownership process. [Login]

---

Tax ID Changes

To make changes to the tax ID (federal employer identification number) or Social Security number (SSN), complete the following:

1. Select the **Tax ID Changes** link.
2. Enter the new number.
3. Select either EIN or SSN.
4. Click **Submit**.

Providers are required to submit a W-9 verifying the new tax ID or SSN provided.

Figure 29 – Provider Maintenance: Request Tax ID Changes
Contact and Delegated Administrator Information Changes
To make changes to the contact and delegated administrator information, select the Contact and Delegated Administrator Information Changes link and make changes as instructed.

Note: A delegated administrator is an individual that the provider designates, during initial IHCP enrollment, as having the authority to submit provider profile updates by mail on the provider’s behalf. Delegated administrators are authorized for paper submissions only. This option is not related to the task of registering delegates in the Portal to submit updates online.

Figure 30 – Provider Maintenance: Contact and Delegated Administrator Information

Address Changes
To make address changes, select the Address Changes link and then click the plus sign (+) to view or change the details for any of the following addresses on file:

- **Mail-To** – Address that receives provider enrollment and update confirmation letters, recertification or revalidation notices, and special correspondence
- **Pay-To** – Address that receives claim payment and PMP disenrollment letters
- **Legal** – The “home office” address (corporate address or headquarters on file with the Internal Revenue Service [IRS])
- **Service Location** – Address where services are rendered
The service location 9-digit ZIP Code is also used in the billing provider NPI crosswalk process for claim submission.

All four addresses are required. See the Provider Enrollment module for more information.

**Note:** To add an additional service location for a billing provider, the provider must submit a new provider enrollment application.

To entirely remove a service location, providers must use the Disenroll link on the Portal’s My Home page.

Figure 31 shows the service location address expanded.
**Specialty Changes**

To add, change, or delete a specialty, select the **Specialty Changes** link and make changes as instructed.

Figure 32 shows the screen as a physician provider specialty is being added.

![Figure 32 – Provider Maintenance: Specialties](image)

**Presumptive Eligibility Changes**

To enroll as a qualified provider (QP) for the Presumptive Eligibility (PE) process, select the **Presumptive Eligibility Changes** link and complete the fields as instructed. (See **Figure 33**.)

Depending on provider type and specialty, a provider may have the option to enroll as a QP for all PE determinations or for Presumptive Eligibility for Pregnant Women (PEPW) only. See the **Presumptive Eligibility** module for more information.

Existing QPs can terminate their QP status by selecting the appropriate check box.
EFT Changes

To authorize the IHCP to establish a direct deposit account for electronic funds transfers, or to change account information for an existing direct deposit account, select the **EFT Changes** link and complete the information as instructed.
Language Changes

To add or remove languages that a service location is able to interpret for non-English-speaking patients, including American Sign Language (ASL) interpretation, select the Language Changes link and make changes as instructed.

Figure 35 – Provider Maintenance: Languages
ERA Changes

To sign up to receive electronic remittance advance (ERA) as an 835 transaction, cancel receipt of 835 transactions, or make related changes, select the ERA Changes link and enter information as instructed.

Figure 36 – Provider Maintenance: ERA Information

Other Information Changes

To add or remove participation in the 590 Program, PASRR, or MRT programs, select the Other Information Changes link and make changes as instructed. Not all options are available to all provider types.
Note: Effective April 1, 2017, the IHCP does not cover drugs acquired through the 340B drug pricing program and dispensed by 340B contract pharmacies. This policy applies to the fee-for-service (FFS) pharmacy benefit. Questions regarding 340B policies of the managed care entities (MCEs) should be referred directly to the MCEs.
Rendering Provider Changes

Select the Rendering Provider Changes link to add or remove rendering providers. Only group or clinic providers (or their authorized delegates) can access and make changes to the Provider Maintenance: Rendering Providers page (see Figure 38 and Figure 40).

Add Rendering Providers to a Group Service Location

Only rendering providers that are already actively enrolled in the IHCP can be added (linked) to the group service location. If a group provider wants to add a rendering provider that is not yet enrolled in the IHCP, the group provider must enroll the rendering provider through the Provider Enrollment function on the Portal.

To add (link) an enrolled rendering provider to a group service location, follow these steps:

1. At the Provider Maintenance: Rendering Providers page (Figure 38), enter an effective date in the Rendering Linkage Effective Date field.
2. Enter either an IHCP Provider ID or NPI for the rendering provider being added. (The Provider ID is preferred, but NPI is also an option. Waiver providers must enter a Provider ID and not an NPI.)
3. Select the I Accept check box to confirm that a signed Rendering Provider Agreement and Attestation form will be uploaded or sent by mail (as described in steps 8–11).
4. Select the Rendering Provider Agreement and Attestation Form link and print the form.
5. Click Add.
6. If you have more rendering providers to add to this group service location, complete steps 1 through 5 for each rendering provider. Do not click Submit until you have added all rendering providers that you intend to add during this session.

Figure 38 – Provider Maintenance: Rendering Providers – Top Half

If you are adding new rendering providers, you will be required to supply a Rendering Agreement and Attestation Form for each. You are allowed to upload up to 10 Rendering agreement and Attestation forms. Any additional forms must be sent by mail along with the ATN cover sheet presented at the end of this process.

* Indicates a required field.
*Rendering Linkage Effective Date

Only currently enrolled rendering providers can be added to this group provider.

NPI

Provider ID

I accept

I attest that a signed Rendering Provider Agreement and Attestation Form will be sent by mail along with the cover sheet furnished at the end of this application submission. Please use the link below to obtain a copy of the most current Rendering Provider Agreement and Attestation Form. Both the group’s owner or authorized official and the rendering provider must sign this form.

Rendering Provider Agreement and Attestation Form

Add
Reset
7. After you finish adding all rendering providers, click **Submit**.

8. At the **Provider Maintenance: Application Attachments** page (Figure 39), select the Rendering Provider Agreement and Attestation Form option from the Attachment Type drop-down menu.

   **Note:** A signed Rendering Provider Agreement and Attestation Form must be submitted for every rendering provider that was added to the group service location. Each form is identified with the NPI or Provider ID that was entered in step 2. Both the group provider (or authorized official) and the rendering provider must sign the agreement and attestation forms.

   ![Figure 39 – Provider Maintenance: Application Attachments](image)

9. In the Transmission Method drop-down menu, select the method that will be used to submit the forms:
   - Select **FT-File Transfer** if uploading the form electronically. Both the group provider and the rendering provider identified must sign the form. The form must then be digitized and attached using the Upload File field.
   - Select **BM-By Mail** if sending the form by mail. Both the group provider and the rendering provider identified must sign the form. The form must then be sent by mail along with the agreement and attestation forms for all other providers added during this session and the coversheet, printed in step 13.

10. Click **Add** to finalize the process for the selected attachment.
11. Repeat steps 8–10 for all rendering providers added during this session.

12. Click **Submit** to complete the transaction.

13. If BM-By Mail was selected for any of the agreement and attestation forms, **select the option to print the coversheet and follow the instructions to send the signed forms and the coversheet to the address listed.**

### Remove Rendering Provider from Group Service Location

To remove a rendering provider from the group service location, follow these steps:

1. At the bottom of the **Provider Maintenance: Rendering Providers** page (Figure 40), click the **Remove** link for each provider you wish to remove (unlink from the group).

   ![Note: If the rendering provider is currently enrolled as a PMP, the provider must first contact the appropriate MCE to change his or her PMP status before the Remove option will appear on this screen.]

2. Click **Submit**.

   **Figure 40 – Provider Maintenance: Rendering Providers – Bottom Half**

   ![Click the Remove link to remove the row.]

<table>
<thead>
<tr>
<th>NPI</th>
<th>Provider ID</th>
<th>Name</th>
<th>Rendering linkage effective date</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>XXXXXXXX</td>
<td>XXXXXXXX</td>
<td>XXXXXXXX XXXXXX</td>
<td>04/01/2011</td>
<td>Remove</td>
</tr>
<tr>
<td>XXXXXXXX</td>
<td>XXXXXXXX</td>
<td>XXXXXXXX XXXXXX</td>
<td>04/06/2015</td>
<td>Remove</td>
</tr>
<tr>
<td>XXXXXXXX</td>
<td>XXXXXXXX</td>
<td>XXXXXXXX XXXXXX</td>
<td>01/28/2011</td>
<td>Remove</td>
</tr>
<tr>
<td>XXXXXXXX</td>
<td>XXXXXXXX</td>
<td>XXXXXXXX XXXXXX</td>
<td>01/26/2011</td>
<td>Remove</td>
</tr>
<tr>
<td>XXXXXXXX</td>
<td>XXXXXXXX</td>
<td>XXXXXXXX XXXXXX</td>
<td>01/26/2011</td>
<td>Remove</td>
</tr>
<tr>
<td>XXXXXXXX</td>
<td>XXXXXXXX</td>
<td>XXXXXXXX XXXXXX</td>
<td>01/26/2011</td>
<td>Remove</td>
</tr>
<tr>
<td>XXXXXXXX</td>
<td>XXXXXXXX</td>
<td>XXXXXXXX XXXXXX</td>
<td>01/12/2011</td>
<td>Remove</td>
</tr>
<tr>
<td>XXXXXXXX</td>
<td>XXXXXXXX</td>
<td>XXXXXXXX XXXXXX</td>
<td>01/12/2011</td>
<td>Remove</td>
</tr>
<tr>
<td>XXXXXXXX</td>
<td>XXXXXXXX</td>
<td>XXXXXXXX XXXXXX</td>
<td>01/06/2015</td>
<td>Remove</td>
</tr>
<tr>
<td>XXXXXXXX</td>
<td>XXXXXXXX</td>
<td>XXXXXXXX XXXXXX</td>
<td>01/06/2015</td>
<td>Remove</td>
</tr>
<tr>
<td>XXXXXXXX</td>
<td>XXXXXXXX</td>
<td>XXXXXXXX XXXXXX</td>
<td>01/06/2015</td>
<td>Remove</td>
</tr>
<tr>
<td>XXXXXXXX</td>
<td>XXXXXXXX</td>
<td>XXXXXXXX XXXXXX</td>
<td>01/06/2015</td>
<td>Remove</td>
</tr>
<tr>
<td>XXXXXXXX</td>
<td>XXXXXXXX</td>
<td>XXXXXXXX XXXXXX</td>
<td>01/06/2015</td>
<td>Remove</td>
</tr>
</tbody>
</table>

### Provider Identification Changes

Select the **Provider Identification Changes** link to make changes to any of the following, as instructed:

- Provider legal name (that is not related to a CHOW) or DBA name
- Organizational structure
- NPI
- Taxonomy
- License information
- Medicare number
- Patient population
- CLIA certification
- DEA number

Figure 41 – Provider Maintenance: Provider Identification (Top Half)

<table>
<thead>
<tr>
<th>Provider Legal Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>The legal name and provider federal tax identification number (TIN) must match the information on the W-9. The provider legal name is considered to be the entity maintaining ownership of the named business. The legal name must match the information registered with the Secretary of State, if registered. If this Legal Name and Tax Identification Number is associated with more than one provider ID, the legal name change will be applied to all provider IDs associated with this Tax ID (W-9):</td>
</tr>
</tbody>
</table>

| *Is the change in Legal Name a result of a Change of Ownership? | Yes | No |

<table>
<thead>
<tr>
<th>*Provider Legal Name</th>
<th>XXXXXXX XXXX</th>
</tr>
</thead>
</table>

The doing business as (DBA) name identifies the site where members obtain services and that is owned or rented by the provider. The DBA name must match the business name on the W-9.

<table>
<thead>
<tr>
<th>Doing Business As Name</th>
</tr>
</thead>
</table>

Organizational Structure

- If your business is chain affiliated, the information about the company or organization must be included in the disclosure information.
- If your business is operated by a management company or leased (in whole or in part) by another organization, information about the management company or organization must be included in the disclosure information.
- Entities doing business in Indiana, except for information associates such as sole proprietorships or general partnerships, must be registered with the Secretary of State. Go to [indiana.gov](http://indiana.gov) to find out how to complete the registration process.

<table>
<thead>
<tr>
<th>*Organization Type</th>
<th>Individual/Sole Proprietor</th>
</tr>
</thead>
</table>

Entities doing business in Indiana, except for information associates such as sole proprietorships or general partnerships, must be registered with the Secretary of State. Go to [indiana.gov](http://indiana.gov) to find out how to complete the registration process.

<table>
<thead>
<tr>
<th>Registered with Indiana Secretary of State</th>
<th>Business Start Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ]</td>
<td>07/26/2017</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Incorporated</th>
<th>Incorporation Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Operated by Management Company</th>
</tr>
</thead>
</table>

Provider Identification

The National Provider Identifier (NPI) is a unique identification number for healthcare providers:

- [NPI lookup information](http://npilookup.com)

<table>
<thead>
<tr>
<th>*NPI</th>
<th>XXXXXXXXXX</th>
</tr>
</thead>
</table>

Taxonomy Information

A taxonomy code identifies a healthcare provider type and specialty; it is not a unique physician identification number (UPIN), a Medicare provider number, or an HIP provider number. The full taxonomy code set can be found at [www.cdc.gov](http://www.cdc.gov) under Reference. The taxonomy requested is the taxonomy associated with the provider’s NPI.

Please include all taxonomy codes that reflect the services to be provided at this service location.

- At least one taxonomy code must be entered.

<table>
<thead>
<tr>
<th>Taxonomy</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>207Q00000X-Family Medicine</td>
<td>Remove</td>
</tr>
</tbody>
</table>

Click to add taxonomy.
Disclosure Changes

To report new or departing owners, board members or managers or to update information for disclosed corporations and subcontractors, select the Disclosure Changes link and make changes as instructed. Do not use the Disclosure Changes link to report CHOW information.
**Figure 43 – Provider Maintenance: Disclosures**

### Fingerprint Background Check Information

Fingerprinting and Criminal Background Check: Providers assigned to the high-risk category are required to have a national fingerprint-based criminal background check. (Please refer to the HCP Provider Enrollment Risk Category and Application Fee Matrix to determine if your provider type is high-risk.) This requirement applies to all individuals who have at least 5% ownership or controlling interest in the enrolling business entity. The requirement also applies to individual practitioners who have been assigned to the high-risk category.

Refer to the IndianaMedicaid.com website for additional information about Fingerprinting and Criminal Background Check.

### Individuals with Ownership or Control Interest and Managing Individuals

Please list all individuals with an ownership or control interest in the applicant. If the applicant is a not-for-profit entity, please list the board of directors or advisory board. Not-for-profit providers must also list their managing individuals: a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or directly or indirectly conducts, the day-to-day operations of the provider entity.

Include each person’s name, address, date of birth (DOB), and Social Security number (SSN). Also indicate the title (e.g., chief executive officer, owner, board member) and if an owner, the percent of ownership.

#### Managing Individuals

List all agents, officers, directors, and managing employees who have expressed or implied authority to obligate or act on behalf of the provider entity. Not-for-profit providers must also list their managing individuals:

- **An agent is any person who has express or implied authority to obligate or act on behalf of the entity:**
  - An agent is any person whose position is listed as an officer in the provider’s articles of incorporation or corporate bylaws, or is appointed as an officer by the board of directors or corporate body.
  - A director is a member of the provider’s board of directors, board of trustees, or other governing body. It does not necessarily include a person who has the word director in his or her title, such as director of operations or departmental director.
  - A managing employee is a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over or directly or indirectly conducts the day-to-day operations of the provider entity.

* Indicates a required field.

<table>
<thead>
<tr>
<th>Name of individual</th>
<th>Disclosure Type</th>
<th>SSN</th>
<th>Birth Date</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>XXXXXXXX XXXXX</td>
<td>Managing Individuals, Ownership and Control</td>
<td>12345678</td>
<td>xxxx/xxxx/xxxx</td>
<td>Remove</td>
</tr>
</tbody>
</table>

Click “X” to add disclosed entity.

### Corporations with an Ownership or Control Interest

If a corporation, please list all corporations with an ownership or control interest in the applicant. Include the Tax Identification Number (TIN), the percent of ownership in the applicant, the primary business address, every business location, including P.O. Box address(es).

Click “+” to view or update the details in a row. Click “-” to collapse the row. Click Remove to remove the entire row.

<table>
<thead>
<tr>
<th>Name of Corporation</th>
<th>TIN</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Click “X” to add disclosed entity.

### Subcontractors

Subcontractors - Please list all subcontractors in which the applicant has a 5% or more ownership or control interest, include any subcontractor and their address and Tax Identification Number (TIN).

Click “+” to view or update the details in a row. Click “-” to collapse the row. Click Remove to remove the entire row.

<table>
<thead>
<tr>
<th>Name of subcontractor</th>
<th>Street Address</th>
<th>City, State, Postal Code</th>
<th>TIN</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Click “X” to add disclosed entity.
Check Status

Each time a change request is submitted, a tracking number is assigned. Be sure to make a note of the tracking number for future reference, so that you can check the status of your request.

Figure 44 – Provider Maintenance: Tracking Information

To check the status of your request, click Check Status from the left menu of the Provider Maintenance Instructions page and enter the tracking number and the TIN, EIN, or SSN:

Figure 45 – Provider Maintenance: Status

Provider Enrollment/Revalidation Status

The Portal allows users to check the status of their enrollment or revalidation.

If you submitted a revalidation, select the Enrollment/Revalidation Status link on the My Home page, and enter the application tracking number assigned to the revalidation submission and the TIN, EIN, or SSN associated with the application, to monitor the status of your revalidation.

Figure 46 – Provider Enrollment/Revalidation Status
**Member Focused Viewing**

The Member Focused Viewing link allows users to find a member and place that member in focus. When a member is in focus, that member’s information is automatically populated within the Portal. For example, if you select the Claims tab on the menu bar and then select Claim Submission, the information from the member in focus automatically appears in the appropriate fields of the claim and you do not need to enter it.

To place a member in focus, complete the following steps:

1. Click the **Member Focused Viewing** link in the Provider Services section of the My Home page.

2. In the Member Focus Search panel, the **Last Members Viewed** tab shows the last 10 members that have been placed in focus. To place one of these members back in focus, just select his or her name and skip to step 5.

   **Figure 47 – Last Members Viewed**

   ![](image1)

3. To place a new member in focus, select the **Search** tab, enter the member’s information, and then click **Search**. The Search Results list shows those members that match the search criteria entered.

   **Figure 48 – Member Focus Search**

   ![](image2)

4. From the Member column in the Search Results panel, click the name of the member you want to put in focus.

5. With that member now in focus, the Portal shows the member’s information and includes links to several actions you can perform for this member, such as view eligibility verification information, see details about a past claim or authorization request, send secure correspondence, or submit a new claim or authorization request.
Secure Correspondence

The Portal allows users to send secure correspondence messages to the IHCP.

1. From the My Home page, click the Secure Correspondence link to access the Secure Correspondence – Message Box.

2. To create a new message, click the Create New Message link.

Note: The Secure Correspondence – Message Box shows previous messages you have sent from this same service location. Correspondence in this message box can be sorted by status, subject, message category, date opened (date the secure correspondence was submitted), or date closed (date of response). You can check the status and other details of messages you have sent by clicking the subject of the message.
3. In the **Create Message** panel, enter the subject of the new message, the category that best reflects the purpose of the message, return email address, any other pertinent information, and the message itself. The message category options are as follows:
   - **Administrative Review Request** – For requesting a claim-related administrative review (fee-for-service, nonpharmacy only)
   - **Appeal** – For sending a claim-related appeal (fee-for-service, nonpharmacy only)
   - **Banking/Financial/RA** – For requesting an RA or submitting a question about an RA (fee-for-service, nonpharmacy only)
   - **Claim Inquiry** – For inquiries related to a claim (fee-for-service, nonpharmacy only)
   - **Coverage Inquiry** – For inquiries related to benefit limits (fee-for-service, nonpharmacy only)
   - **Enrollment** – For inquiries regarding provider enrollment status
   - **Portal Assistance** – For questions about the Portal
   - **Prior Authorization** – For questions related to PA (fee-for-service, nonpharmacy only)
   - **TPL Update** – For updates and questions regarding third-party liability (TPL)
   - **Other** – For all other types of secure correspondence

4. The **Attachments** panel allows you to add attachments to the correspondence.

   **Figure 51 – Secure Correspondence – Create Message**

5. When all the appropriate information is entered, click **Send** to submit the message.
6. When the Confirmation window pops up, click **OK**.

![Figure 52 – Confirmation Window](image)

7. After the secure message is sent, a secure correspondence contact tracking number (CTN) is sent to the email address submitted in the **Secure Correspondence – Create Message** panel. The provider can use this CTN to track the status of the correspondence when logged into the same service location from which the correspondence was sent.

8. When the inquiry is resolved by the Written Correspondence analyst, the response is documented in the **Secure Correspondence – Message Box** and the status of the secure correspondence is updated. A notification email containing a link to the Portal’s **Secure Correspondence** page is sent to the provider so the response can be reviewed. Providers cannot reply to the notification email. If a provider has questions or concerns about the response received, he or she must create a new secure message.

**Eligibility**

The Eligibility tab on the Portal menu bar enables users to verify member eligibility, review member coverage information, apply for presumptive eligibility when applicable, and view information about other insurance coverage if a member has third-party liability (TPL).

**Eligibility Verification Request**

To ensure that a member has active IHCP benefits, the eligibility of the member can be confirmed within the Portal as follows:

1. Click the **Eligibility** tab on the Portal menu bar to access the Eligibility Verification Request panel.

2. The Portal offers three methods to search for a member. Enter one of the following:
   - Member ID
   - Member’s SSN and birth date
   - Member’s last name, first name, and birth date

3. Enter the date, or date range, for which eligibility is being checked:
   - The Effective From field is always required. If a date is not entered in this field, the Portal defaults this field to the current date. This field only accepts current and previous dates.
   - The Effective To field is optional. If a date is entered, it must be on or after the date in the Effective From field and must be within the same calendar month as that date. If a date is not entered in this field, it will default to the date in the Effective From field.
Note: Eligibility cannot be verified for future dates, because eligibility cannot be guaranteed in the future.

A provider can only check eligibility for dates of service within the provider’s enrollment dates. A provider cannot view eligibility if the provider was not actively enrolled with the IHCP for the dates being checked. For example, if a provider is enrolled in the IHCP starting on March 1, 2017, but attempts an eligibility verification search with an Effective From date of January 3, 2017, (prior to the provider’s enrollment period), the Portal will not display eligibility information for that member.

4. Click Submit to determine the member eligibility for the specified date or date range.

Figure 53 – Eligibility Verification Request Panel

5. The Portal displays results of the search:
   - If the search criteria does not match information in the Portal, a message appears above the search panel stating: “Error: Member not found; confirm and/or revise search criteria.” (See Figure 54.)
   - If the Portal finds results for the search criteria entered, but the member does not have coverage for the dates searched, the words Not Eligible appear in the coverage details for that member. (See Figure 55.)
   - If the Portal finds coverage for the dates entered, it lists the member’s benefit plans, as well as additional information, in the Coverage Details panel. (See Figure 56.)

Figure 54 – Eligibility Verification Request – No Information Found

Figure 55 – Eligibility Verification Request – No Coverage for Dates Searched

Figure 56 – Eligibility Verification Request – Coverage Details for Dates Searched
Figure 56 – Eligibility Verification Information

Note: For a claim to be considered for payment, the date of service must fall within an effective date range.

6. Within the Coverage Details panel, all panels other than Benefit Details are initially collapsed. As you expand (+) the panels, you are able view to more information. You can also select Expand All to display all the information for all the panels. Table 3 lists all possible detail panels. Only panels applicable to the member’s coverage are displayed.

Table 3 – Coverage Detail Panels

<table>
<thead>
<tr>
<th>Panel</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefit Details</td>
<td>The Benefit Details panel lists the member’s coverage, including benefit plan name and description and copayment amounts. For more information about IHCP benefit plans, see the Member Eligibility and Benefit Coverage module.</td>
</tr>
<tr>
<td>Limit Details</td>
<td>The Limit Details panel lists the member’s dollar and service limits based on the claim information received. These amounts may be different than the actual amounts available based on paid claims accounted for in the system.</td>
</tr>
<tr>
<td>Panel</td>
<td>Description</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Managed Care Assignment Details</td>
<td>The Managed Care Assignment Details panel is displayed only for members enrolled in a managed care program, such as Healthy Indiana Plan (HIP), Hoosier Care Connect, or Hoosier Healthwise. If this detail panel does not appear, the member’s coverage is fee-for-service (FFS). The panel identifies the member’s managed care program, primary medical provider (PMP), managed care entity (MCE), and delivery network associated with the PMP, if a delivery network is applicable. Telephone numbers and effective dates are also provided. The option to submit a Notification of Pregnancy (NOP) is also available from this panel. See the <em>Obstetrical and Gynecological Services</em> module for details.</td>
</tr>
</tbody>
</table>

| Right Choices Program        | The Right Choices Program panel lists the providers assigned to the Right Choices Program (RCP) member. These providers are approved for a member to use for services. See the *Right Choices Program* module for details. |

| Waiver Liability Details     | The Waiver Liability Details panel shows the member’s Medicaid waiver liability obligation and the remaining balance. Similar to the Limit Details panel, the balance amount may not reflect claims not yet processed. |

| Nursing Home/Hospice Level of Care | The Nursing Home/Hospice Level of Care panel displays level of care (LOC), eligibility dates, and the member’s liability obligation for the effective coverage plan. |
### Panel | Description
--- | ---
Detail Information | The Detail Information panel displays information for authorized Medicaid Rehabilitation Option (MRO) and 1915(i) services. Note that only those users with the correct specialty for MRO or the 1915(i) specialties can see this information. All other provider specialties cannot see this data. For details, see the Medicaid Rehabilitation Option Services module or the applicable Division of Mental Health and Addiction (DMHA) module: Adult Mental Health Habilitation Services, Behavioral and Primary Healthcare Coordination Services, or Child Mental Health Wraparound Services.

<table>
<thead>
<tr>
<th>PA Number</th>
<th>Status</th>
<th>Provider</th>
<th>Code</th>
<th>Description</th>
<th>Service Dates</th>
<th>Units Authorized</th>
<th>Units Used</th>
<th>Amount Authorized</th>
<th>Amount Used</th>
</tr>
</thead>
<tbody>
<tr>
<td>A1131111111</td>
<td>APPROVED</td>
<td>PROVIDER NAME</td>
<td>H9012</td>
<td>MRO</td>
<td>06/21/2017 – 12/31/2017</td>
<td>252</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

Other Insurance Details | The Other Insurance Details panel displays information on other carriers, including the carrier’s name (and Carrier ID), address, and telephone number and the policyholder’s policy ID, group ID, name, and coverage type.

**Note:** Providers can update information about a member’s other insurance by using the Portal’s Secure Correspondence link, with TPL Update selected as the category. See the Secure Correspondence section for details. For more information about members with other insurance, in addition IHCP coverage, see the Third Party Liability module.

Demographic Details | The Demographic Details panel displays the address on file for the member.

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**Presumptive Eligibility Application**

In some instances, when an eligibility search results in no coverage details (or in PASRR or MRT coverage only), the Portal displays options that enable qualified providers to submit a presumptive eligibility application for eligible individuals to receive temporary coverage until the application for enrollment in the IHCP is approved by the Indiana Family and Social Services Administration (FSSA).

When no coverage exists for the individual searched, qualified providers (QPs) may see the **PE Application for Pregnant Women** button and/or the **PE Application** button, depending on whether the provider is qualified for all Presumptive Eligibility (PE) applications or only for Presumptive Eligibility for Pregnant Women (PEPW) applications. For more information on these processes, see the Presumptive Eligibility module.

**Note:** QPs that are hospitals are able to make PE determinations for incarcerated individuals under the PE for Inmates process. If the individual has no current coverage, the PE Application may be used. If current coverage is found for the individual, the PE Application for Inmate button appears.
Claims

The Portal allows providers to submit individual FFS, nonpharmacy claims electronically to the IHCP. The Portal accepts all FFS institutional, professional, and dental claims, including:

- Inpatient
- Outpatient
- Home health
- Long-term care
- Medical
- Dental
- Medicare and Medicare Replacement Plan crossover claims

A claim submitted through the Portal is assigned a Claim ID, which can be used for tracking purposes, and is available for viewing through claim inquiry approximately two hours after submission.

⚠️ Note: Providers cannot use the Portal to submit claims to MCEs or to view claims submitted to MCEs. Contact the member’s MCE for managed care claim-submission instructions.

The Portal may not be used for submitting or viewing pharmacy claims. See the Pharmacy Services module for information about pharmacy claim submission.

In addition, HIP Employer Link claims cannot be submitted or viewed using the Portal, due to the “L” prefix required for Member IDs on HIP Employer Link claims. After a HIP Employer Link claim has been adjudicated by the employer-sponsored insurance (ESI) plan, providers may submit the claim to the IHCP via 837 electronic transaction or by mail for reimbursement of the member’s out-of-pocket costs.

See the Quick Reference Guide at indianamedicaid.com for MCE, pharmacy, and HIP Employer Link contact information.

To access the Claims page, select the Claims tab from the menu bar. The Claims page displays links to claim-related options that users can perform through the Portal. These options can also be accessed by placing your cursor over the Claims tab to activate the drop-down menu.
Search Claims

You can search for specific claims related to the search criteria you select from the Search Claims link.

1. On the Search Claims page, you are required to enter at least one field or a combination of fields to conduct a search. Search for a claim using:
   - Claim information
   - Member information
   - Service information
   Paid Date or Service From and To fields are required if no claim information is entered on the request.

2. The result shows claim information such as the Claim ID, claim type, claim status, service date, Member ID, Medicaid paid amount, and paid date.
3. Click the **Claim ID** link to view details about a particular claim.

**Figure 61 – Claim Detail Information**

**Note:** If you have submitted an adjustment to a claim, the adjustment will be listed in your search results if you search by Member ID and date of service.

**Note:** Additional information about the claim and claim processing may be displayed by clicking the plus sign (+) to expand each panel.
Submit Claim

The following table lists the types of claim submissions that can be made through the Portal.

<table>
<thead>
<tr>
<th>Submit Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Submit Claim Dental</td>
<td>To submit dental claims via the Portal, complete these three steps:</td>
</tr>
<tr>
<td></td>
<td>• Enter provider, patient, and claim information.</td>
</tr>
<tr>
<td></td>
<td>• Enter other insurance (TPL) information.</td>
</tr>
<tr>
<td></td>
<td>• Enter service details, attachments, and claim notes.</td>
</tr>
<tr>
<td>Submit Claim</td>
<td>To submit institutional claims via the Portal, complete these three steps:</td>
</tr>
<tr>
<td>Institutional</td>
<td>• Enter provider, patient, and claim information.</td>
</tr>
<tr>
<td></td>
<td>• Enter diagnosis codes, other insurance (TPL), condition codes, occurrence</td>
</tr>
<tr>
<td></td>
<td>codes, value codes, and surgical procedure information.</td>
</tr>
<tr>
<td></td>
<td>• Enter service details, attachments, and claim notes.</td>
</tr>
<tr>
<td>Submit Claim</td>
<td>To submit professional claims via the Portal, complete these three steps:</td>
</tr>
<tr>
<td>Professional</td>
<td>• Enter provider, patient, and claim information.</td>
</tr>
<tr>
<td></td>
<td>• Enter diagnosis codes and other insurance (TPL).</td>
</tr>
<tr>
<td></td>
<td>• Enter service details, attachments and claim notes.</td>
</tr>
</tbody>
</table>

Note: Throughout the submission process for all claim types, fields marked with an asterisk (*) are required to continue through the Portal process. However, the asterisk does not necessarily indicate all fields that are required for a claim to be reimbursed. Based on factors such as the procedure code billed, the provider specialty submitting the claim, and so forth, some fields without an asterisk may be denied with an appropriate EOB if they were left blank during the Portal claim-submission process.

The following sections provider step-by-step examples of the Portal claim-submission process for a dental, institutional, and professional claim.

Note: You must complete the claim submission in a single session, so make sure to have all the necessary information before starting the submission. There is not an option to save and complete the claim at a later time.

If you need to go back to a previous step during the claim-submission process, do not use the breadcrumbs at the top of the page or the Back button on your browser; instead, use the Back to Step buttons at the bottom of the page to move between steps; otherwise, your data may be lost!

Submission Process Example: Dental Claim

From the Portal menu bar, select Claims > Submit Claim Dental.

Step 1: Provider, Patient, and Claim Information

Step 1 of submitting a dental claim entails adding provider, patient, and claim information.
Provider Information Section

The Provider Information section displays the billing provider’s NPI or Provider ID and name. This section also allows users to identify the rendering provider and the service facility location.

> Figure 63 – Provider Information Section (Dental Claim)

1. When you click a magnifying glass icon, you can search for a provider in one of three ways (select one tab):
   - Search by ID
   - Search by name
   - Search by organization
2. Enter the required information and click **Search**.
3. In the Search Results panel, click the Provider ID or NPI of the rendering provider or service facility location you would like to add to the claim submission. The chosen provider’s information will automatically populate the corresponding fields of the Provider Information section (Figure 63).

**Patient Information Section**

The Patient Information section is intended to collect information about the member for whom the claim is being submitted and associates all the plan and benefit information to that particular member.

**Claim Information Section**

The Claim Information section is intended to collect general information about the claim.

If the claim is for an emergency service, the Emergency checkbox must be selected.

The patient number is the unique number used by the provider to identify the person who received the services.

If the member has insurance coverage through another carrier, select the Include Other Insurance box located at the bottom of the page before clicking Continue. This option allows you to enter coordination of benefits (COB) information (if you do not check this box, the Other Insurance Details section in Step 2 will not be visible).

After you enter all required information for Step 1 and are ready to advance to Step 2 of the claim-submission process, click **Continue**.
**Step 2: Other Insurance (TPL)**

Before entering information for Step 2, review a summary of the provider, patient, and claim information you entered in Step 1. This summary is located at the top of the Submit Dental Claim: Step 2 panel.

*Figure 68 – Submit Dental Claim: Step 2 – Provider, Patient, and Claim Information Summary*

**Other Insurance Details**

If other insurance details or TPL insurance information for a member is already in the Portal, that information will automatically populate fields in the Other Insurance Details panel.

*Figure 69 – Other Insurance Details Panel (Dental Claim)*
You can add, remove, or edit information in the Other Insurance Details panel.

- Click **Remove** to delete any unneeded carriers from the claim.
- Click the **hyperlinked number** in the # column to update a carrier’s information.
- Click **[+] Click to add a new other insurance** to expand the section where you can add new insurance information. After all information is entered, click **Add** to add the new carrier.

![Figure 70 – Add a New Insurance Carrier](image)

**Note:** The carrier ID is the identification number the insurance company uses in electronic claim submission.

**Claim Adjustment Details**

The Claim Adjustment Details panel is intended to identify adjustments made to the final payment by the primary insurer. After you have added other insurance, click on the hyperlinked number in the # column to add claim adjustment details for that carrier. When completing the Claim Adjustment Details panel, the Claim Adjustment Group Code, Reason Code, and Adjusted Amount are required fields. If you add claim adjustment details, click **Add Adjustment** to save those changes.
After you enter all required information for Step 2 and are ready to advance to Step 3, click **Continue**.

**Step 3: Service Details, Attachments, and Claim Note Information**

Before entering information for Step 3, review a summary of the information entered during Step 1 and Step 2. This summary is located at the top of the Submit Dental Claim: Step 3 panel.
Service Details

The Service Details panel is used to enter information for each service detail, such as service date, procedure code, and number of units. Click Add after completing the information for a service detail. Up to 50 detail lines are allowed per dental claim.

Figure 74 – Service Details Panel (Dental Claim)

Attachments

The Attachments panel is used to upload supporting documents electronically or to indicate that you intend to mail the appropriate documentation.

Figure 75 – Attachment Transmission Methods

Note: If you plan to upload an attachment, be aware that the attachment file size limit is 5 MB, and valid file types for upload include: .bmp, .gif, .jpg, .jpeg, .pdf, .png, .tif and .tiff.

1. Select FT–File Transfer to upload a file or BM–By Mail to send documents to the IHCP by mail.
2. Identify the attachment being mailed or uploaded:
   - If sending the attachment by mail, create a unique attachment control number (ACN) and enter that number in the Control # field. This number must match the number submitted on the IHCP Claims Attachment Cover Sheet (available on the Forms page at indianamedicaid.com) that is mailed with the documentation.
3. Select the appropriate option from the Attachment Type drop-down menu.

4. Click **Add** after selecting each individual document to attach.

### Claim Note Information

Although the fields in the Claim Note Information panel are not required, they can be used if needed to provide clarifying information about the claim as follows:

1. Select **Additional Information** from the Note Reference Code drop-down menu.
2. Enter any necessary information in the Note Text field.
3. Click **Add** to add the claim note.
4. Click **Submit** to proceed to the final preview, from which you can modify or submit the claim.
Final Preview

The Portal displays the claim information for review before you confirm your submission.

Figure 79 – Confirm Dental Claim Information

1. Review the information and then select the appropriate option from the bottom of the page:
   – If you discover that you need to edit the claim information, use the **Back to Step** buttons to navigate to the appropriate step and edit the desired information.
   – Click **Print Preview** to print a copy of the claim information being submitted.
   – Click **Cancel** if you decide not to submit the claim. When you choose to cancel the claim submission, data entered during the process will be lost, and the claim data will not be submitted.
   – If, after reviewing the information, you are ready to submit the claim, click **Confirm**.

Figure 80 – Submitting the Dental Claim
2. After you click **Confirm** to submit the claim for processing, the Portal displays a claim receipt with the Claim ID and current claim status.

   ![Note: Use the Claim ID as the reference to check the status of your claim or any time you reference this claim in an inquiry.](image)

   **Figure 81 – Dental Claim Submission Confirmation**

3. The confirmation panel also includes the following options:
   - The **Print Preview** button allows you to view and print a copy of your claim receipt.
   - The **Copy** button allows you to select member or claim data to paste into a new claim submission.
   - The **New** button allows you to start a new dental claim.

**Submission Process Example: Institutional Claim**

From the Portal menu bar, select **Claims > Submit Claim Institutional**.

**Step 1: Provider, Patient, and Claim Information**

Before entering information, identify whether the claim is for an inpatient or outpatient service. The **Inpatient/Outpatient** selection determines which fields are required during later steps of the claim submission.
Provider Information Section

The Provider Information section displays the billing provider’s NPI or Provider ID and name, and allows users to identify additional providers associated with the claim.
1. When you click a magnifying glass icon, you can search for a provider in one of three ways:
   - Search by ID
   - Search by name
   - Search by organization
2. Enter the required information and click Search.
3. From the results, click the Provider ID or NPI of the provider you would like to add to the corresponding field on the claim submission. The chosen provider’s information will automatically populate the Provider Information section of the claim.

### Patient Information Section

The Patient Information section is intended to collect information about the member for whom the claim is being submitted, and associates all the plan and benefit information to that particular member.

![Patient Information Section](image)

Note: If the system does not find a match based on Member ID, first name, and last name, it displays the error message, “Member not found,” and the claim submission process will not be able to continue until valid information is entered.

### Claim Information Section

The Claim Information section is intended to collect information about the claim (header instructions).

![Claim Information Section](image)

The Covered Dates fields are the dates of service for the claim and are used to verify eligibility. Every date entered on the service lines of the claim should be within those two dates.

If you have other insurance information to enter, check the Include Other Insurance box located at the bottom of the page before clicking Continue. Use this option to create Medicare crossover claims as well as to enter TPL information on a claim.

After entering all the required information for Step 1, click Continue to proceed to Step 2.
Step 2: Diagnosis Code, Other Insurance (TPL), Condition Codes, Occurrence Codes, and Value Codes

Before entering information for Step 2, review a summary of the provider, patient, and claim information you entered in Step 1. This summary is located at the top of the Submit Institutional Claim: Step 2 page.

Figure 86 – Submit Institutional Claim: Step 2 – Provider, Patient, and Claim Summary Information

Note: The sections and fields that are visible within Step 2 depend on the information entered in Step 1.

Diagnosis Codes

Add one or more diagnosis codes for the claim. The number of diagnosis codes allowed varies by claim type. Note that the first diagnosis code entered is considered the principal (primary) diagnosis code. For each diagnosis code, follow these steps:

1. Select the diagnosis type. (The default is ICD-CM-10.)
2. Enter the appropriate diagnosis code. As you type, diagnosis codes and descriptions will appear in a pop-up window. Select the appropriate code from the pop-up window to add it to the Diagnosis Code field.
3. Select the appropriate present-on-admission (POA) indicator, if applicable. For inpatient claims, this field is required for all diagnosis codes except those explicitly exempt from POA reporting. See the Inpatient Hospital Services module for details.
4. Click Add.

Figure 87 – Diagnosis Codes Panel
To edit a diagnosis code from the list, select the number in the # column. To remove a code from the list, select **Remove** from the Action column.

**Other Insurance Details**

If the IHCP has information about commercial insurance coverage for the member, carrier information will automatically be displayed in the Other Insurance Details panel. Medicare carrier information must be added here, if applicable.

![Figure 88 – Other Insurance Details](image)

You can add, remove, or edit information in the Other Insurance Details panel:

- Click **Remove** to delete any nonapplicable carriers from the claim.
- Click the *hyperlinked number* in the # column to update a carrier’s information.
- Click **[+] Click to add a new other insurance** to access the section where you can add new insurance information.

To add a new carrier, follow these steps:

1. Complete all required fields.
   - The carrier ID is the identification number the insurance company uses in electronic claim submission.
   - When submitting Medicare or Medicare Replacement Plan crossover claims, you must always select one of the following options from the **Claim Filing Code** drop-down menu, depending on the type of claim:
     - 16-Health Maintenance Organization (HMO) Medicare Risk [for Medicare Replacement Plans]
     - MA-Medicare Part A
     - MB-Medicare Part B
   - For commercial insurance claims, select the claim filing code CI-Commercial Insurance Co.
2. After entering all the required information, click Add to append this carrier to the Other Insurance Details table.

Figure 89 – Adding Other Insurance

3. After you have added other insurance, click on the new carrier’s number in the # column to add claim adjustment details. Note: This step is for Medicare and Medicare Replacement Plan claims only; it is not applicable for commercial insurance claims.

4. Enter the required information in the Claim Adjustment Details panel and click Add. Then click Save. Header adjustment information is required for header-processed crossover claims.

Figure 90 – Adding Carriers to Other Insurance Details Panel
Figure 91 – Claim Adjustment Details Panel

Condition Codes

If required for the claim, enter condition codes.

1. When you type the first few characters into the Condition Code field, a list populates with several options based on your entry.

2. Choose the code from the options and then click Add.

3. Repeat these steps to add any additional condition codes.

Figure 92 – Condition Codes

Occurrence Codes

If required for the claim, enter occurrence codes.

1. When you type the first few characters into the Occurrence Code field, a list populates with several options based on your entry.

2. Choose the code from the options.

3. Enter the required from and to dates for the occurrence code.

4. Click Add.

5. Repeat these steps to add any additional occurrence codes.
Value Codes

Value codes identify special circumstances that may affect the processing of a claim.

1. Similar to condition and occurrence codes, when you add value codes, a list populates with several options based on the first few characters you enter into the Value Code field.

2. Choose a value code from the list, enter an amount in the Amount field, and click Add.

3. After you enter all information for Step 2 and are ready to continue to Step 3 of the claim, click Continue.

Step 3: Service Details, Attachments, and Claim Notes

Before entering information for Step 3, review a summary of the information entered during Step 1 and Step 2. This summary is located at the top of the Submit Institutional Claim: Step 3 page.

Service Details

The Service Details panel is used to enter detail-level information such as service date, revenue code, and number and type of units. When certain procedure codes are billed on the outpatient claim, National Drug Code (NDC) information is also required, including NDC number, quantity, and unit of measure. See Procedure Codes That Require NDCs on the Code Sets page at indianamedicaid.com for a table of applicable codes.
Up to 450 service lines are allowed for institutional claims. After you have entered all the detail information for a service, click Add.

Figure 96 – Adding a Service Detail

![Figure 96 – Adding a Service Detail](image1)

Figure 97 – NDC for Service Detail

![Figure 97 – NDC for Service Detail](image2)

Figure 98 – Service Details Added

![Figure 98 – Service Details Added](image3)

**Other Insurance for Service Details**

When submitting outpatient claims, be sure to complete the other insurance information for each of the service lines. The primary carrier information should have already been entered for the claim (header level) in Step 2.

To add other insurance information to each service line, follow these steps:

1. Click the hyperlinked number for each service line in the Service Details panel, and you will be prompted to provide the Other Insurance for Service Detail information.
2. Select the carrier name from the Other Carrier drop-down menu and enter information in the TPL/Medicare Paid Amount and the Paid Date fields.

Figure 100 – Adding Other Carrier Information for a Service Detail

3. Click Add.

4. After saving the other insurance detail information for the service line, add the adjustment. This adjustment is where amounts such as coinsurance and deductible are entered. Click the hyperlinked number for the service detail for which you want to add the adjustment. Note: This step is for Medicare and Medicare Replacement Plan claims only; it is not applicable for commercial insurance claims.

5. In the Other Insurance for Service Detail panel, click the hyperlinked number in the # column to access the Claim Adjustment Details panel for that carrier.

6. Enter the adjustment information.
7. Click Add and then click Save.

**Attachments**

The Attachments panel is used to upload supporting documents electronically or to indicate that you intend to mail the appropriate documentation to the IHCP.

1. In the Transmission Method drop-down menu, select **FT–File Transfer** to upload a file or **BM–By Mail** to send documents to the IHCP by mail.

![Figure 102 – Attachment Transmission Methods](image)

**Note:** If you plan to upload an attachment, be aware that the attachment file size limit is 5 MB and valid file types for upload include: .bmp, .gif, .jpg, .jpeg, .pdf, .png, .tif, and .tiff.

2. Identify the attachment being mailed uploaded:
   - If sending attachment by mail, create a unique attachment control number (ACN) and enter that number in the Control # field. This number must match the number submitted on the IHCP Claims Attachment Cover Sheet (available on the Forms page at indianamedicaid.com) that is mailed with the documentation.
Figure 103 – Attachments Panel Using By Mail Transmission Method

If sending the attachment using the file transfer method, click **Browse** in the Upload File field to locate the file you wish to upload.

Figure 104 – Attachments Panel Using File Transfer Method

3. Select the appropriate option from the Attachment Type drop-down menu.
4. Click **Add** after selecting each individual document to attach.

**Claim Note Information**

Although the fields in the Claim Note Information panel are not required, they can be used if needed to provide clarifying information about the claim, as follows:

1. Select an option from the Note Reference Code drop-down menu:
   – Allergies
   – Goals, rehabilitation potential, or discharge plans
   – Diagnosis description
   – Durable medical equipment (DME) and supplies
   – Medications
   – Nutritional requirements
   – Orders for disciplines and treatments
   – Functional limitations, reason homebound, or both
   – Reasons patient leaves home
   – Times and reasons patient not at home
   – Unusual home, social environment, or both
   – Safety measures
   – Supplementary plan of treatment
   – Updated information

**Note:** The Note Reference Code field provides a list of options to identify the functional area or purpose to which the note applies. The note reference code will not impact processing.
2. Enter any necessary information in the Note Text field.
3. Click Add to add the claim note.

**Figure 105 – Claim Note Information Panel**

<table>
<thead>
<tr>
<th>#</th>
<th>Note Reference Code</th>
<th>Note Text</th>
</tr>
</thead>
</table>

4. After you have provided all the information for the claim, click Submit to proceed to the final preview, from which you can modify or submit the claim.

**Final Preview**

The Portal displays the claim information for review before you confirm your submission.

**Figure 106 – Confirm Institutional Claim**

1. Review the information and then select the appropriate option from the bottom of the page:
   - If you discover that you need to edit the claim information, use the Back to Step buttons to navigate to the appropriate step and edit the desired information.
   - Click Print Preview to print a copy of the claim information being submitted.
Click **Cancel** if you decide not to submit the claim. When you choose to cancel the claim submission, data entered during the process will be lost and the claim data will not be submitted.

If, after reviewing the information, you are ready to submit the claim, click **Confirm**.

**Figure 107 – Submitting the Institutional Claim**

2. After you click **Confirm** to submit the claim for processing, the Portal displays the Claim ID and current claim status.

   **Note:** Use the Claim ID as the reference to check the status of your claim or any time you reference this claim in an inquiry.

**Figure 108 – Institutional Claim Submission Confirmation**

3. You will also see a few options at the bottom of page:
   - The **Print Preview** button allows you to view and print a copy of your claim receipt.
   - The **Copy** button allows you to select member or claim data to paste into a new claim submission.
   - The **New** button allows you to start a new institutional claim.

**Submission Process Example: Professional Claim**

From the Portal menu bar, select **Claims > Submit Claim Professional**.
Step 1: Provider, Patient, and Claim Information

Figure 109 – Submit Professional Claim: Step 1

Provider Information Section

The Provider Information section displays the billing provider’s NPI or Provider ID and name, and allows users to identify the rendering provider, referring provider, and service facility location.

Figure 110 – Provider Information Section (Professional Claim)
1. When you click a magnifying glass icon, you can search for a rendering or referring provider or service facility location in one of three ways:
   - Search by ID
   - Search by name
   - Search by organization

2. Enter the required information and click **Search**.

3. From the results, click the Provider ID or NPI of the provider you would like to add to the claim submission. The chosen provider’s information will automatically populate the Provider Information section.

**Patient Information Section**

The Patient Information section is intended to collect information about the member for whom the claim is being submitted, and associates all the plan and benefit information to that particular member.

**Figure 111 – Patient Information Section (Professional Claim)**

![Patient Information Section](image)

**Note:** If the system does not find a match based on Member ID, first name, and last name, it displays the error message, “Member not found,” and the claim submission process will not be able to continue until valid information is entered.

**Claim Information Section**

The Claim Information section is intended to collect information about the claim (header instructions).

**Figure 112 – Claim Information Section (Professional Claim)**

![Claim Information Section](image)
The **Hospital From Date** and **Hospital To Date** fields are the dates of service for the claim. The system will automatically enter a date range in these two fields that encompasses every date entered in the service detail lines of the claim.

To indicate pregnancy on the claim, select *Pregnancy* as the **Date Type** and enter the date of the last menstrual period (LMP) in the **Date of Current** field.

If you have other insurance information to enter, check the **Include Other Insurance** box located at the bottom of the page before clicking Continue. Use this option to create Medicare crossover claims as well as to enter TPL information on a claim.

After entering all the required information for Step 1, click **Continue** to proceed to Step 2.

**Step 2: Diagnosis Codes and Other Insurance (TPL)**

Before entering information for Step 2, review a summary of the provider, patient, and claim information you entered in Step 1. This summary is located at the top of the *Submit Professional Claim: Step 2* page.

![Figure 113 – Submit Professional Claim: Step 2 – Provider, Patient, and Claim Summary Information](image)

**Note:** The sections and fields that are visible within Step 2 depend on the information entered in Step 1.

**Diagnosis Codes**

Add one or more diagnosis codes for the claim. Up to 12 diagnosis codes lines are allowed for professional claims. Note that the first diagnosis code entered is considered the primary diagnosis code. For each diagnosis code, follow these steps:

1. Select the diagnosis type. (The default is ICD-10-CM.)
2. Enter the appropriate diagnosis code. As you type, diagnosis codes and descriptions will appear in a pop-up window. Select the appropriate code from the pop-up window to add it to the Diagnosis Code field.
3. Click **Add** to add the diagnosis code to the claim detail.
Figure 114 – Diagnosis Codes Panel

To edit a diagnosis code from the list, select the number in the # column. To remove a code from the list, select Remove from the Action column.

Other Insurance Details

If the IHCP has information about commercial insurance coverage for the member, carrier information will automatically be displayed in the Other Insurance Details panel. Medicare carrier information must be added here, if applicable.

Figure 115 – Other Insurance Details

You can add, remove, or edit information in the Other Insurance Details panel:

- Click Remove to delete any nonapplicable carriers from the claim.
- Click the number in the # column to update a carrier’s information.
- Click [+ Click to add a new other insurance to access the section where you can add new insurance information.

See the Other Insurance Details section of the institutional claim example for details about entering TPL or Medicare information. The process for professional claims is similar to the process for institutional claims.

Step 3: Service Details and Attachments

Before entering information for Step 3, review a summary of the information entered during Step 1 and Step 2. This summary is located at the top of the Submit Professional Claim: Step 3 page.
Figure 116 – Submit Professional Claim: Step 3 – Review Summary Information

Service Details

The Service Details panel is used to enter detail-level information such as service date, place of service code, procedure code, modifiers, diagnosis pointer, number of units, and unit type. If the claim is for an emergency service, the EMG checkbox must be selected.

When certain procedure codes are billed, National Drug Code (NDC) information is also required, including NDC number, quantity, and unit of measure. See Procedure Codes That Require NDCs on the Code Sets page at indianamedicaid.com for a table of applicable codes. To add NDC information for a service detail, click [+] to expand the NDC for Service Detail panel, and enter the NDC information for the drug administered.

Up to 50 service lines are allowed for professional claims. After you have entered all the detail information for a service, click **Add**.
Other Insurance for Service Details

When a professional claim has been submitted and processed by Medicare or another third-party payer, the Other Insurance for Service Details section is required. TPL information, including the amount paid by the other carrier, must be entered for every procedure code. For Medicare and Medicare Replacement Plan crossover claims, the Claim Adjustment Details section must also be completed, including the applicable reason code (see Figure 119).
To add other insurance information to each service line, follow these steps:

1. Click the hyperlinked number for each service line in the Service Details panel, and you will be prompted to provide the Other Insurance for Service Detail information.

   **Figure 118 – Other Insurance for Service Detail**

   2. Select the carrier name from the Other Carrier drop-down menu and enter information in the TPL/Medicare Paid Amount and the Paid Date fields.

   3. Click **Add**.

   4. After you have saved the other insurance detail information for the service line, you can add the adjustment. This adjustment is where amounts such as coinsurance and deductible are entered. Click the hyperlinked number of the service detail for which you want to add the adjustment.

   5. In the Other Insurance for Service Detail panel, click the hyperlinked number in the # column to access the Claim Adjustment Details panel for that carrier. **Note: This step is for Medicare and Medicare Replacement Plan claims only; it is not needed for commercial insurance claims.**

   6. Enter the adjustment information.
7. Click Add, then click Save.

**Attachments**

The Attachments panel is used to upload supporting documents electronically or to indicate that you intend to mail the appropriate documentation to the IHCP.

1. In the Transmission Method drop-down menu, select **FT–File Transfer** to upload a file or **BM–By Mail** to indicate that documents will be sent to the IHCP by mail.

**Figure 120 – Attachment Transmission Methods**

![Attachment Transmission Methods](image)

- **Note:** If you plan to upload an attachment, be aware that the attachment file size limit is 5 MB and valid file types for upload include: .bmp, .gif, .jpg, .jpeg, .pdf, .png, .tif, and .tiff.

2. Identify the attachment being mailed uploaded:

   - If sending attachment by mail, create a unique attachment control number (ACN) and enter that number in the Control # field. This number must match the number submitted on the **IHCP Claims Attachment Cover Sheet** (available on the **Forms** page at indianamedicaid.com) that is mailed with the documentation.
– If sending the attachment using the file transfer method, click Browse in the Upload File field to locate the file you wish to upload.

3. Select the appropriate option from the Attachment Type drop-down menu.
4. Click Add after selecting each individual document to attach.

**Claim Note Information**

Although the fields in the Claim Note Information panel are not required, they can be used if needed to provide clarifying information about the claim, as follows:

1. Select an option from the Note Reference Code drop-down menu:
   – Additional Information
   – Certification Narrative
   – Goals, Rehabilitation Potential, or Discharge Plans
   – Diagnosis Description
   – Third Party Organization Notes

   **Note:** The Note Reference Code field provides a list of options to identify the functional area or purpose to which the note applies. The note reference code will not impact processing.

2. Enter any necessary information in the Note Text field.
3. Click Add to add the claim note.
4. After you have provided all the information for the claim, click **Submit** to proceed to the final preview, from which you can modify or submit the claim.

**Final Preview**

The Portal displays the claim information for review before you confirm your submission.
1. Review the information and then select the appropriate option from the bottom of the page:
   - If you discover that you need to edit the claim information, use the Back to Step buttons to navigate to the appropriate step and edit the desired information.
   - Click Print Preview to print a copy of the claim information being submitted.
   - Click Cancel if you decide not to submit the claim. When you choose to cancel the claim submission, data entered during the process will be lost and the claim data will not be submitted.
   - If, after reviewing the information, you are ready to submit the claim, click Confirm.

   Figure 125 – Submitting the Professional Claim

2. After you click Confirm to submit the claim for processing, the Portal displays the Claim ID and current claim status.

   Note: Use the Claim ID as the reference to check the status of your claim or any time you reference this claim in an inquiry.

   Figure 126 – Professional Claim Submission Confirmation

3. You will also see a few options at the bottom of page:
   - The Print Preview button allows you to view and print a copy of your claim receipt.
   - The Copy button allows you to select member or claim data to paste into a new claim submission.
   - The New button allows you to start a new institutional claim.

What Happens After a Claim Is Submitted?

The following steps occur after you submit a claim through the Portal:

1. The Portal displays the Claim ID and current claim status. Use the Claim ID to look up the status of the claim or to reference the claim any time during an inquiry.
2. The data from the claim entered in the Portal is transferred to CoreMMIS, the IHCP claim-processing system.

3. The claim is reviewed for accuracy, completeness, and validity before it is approved, denied, or suspended/pended for additional review.

4. The status of the claim is updated in the Portal. The status will show as “Finalized Denied,” “Finalized Payment,” or “Pending in Process.”

5. Additional claim information, such as Remittance Advice, is updated in the Portal as it becomes available.

**Search Payment History**

The Search Payment History page is used to view electronic funds transfer (EFT) and to check payment records for claims and zero-pay payments. This page is also where you can view Remittance Advices (RAs) for claims.

1. From the Portal menu bar, select **Claims > Search Payment History**.

2. In the Search Payment History panel, the Issue Date fields automatically populate with the date of the search (today) in the To field and 90 days prior to today’s date in the From field. You can narrow the date range to show fewer search results.

3. You can also narrow search results by payment method and/or payment ID.

4. After you have entered all the desired search parameters, click **Search**.
5. Any claims that fall within the desired search parameters will be displayed in the Search Results section.

Figure 129 – Payment History Search Results

6. You can sort search results by clicking any of the underlined column names. The arrow next to the column name indicates whether the results are displayed in ascending or descending order. The following example shows the search results are sorted in descending order by issue date.

Figure 130 – Search Results Sorted, in Descending Order, by Issue Date

7. To view details about a specific payment, click the corresponding payment ID hyperlink to open the View Payment Details page.
8. The Payment Summary section provides filter options so that you can narrow the Claim Payment Details list to a specific claim, patient, rendering provider, or service date range.

Viewing Remittance Advice

An RA shows all FFS, nonpharmacy activity involved with a given week’s payment. You can search through an RA to see if a specific claim has been paid, suspended, or denied. All RAs from February 21, 2017, onward will be available for viewing on the Portal. To request a copy of an RA for dates on or before February 14, 2017, submit a request using secure correspondence.
PDF copies of an RA can be accessed and viewed in the Portal in the following two ways:

- From the View Payment Details page, click the RA Copy (PDF) button (Figure 133).
- From the Search Payment History page, click the RA icon in the RA Copy (PDF) column of the Search Results section (Figure 134).

**Figure 133 – Accessing the RA PDF from View Payment Details**

**Figure 134 – Accessing the RA PDF from Search Results**

![Figure 133](image1.png)

![Figure 134](image2.png)

**Note:** Adobe Acrobat Reader is required to open and view RA documents in the Portal.

The following figure is an example of an RA report for Long Term Care paid claims.

**Figure 135 – RA LTC Paid Claims Example**

![Figure 135](image3.png)
Note: The RA uses the abbreviation ICN (internal control number) instead of the term Claim ID. The ICN field on the RA corresponds to the Claim ID in the Portal.

For more information about RAs, see the Financial Transactions and Remittance Advice module.

Claim Adjustments: Voids and Edits (Replacements)

Note: Only PAID claims are eligible for adjustments. Claims paid at zero dollars are considered paid claims.

1. To perform a void or edit (replacement) on a paid claim, you need first to search for the claim (see the Search Claims section of this module).
2. Open the claim and click Edit to perform a replacement or Void to void the claim.

Figure 136 – Options for Void and Replacement

Edits (Replacements)

1. When you click Edit for the selected claim, the Portal allows you to navigate through the claim:
   – Click Continue to move to the next section of the claim.
   – Click the appropriate Back to Step button to return to a previous section of the claim.
2. Modify any field needed. For example, to add a service line to the claim:
   – Locate the Service Details panel of the claim and click the [+] Click to add service detail link.
Figure 137 – Adding a Service Detail to a Submitted Claim

Add the information for the new service detail and then click **Add** to add the new service detail to the Service Details panel of the claim.

Figure 138 – Service Detail Information Fields
3. After all fields are modified as needed, click **Resubmit** to initiate the submission process.

![Figure 139 – Claim Replacement Ready to Resubmit](image)

4. Verify the data is correct and then click **Confirm** to submit your claim adjustment.
5. A confirmation message appears, showing the Claim ID for the replacement. Keep this number in your reference records.
Voids

1. When you click **Void** for the selected claim, the Portal will ask you confirm. Click **OK** to confirm and a final message will confirm your request has been processed.

   **Figure 142 – Void Confirmation Question**

   ![Void Confirmation Question]

2. When the final confirmation message appears, click **OK** again.

   **Figure 143 – Void Confirmation Notice**

   ![Void Confirmation Notice]

3. The Portal lists the voided claim in the Search Results panel as a new record with **Finalized Denied** as the claim status.

   **Figure 144 – Voided Claim in Search Results**

   ![Voided Claim in Search Results]

Care Management

The *Care Management* page can be accessed by clicking the Care Management tab on the Portal menu bar. The *Care Management* page displays links to the Care Management options. These options can also be accessed by placing your cursor over the Care Management tab to display a drop-down menu.
Table 5 – Care Management Options

<table>
<thead>
<tr>
<th>Link</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Create Authorization</td>
<td>Allows providers to submit FFS, nonpharmacy PA requests electronically through the Portal. This tool is designed to help IHCP providers file PAs faster and more easily. Providers should be specific, clear, and concise on all PA requests to avoid PA suspensions. All information required for paper PA submissions is also required for Portal submissions.</td>
</tr>
<tr>
<td><strong>Note:</strong> Requests for drugs such as nonpreferred medications and the Medical Necessity Review Form for mental health medications cannot be submitted via the Portal.</td>
<td></td>
</tr>
<tr>
<td>View Authorization Status</td>
<td>Existing FFS, nonpharmacy PAs can be viewed by entering criteria in the search fields: Authorization Number, Service Type, Service Date, Member ID, Birth Date, First/Last Name, Provider ID, or Type. PAs submitted electronically during business hours are viewable within two hours of submission.</td>
</tr>
<tr>
<td>Maintain Favorite Providers</td>
<td>Up to 20 servicing providers may be added to your favorites list from this link. The favorites list is designed to help a user store and retrieve frequently selected providers when creating PA requests.</td>
</tr>
<tr>
<td>Notification of Pregnancy Inquiry</td>
<td>Allows the user to search for Notifications of Pregnancy (NOPs) that were submitted on a member’s behalf. (Applicable to managed care members only.)</td>
</tr>
<tr>
<td>Submit RCP Referral to Lock-In List</td>
<td>Allows an RCP member’s PMP to manage the referred providers on the member’s lock-in list. Only the member’s PMP can submit an RCP referral for a member via the Portal. (This feature is applicable to both FFS and managed care RCP members.)</td>
</tr>
</tbody>
</table>
Create Authorization (Requesting PA)

Some patient healthcare services require prior authorization for claims to be approved and paid. See the Prior Authorization module for details. These prior authorization requests can be submitted electronically via the Portal.

Note: Pharmacy prior authorizations are handled by the vendor OptumRx. MCEs handle PA for the members of their plan. PA requests for these services cannot be submitted through the Portal.

Prior authorization requests can be ordered directly by the following providers; all other providers must include an attachment documenting that the service or supply is physician-ordered:

- Doctor of medicine (MD)
- Doctor of osteopathy (DO)
- Dentist
- Optometrist
- Podiatrist
- Chiropractor
- Home health agency (authorized agent)
- Hospital (authorized agent)
- Psychologist endorsed as a health service provider in psychology (HSPP)
- Transportation provider (authorized agent)

For convenience, multiple services can be added in one authorization request, and different rendering providers can be specified for each service.

Every authorization request has four panels to complete:

- Create Authorization
- Diagnosis Information
- Service Details
- Attachments

Note: Each authorization request will ask for similar information. Dental authorizations will have additional fields available based on the information identified throughout the prior authorization request creation process.

Create Authorization

The Create Authorization panel includes four sections:

- Requesting Provider Information: This section displays information to identify the Portal user making the request.
• Member Information: This section requires you to enter the member’s Member ID and date of birth, and at least one character of the member’s first name and last name. This information helps verify that the request is being made for the correct member.

• Rendering Provider Information: This section asks for rendering provider information, which is optional, and the service type, which is required. If you wish to enter a rendering provider for the authorization, choose one of the following methods to enter the information:
  – Click the Rendering Provider same as Requesting Provider checkbox.
  – Select the provider from the list of favorites.
  – Click the magnifying glass icon to search for the desired provider.
  – Enter the Provider ID or NPI, ID type, and taxonomy (if needed) for the rendering provider.

• Message Information: Although this section does not have any required fields, you can add details pertaining to this authorization request in the Message field. The message you enter should help clarify the reason for the request.

Figure 146 – Create Authorization Panel
Diagnosis Information

In the Diagnosis Information panel, you will add a diagnosis type and code for the PA request, and then click Add. Multiple diagnosis codes can be entered by repeating the diagnosis entry procedure.

Figure 147 – Adding Diagnosis Information for the PA Request

![Diagram of Diagnosis Information]

Note: Diagnosis codes are not required for submitting a prior authorization request, but may be required for the approval of some PA requests. The default Diagnosis Type is ICD-10-CM.

Service Details

The Service Details panel asks for details about the services to be performed. Each service added requires the dates of service, code, code type, and either units or dollars associated with the code.

If the rendering provider for a service differs from the one used in the Create Authorization panel, use the fields in the Rendering Provider area to identify the provider for this specific service.

Figure 148 – Adding Service Details for the PA Request

![Diagram of Service Details]

Note: The Portal is designed to accept either units or dollar amounts for all prior authorization requests.
Attachments

The Attachments panel allows you to attach documents electronically to the authorization request. To upload an attachment to the Portal, follow these steps:

1. Select **FT-File Transfer** from the Transmission Method drop-down menu.
2. Click **Browse** to search for and select the desired files.
3. Select the type of document from the Attachment Type drop-down menu.
4. Click **Add**.

Figure 149 – Adding Attachments

![Attachments Panel]

Note: If sending attachments to the PA vendor by mail or fax instead of uploading them to the Portal, include a note in the Message field of the Create Authorization panel indicating that supporting documents are on their way. A Prior Authorization System Update Request Form, available from the Forms page at indianamedicaid.com, should be sent as a cover letter.

Completing the PA Request

After you complete the four steps to request PA, click **Submit**. After the request passes the series of checks, the **Confirm Authorization** page displays for you to review the information one last time.

- Click **Confirm** to send the request.
- Click **Back** to return to the previous panels and edit any information.
- Click **Cancel** to cancel the authorization request.
After the PA submission is confirmed, an Authorization Receipt window appears. The authorization request is assigned an authorization tracking number to enable you to track the status of the requested authorization.

View Authorization Status

On the View Authorization Status page, you have two ways to search for prior authorization requests: Prospective Authorizations and Search Options.

Prospective Authorizations

The Prospective Authorizations tab lists up to 20 authorization requests where the user is either the requesting or rendering provider and where the service date is today or a date in the future. The list includes requests that have not yet been approved or denied. The list can be sorted by clicking one of the column headers.

To view authorization information, click a tracking number hyperlink in the Authorization Number column.
Search Options – Review and Update PA Requests

Use the Search Options tab to search for older PA requests or requests not displayed in the Prospective Authorizations list.

1. You can search for authorizations by:
   - Authorization number
   - Service type
   - Day range or service date
   - Member information
   - Provider information

2. Click Search after you enter the desired search information. If information is missing or additional search fields are required, a message displays the error.

3. From the resulting list, locate the desired request and click the appropriate link in the Authorization Number column to access the View Authorization Response page.

Note: The search results may be sorted by clicking one of the column headers.
Figure 153 – Authorization Search Options
4. If you are the requesting provider or the provider’s authorized delegate, you can click **System Update** at the bottom of the associated *View Authorization Response* page to make changes to an authorization request that has not been denied.

5. After **System Update** is clicked, the Portal displays the *Resubmit Authorization* page, including the panels from the authorization and additional sections:

6. In the System Update Information panel, indicate the desired updates as follows:
   - Use the Line Item field to enter the number of the service line to be edited (see the # column of the Service Details Information section). If the update applies to the entire authorization, enter 0 in the Line Item field.
   - Use the Message field to provide an explanation of what needs to be changed.

7. Click **Add**.
8. You can also add additional attachments, if needed, using the Attachments panel. (If submitting attachments separately, by fax or by mail, add a message to the System Update Information panel stating that the attachment is being sent, and type 0 as the line item.)

Figure 155 – System Update – Resubmit Authorization

9. After you click Resubmit, the system displays the PA for your review. If all the information is correct, click Confirm.
**Maintain Favorite Providers**

A favorite providers list is a compilation of frequently used facilities and/or providers that are entered in the Portal for quick assignment in authorization requests. The list appears on the *Favorite Providers for Authorizations* page. It can include up to 20 providers and may be sorted by provider name or ID.

There are two ways to add a favorite provider to the list:

- Enter the favorite provider’s Provider ID or NPI and select ID type (either Provider ID or NPI), in the corresponding fields on the *Favorite Providers for Authorizations* page and then click Add. (If you do not know the Provider ID or NPI, you can use the magnifying glass next to the Provider ID field to search for the provider information.)

  ![Figure 156 – Favorite Providers for Authorizations](image)

- You can also add providers to your favorites list during the PA request process by checking the Add to Favorites checkbox in the Rendering Provider Information section.

  ![Figure 157 – Add to Favorites Checkbox](image)

To remove a provider or facility from the favorite providers list, click Remove in the Action column on the *Favorite Providers for Authorization* page for the provider or facility to be removed.

**How Do I Use the Favorite Providers List?**

When you create an authorization request, the Service Details and Requesting Provider Information sections include a Select from Favorites drop-down list. If the desired provider is from your saved favorites list, use these options to automatically populate provider information.
The Right Choices Program (RCP) is Indiana’s Restricted Card Program. The goal of the RCP is to provide quality care through healthcare management, ensuring that the right service is delivered at the right time and in the right place for each member. All RCP members, providers, RCP Administrators, and the State collaborate to create a care coordination team for RCP members. The RCP encourages participation in all coordination efforts available to ensure that RCP processes and guidelines are carried out appropriately while members receive medically necessary care. See the Right Choices Program module for more information about this program.

Providers are responsible for checking the eligibility status of IHCP members before rendering services. While verifying eligibility, providers can determine the member’s RCP status and view the list of providers to which the RCP member is restricted (known as the member’s lock-in list). The IHCP reimburses only the providers on the member’s lock-in list, unless the service is for an emergency condition or is a designated self-referral service. In all other cases, the IHCP does not reimburse services that the RCP member receives from providers that are not locked in.

When an RCP member requires a service from a provider not on his or her lock-in list, the member’s PMP can submit a referral to temporarily add that provider to the lock-in list. When a PMP submits a referral via the Portal, the referred provider is automatically added to the member’s lock-in list. PMPs can authorize RCP provider referrals for up to one year; however, referrals submitted through the Portal will default to a maximum of seven days until reviewed by the RCP Administrator. While reviewing the referral, the RCP Administrator can update the effective dates to match those submitted by the PMP.

PMPs can follow these steps to submit a referral via the Portal and add a provider to the RCP member’s lock-in list:

1. From the Care Management tab of the Portal menu bar, select Submit RCP Referral to Lock-in List.
2. In the Member Information section, enter the RCP member information and click Continue.
3. The Portal displays the Lock-In Providers list for the RCP member. If you are not the member’s PMP (or a delegated user for that PMP), you will see a message that only the member’s PMP can submit a RCP Referral for the member.

Figure 160 – Lock-In Providers
4. Select the appropriate option in the Referral Request Information section and then click **Search Provider**.

**Figure 161 – Referral Request Information**

5. In the **Right Choices Program Provider Search** panel, enter information for the provider to be added to the lock-in list then click **Search**. Providers that match the criteria will be listed in the Search Results section.

6. Click the **Select Provider** link for the desired provider to add that provider’s information to the Referral Request Information section.

**Figure 162 – Search Results**

7. Enter the effective dates and the claim type for the referral.
8. If appropriate, click the plus sign (+) in the Attachments panel and follow the instructions to add one or more files to support the referral being made. The RCP Administrator uses this information during the referral review process.

9. Click Submit to finalize the submission of the RCP referral.

10. Click OK when the Portal displays a confirmation message for the referral submission.
Resources

You can access other useful information by selecting the Resources tab from the Portal menu bar. The Resources page includes links to pages on the IHCP website where providers can find additional information.

Figure 166 – Resources