Serving Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect

Anthem

End-to-end process for filing a *CMS-1500 Professional Claim*

2022 Indiana Health Coverage Programs (IHCP) works seminar

Agenda

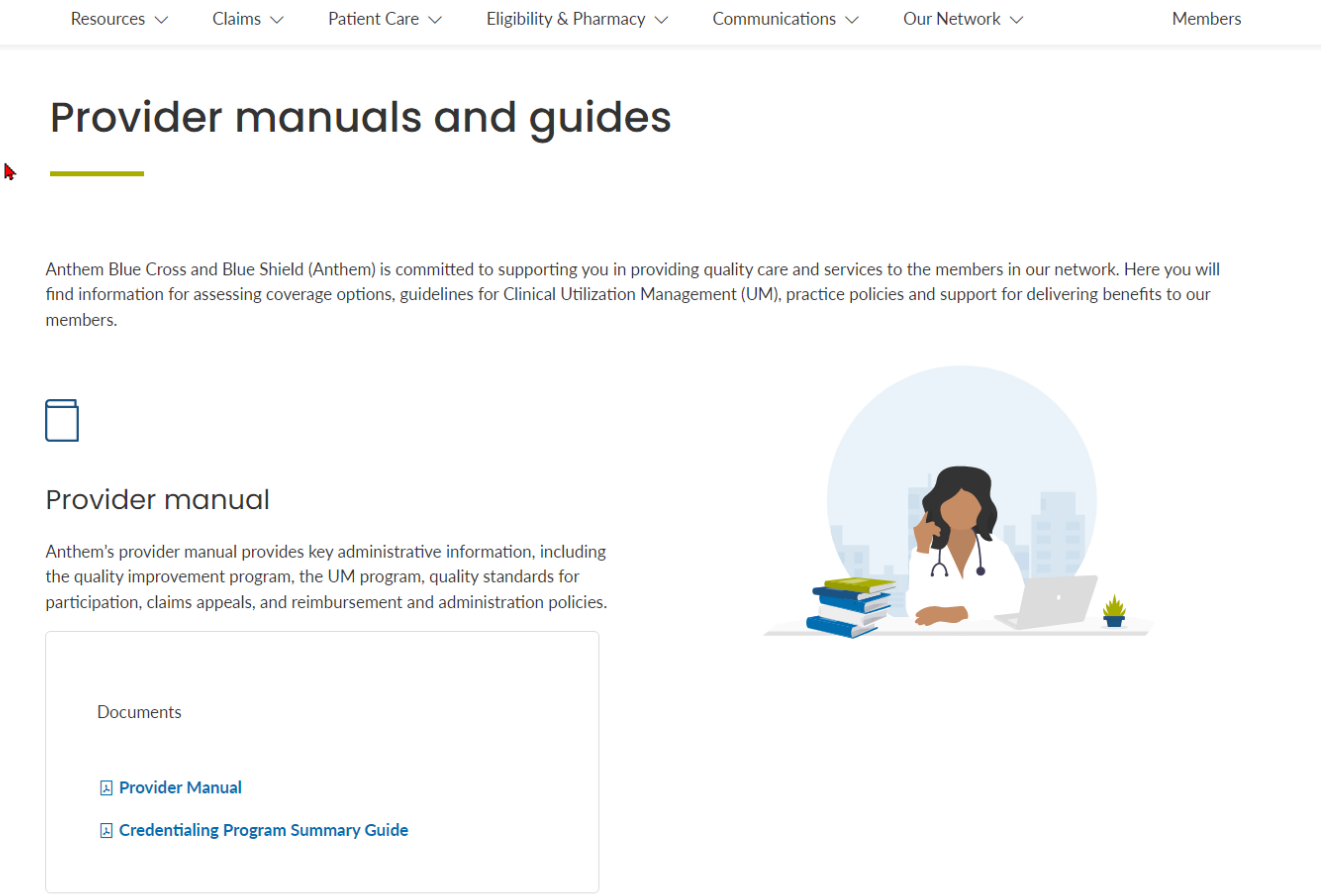
- Acronyms
- Provider manual
- Eligibility
- Managed care model
- Prior authorization (PA)
- Claims
- Contact information

Acronyms

- **PMF** — Provider Maintenance Form
- **IHCP** — Indiana Health Coverage Programs
- **PSO** — Provider Solutions Organization
- **HIP** — Healthy Indiana Plan
- **MCE** — Managed Care Entity
- **PMP** — Primary Medical Provider
- **COB** — Coordination of Benefits
- **RCP** — Right Choices Benefits
- **EDI** — Electronic Data Interchange
- **UM** — Utilization Management
- **ICR** — Interactive Care Reviewer

Provider manual

https://providers.anthem.com/indiana-provider/resources/manuals-and-guides



Provider file updates and changes

Anthem Blue Cross and Blue Shield (Anthem) provider files must match Indiana's provider information. This is a two-step process:

1. Submit all accurate provider updates to Indiana Health Coverage Programs (IHCP) by visiting www.in.gov/medicaid/providers or by calling IHCP Provider Services at **800-457-4584**. For more information, please refer to the IHCP provider reference modules.
2. After IHCP uploads the information, the provider will submit the information to Anthem using the Digital Provider Enrollment (DPE) tool via Availity* to enroll new providers. When Anthem receives the DPE application, we will verify the information submitted on both the application and the provider healthcare website.

Or submit any demographic changes through the *Provider Maintenance Form.*

Provider file updates and changes (cont.)

Our PSO department handles all provider file updates. This includes the following provider networks:

- Medicaid under Anthem:
  - Hoosier Healthwise
  - Healthy Indiana Plan (HIP)
  - Hoosier Care Connect
- Commercial insurance under Anthem

If you have questions about provider network agreements and provider file information, you can contact your assigned Provider Experience (PE) manager and they can get you to your PSO representative.

Eligibility

Eligibility

Always verify a member's eligibility prior to rendering services. Anthem recommends a two-step verification process.

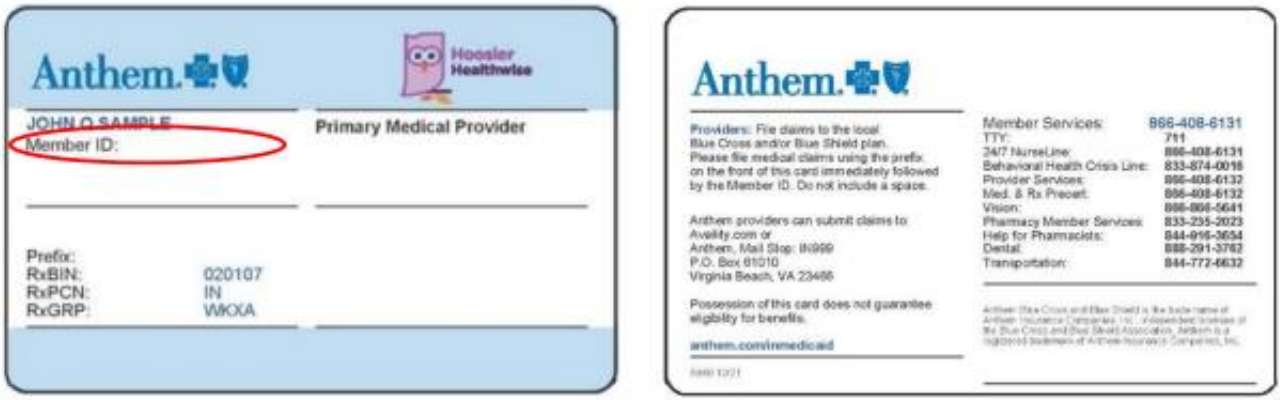
Providers can access this information by visiting:

- IHCP Provider healthcare portal: Use to verify eligibility, assigned Managed Care Entity (MCE), and Medicaid product
- Availity Portal: use for PMP verification, benefit limitations, COB the Anthem member ID (if needed), and much more

Eligibility (cont.)

Hoosier Healthwise:

- Anthem assigns the YRH prefix with the member ID (MID).

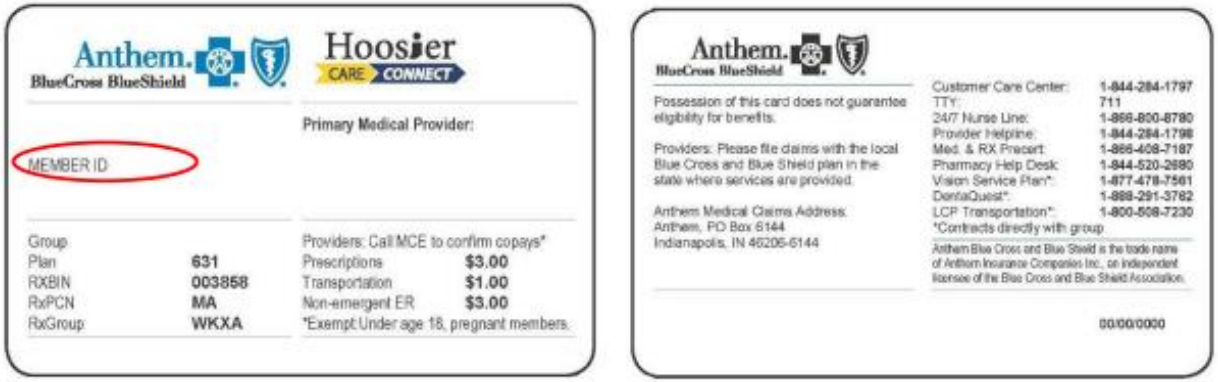


- *Effective January 1, 2023, when filing claims and inquiries, it will no longer be required to include the YRH prefix before the MID.*

Eligibility (cont.)

Hoosier Care Connect:

- Anthem assigns the YRH prefix.

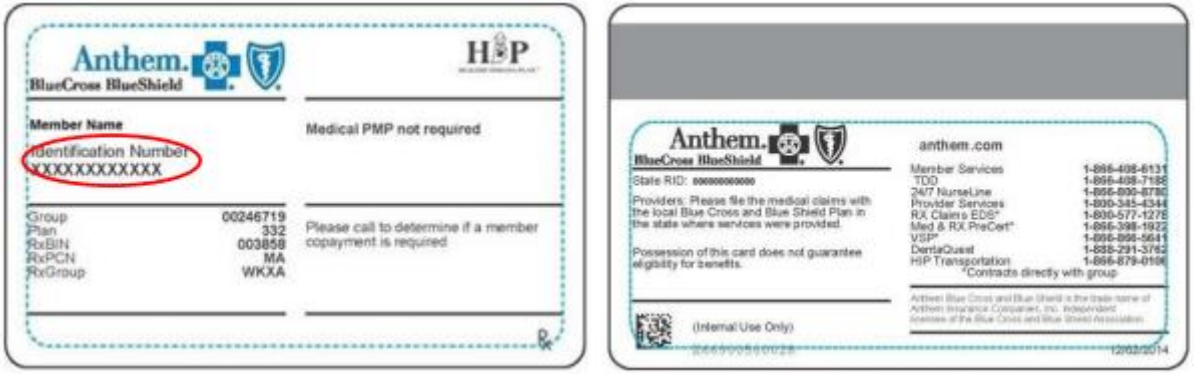


- *Effective January 1, 2023, when filing claims and inquiries, it will no longer be required to include the YRH prefix before the MID.*

Eligibility (cont.)

Healthy Indiana Plan (HIP):

- Anthem assigns the YRK prefix with the member ID.



- *Effective January 1, 2023, when filing claims and inquiries, it will no longer be required to include the YRK prefix before the MID.*

RCP

- RCP is a program for Indiana Medicaid recipients who may need assistance learning how to properly use their health insurance.
- The program provides members with a lock-in provider who acts as a safeguard against the unnecessary or inappropriate use of benefits.

RCP (cont.)

- Members enrolled in RCP must see the providers who are assigned per CoreMMIS.
- The member's PMP may call **866-902-1690 option 1** to add new providers to the member's list of authorized providers.
- Refer to page 54 of the Anthem provider manual for more information.
- RCP members are no longer required to be locked into a single hospital.
  - **Although members are no longer locked into a single hospital, they will still be locked into one primary medical provider to coordinate their care and one pharmacy to fill prescriptions.**

Managed Care Model (Assigned PMP)

Managed care model (assigned PMP)

All members must see their assigned PMP. Please view the Availity PMP assignments.

Specialty providers must have a referral from the PMP:

- Include the individual (type one) national provider identifier (NPI) of the member's assigned referring PMP when you submit the *CMS-1500* claim form or electronic data interchange (EDI) claim.
- If one physician is on call or covering for another, the billing provider must complete Box 17b of the *CMS-1500* claim form to receive reimbursement.

If you are a non-contracted provider, you need to obtain prior authorization (PA) from Anthem before you provide services to our members.

Note: Out-of-network behavioral health and routine dental services do not require PA.

Managed care model (assigned PMP) (cont.)

Exceptions to this policy include:

- Self-referrals. Members may self-refer for certain services provided by an IHCP-enrolled provider:
  - **Note:** Refer to the provider manual for a listing of self-referral services.
- A PMP not yet assigned to the member.
- A provider in the same provider group, with the same tax ID, or group NPI as the referring physician (and is an approved provider type).
- Emergency services (services performed in place of service 23).
- Family planning services.

Managed care model (assigned PMP) (cont.)

Exceptions to this policy include (cont.):

- Services provided after hours (codes 99050 – Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed and 99051 – Service(s) provided in the office during the regularly scheduled evening, weekend, or holiday office hours).
- Diagnostic specialties (such as lab and X-Ray services).
- The billing or referring physician is an Indian health provider or is providing services at a federally qualified health center (FQHC) or urgent care center.

Prior authorization

Precertification lookup tool

Visit the provider website to utilize the precertification lookup tool at https://providers.anthem.com/indana-provider/home > Claims > Precertification Lookup Tool (PLUTO)

Providers can quickly determine PA requirements for outpatient services. If a PA is required, we strongly recommend utilizing our Availity Authorization tool to request PA.

Note: All inpatient services require PA.

How to obtain prior authorization

Providers may call Anthem to request PA for medical and behavioral health (BH) services using the following phone numbers:

Program	Phone number
HIP	**844-533-1995**
Hoosier Care Connect	**844-284-1798**
Hoosier Healthwise	**866-408-6132**

How to obtain prior authorization (cont.)

Fax clinical information for all members to:

	Inpatient	Outpatient
Physical health	**888-209-7838**	**866-406-2803**
Behavioral health	**844-452-8074**	**844-456-2698**

How to obtain prior authorization (cont.)

When calling/faxing our Utilization Management (UM) department, have the following information available:

- Member name and ID
- Prefix — YRK (HIP), YRH (Hoosier Healthwise, Hoosier Care Connect)
- Diagnosis with ICD-10 code
- Procedure with CPT® code
- Date(s) of service
- PMP, specialist, or facility performing services
- Clinical information can be uploaded to the Availity Authorization Tool, ICR, or faxed to support the request
- Treatment and discharge plans (if known)

How to obtain prior authorization (cont.)

Anthem is pleased to offer the Availity Authorization Tool to request PA for Hoosier Healthwise, HIP, and Hoosier Care Connect services at no cost to providers. This tool will accept the following types of requests for our members:

- Inpatient
- Outpatient
- Medical/surgical

If you have any questions about the prior authorization lookup tool or Availity, contact your assigned PE manager.

Timeliness of prior authorization decisions

Request type	Turn around time from request time
Emergency services	Does not require PA
Urgent concurrent requests	1 business day
Urgent pre-service requests	72 hours
Routine non-urgent requests	7 days
Urgent appeals	48 hours
Routine appeals	30 days

Outpatient services

When authorization of outpatient healthcare services is required, providers should utilize the Availity Authorization Tool, or call or fax to request PA.

- Providers should submit all clinical documentation required to determine medical necessity at the time of the request.
- We will make at least one attempt to contact the requesting provider to obtain missing clinical information:
  - If additional clinical information is not received, a decision is made based upon the information available.

Cases are either approved or denied based upon medical necessity and/or benefits. Members and providers will be notified of the determination by letter. Upon adverse determination, providers will also be notified verbally.

Emergency medical services and admission

For emergency medical conditions and services, Anthem does not require PA for treatment. In the event of an emergency, members may access emergency services 24/7. The facility does not have to be in the network.

- If the emergency room visit results in the member's admission to the hospital, hospitals must notify Anthem of the admission within 48 hours (excludes Saturdays, Sundays, and observed holidays).
- This must be followed by a written certification of medical necessity within 14 business days of admission.

Emergency medical services and admission (cont.)

Note: If the provider fails to notify Anthem within the required time frame, the admission will be administratively denied. Providers should submit all clinical documentation required to determine medical necessity at the time of the notification.

Hospital admissions for observations up to 72 hours do not require PA.

Medical necessity denials

When a request is determined to not be medically necessary, the requesting provider, servicing provider, and the member will be notified in writing of:

- The review outcome
- The clinical rationale
- How to request a copy of how the decision was made
- How to reach the reviewing physician for peer-to-peer (P2P) discussion of the case, if desired
- The Member’s rights
  - The process for grievance and appeals
  - State Fair Hearing

Medical necessity denials (cont.)

The provider may request a P2P discussion within seven days of notification of an adverse determination:

- Upon request for P2P discussion beyond seven days, the provider will be directed to the appeal process:
  - Clinical information submitted after a determination has been made, but not in conjunction with a P2P discussion or appeal request, will not be considered.

If a provider disagrees with the denial, an appeal may be requested:

- The appeal request must be submitted within 60 days from the date of the denial.

Late notifications or failure to obtain PA

- Late notifications of admission or failure to obtain PA for services when PA is required will not receive a medical necessity review, and the claim will be administratively denied.
- If you have questions regarding PA requirements, providers may contact Provider Services Monday through Friday, 8 a.m. to 8 p.m. ET at the following numbers:

	HIP	Hoosier Care Connect	Hoosier Healthwise
Phone	**844-533-1995**	**844-284-1798**	**866-408-6132**
Fax	**866-406-2803**	**866-406-2803**	**866-406-2803**

Claims

Initial claim submission

For participating providers, the claim filing limit is 90 calendar days from the date of service.

Submit the initial claim electronically via electronic data interchange (EDI), Availity, or by mail to:

Anthem Blue Cross and Blue Shield
Claims Department
Mail Stop: IN999
P.O. Box 61010
Virginia Beach, VA 23466

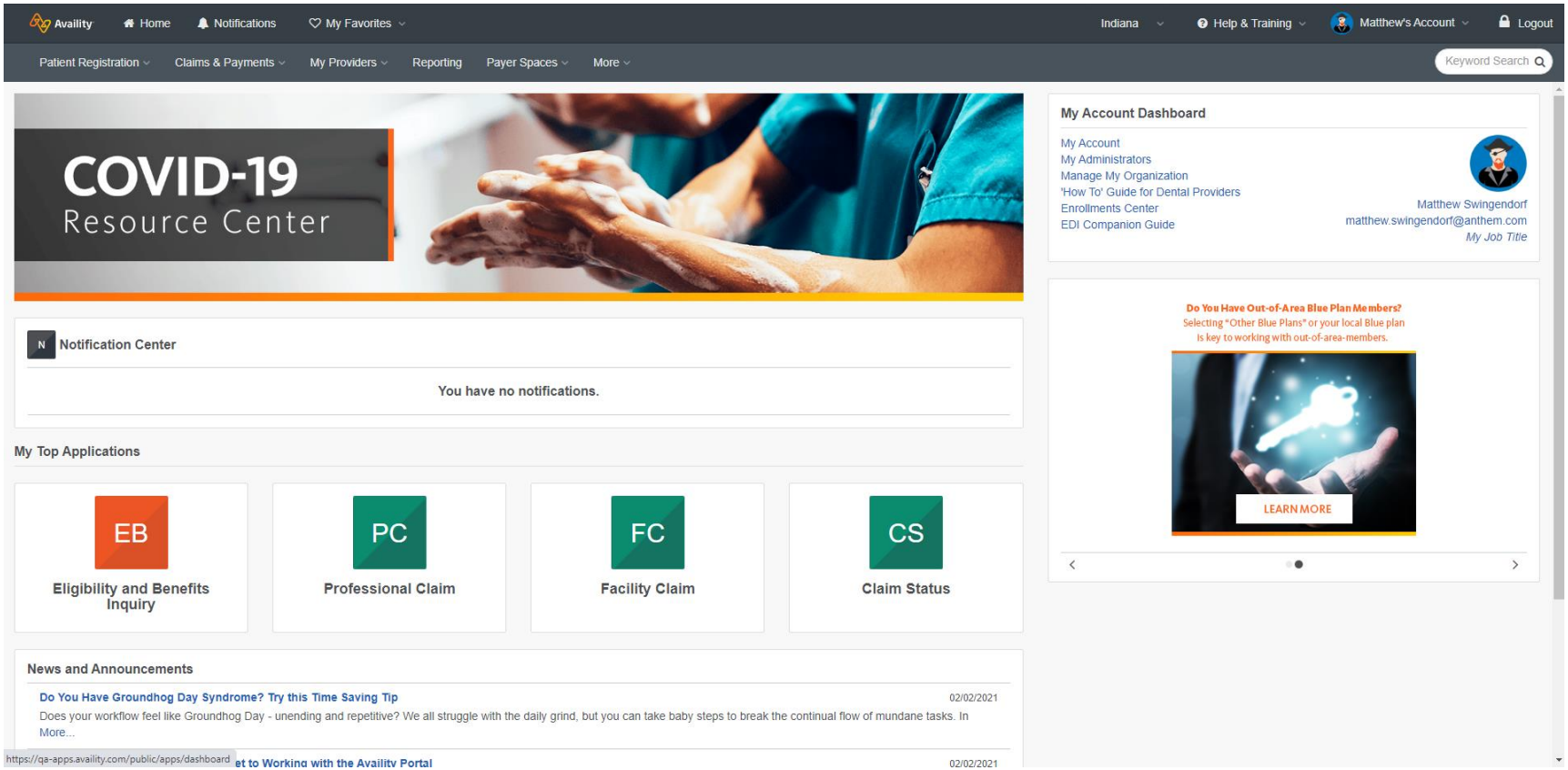
Note: Nonparticipating providers have 180 days from the date of service to submit claims.

Claim Submissions

Using Availity to file a professional claim

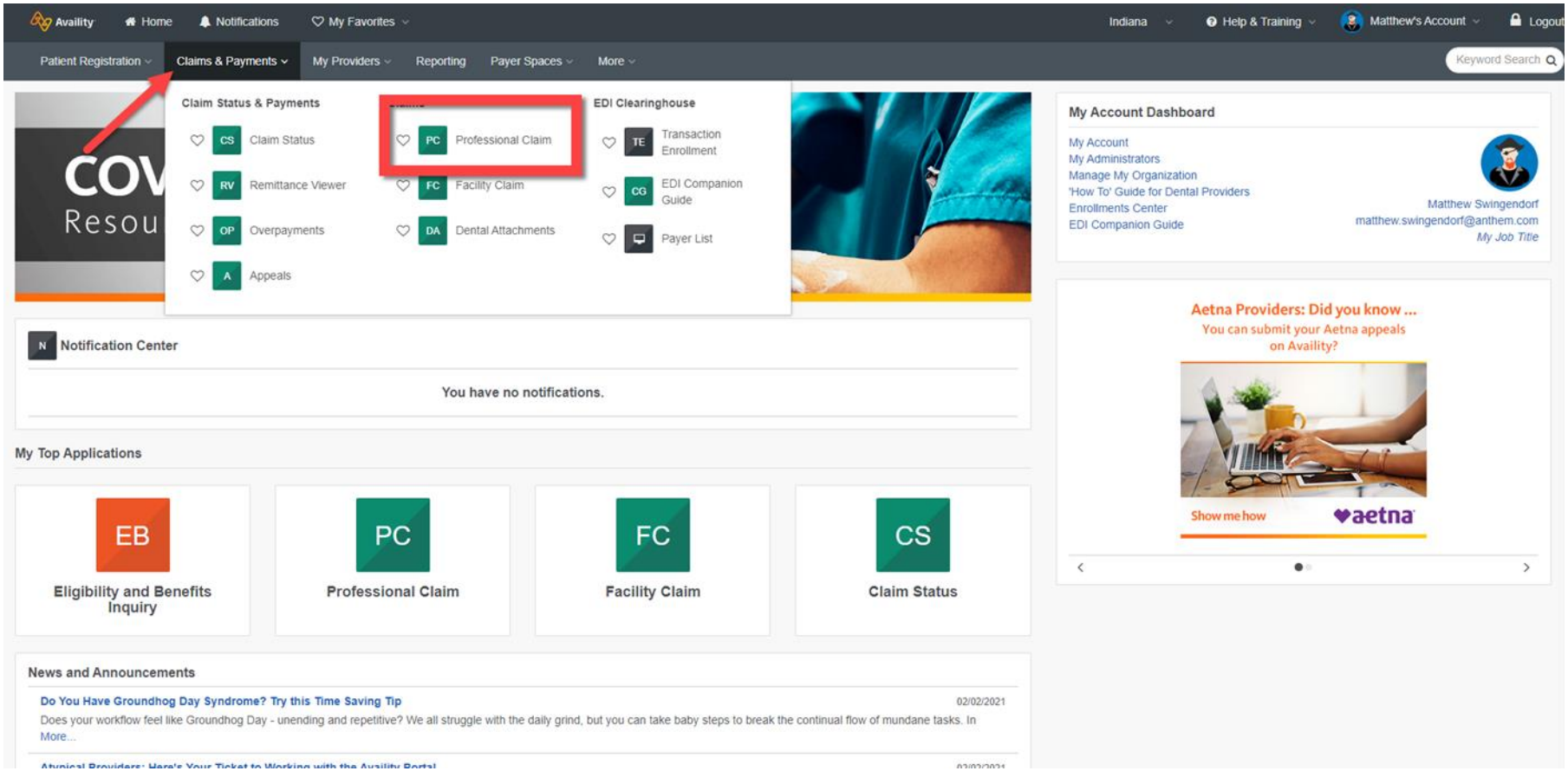
Log on to Availity

Once logged in, this is what the home page will look like:



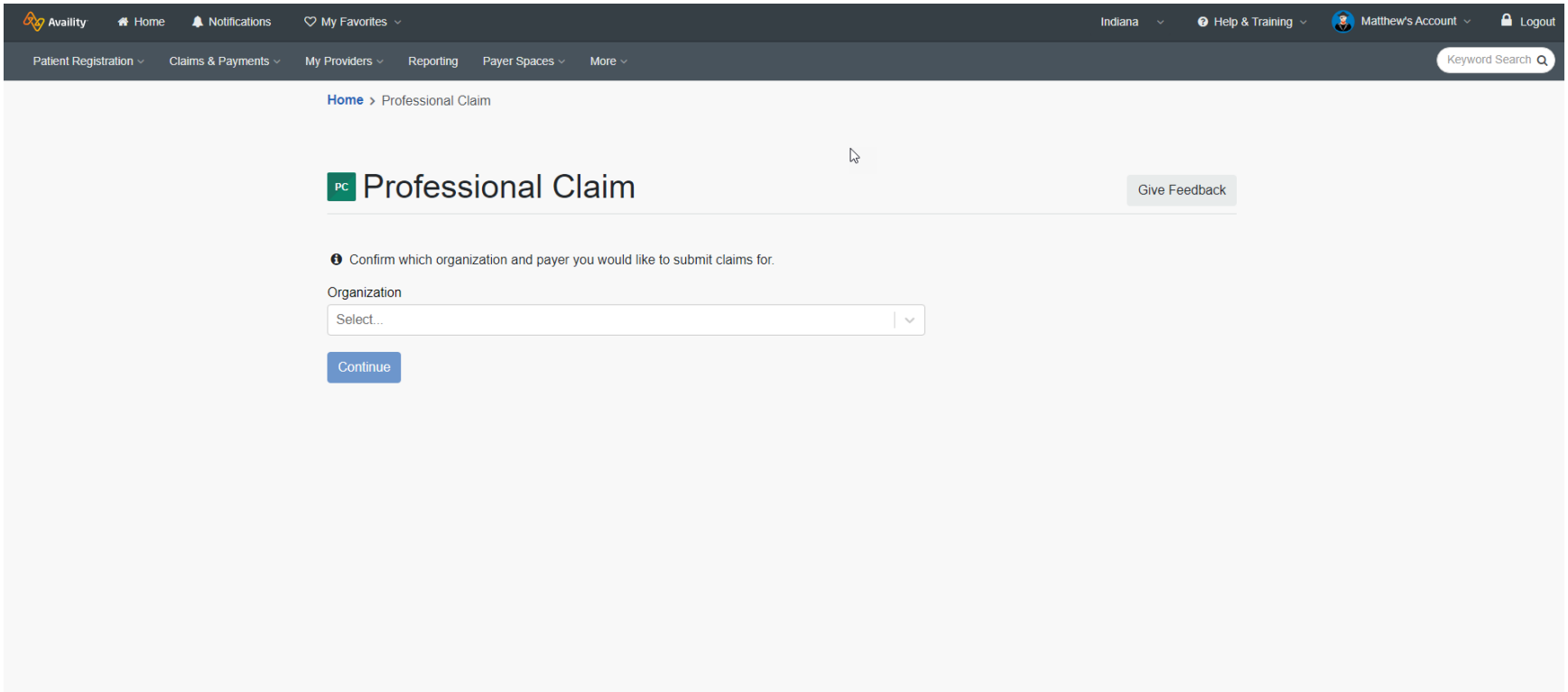
Filing a claim

Select the drop-down **Claims & Payments** and select **Professional Claim**.



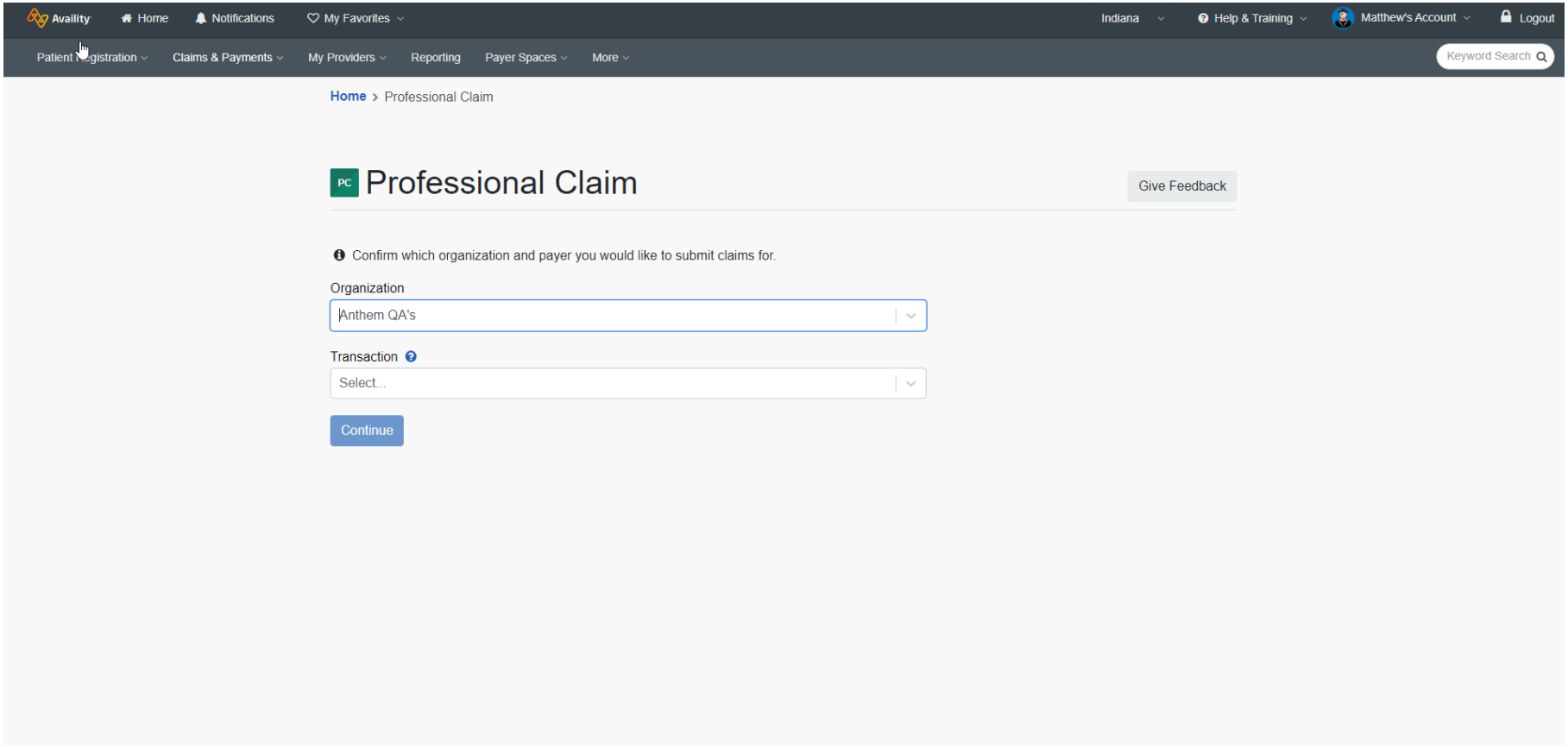
Filing a claim (cont.)

Select your *organization*.



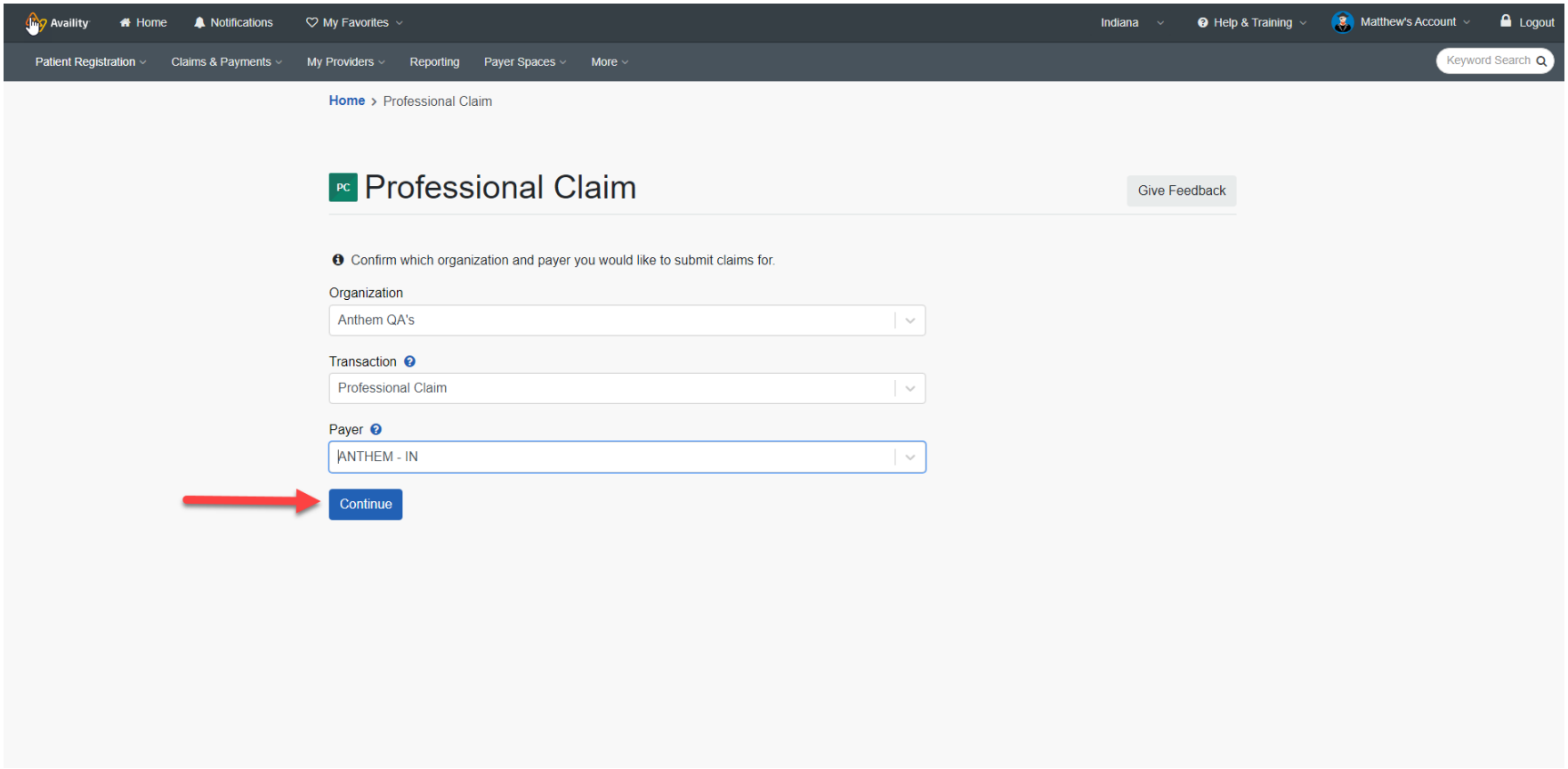
Filing a claim (cont.)

Select your *transaction type* (professional claim).



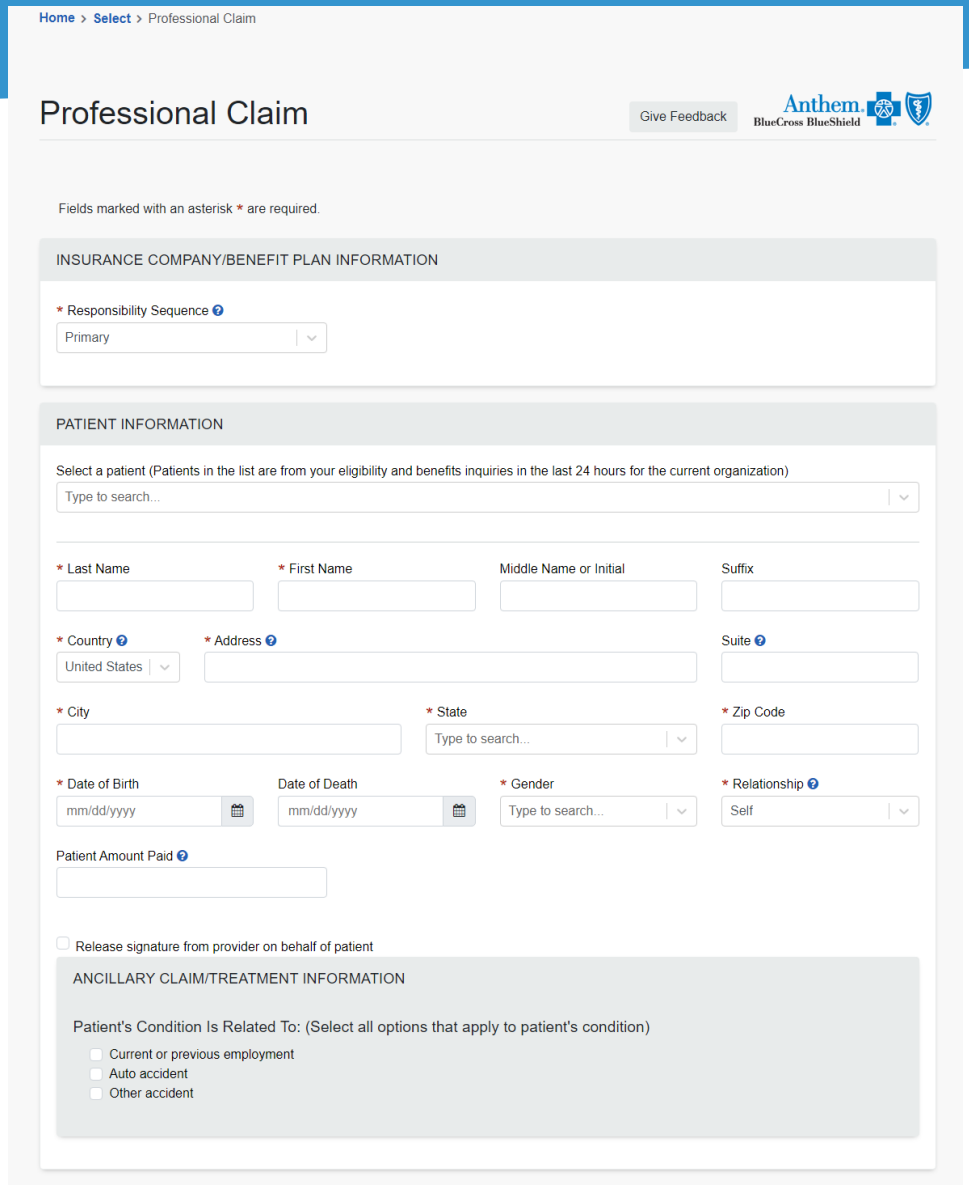
Filing a claim (cont.)

Select the *payer* and then **Continue**.



Claim form (cont.)

- Select **Responsibility Sequence**:
  - Primary
  - Secondary
  - Tertiary
- Fill in the *patient information* section:
  - All fields with the red asterisk (*) are required fields.

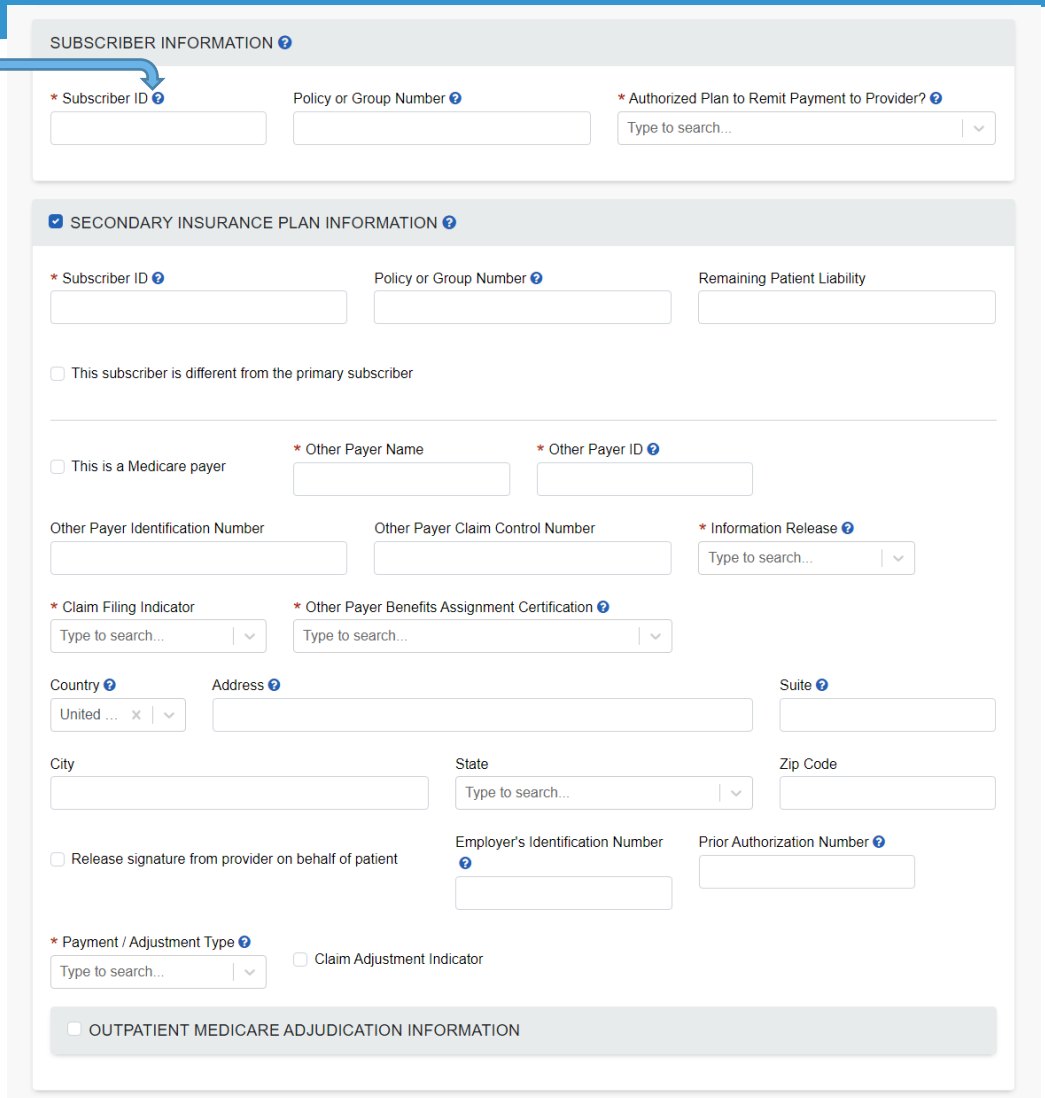


Claim form (cont.)

The member ID goes here as well as their other insurance if there is another policy.

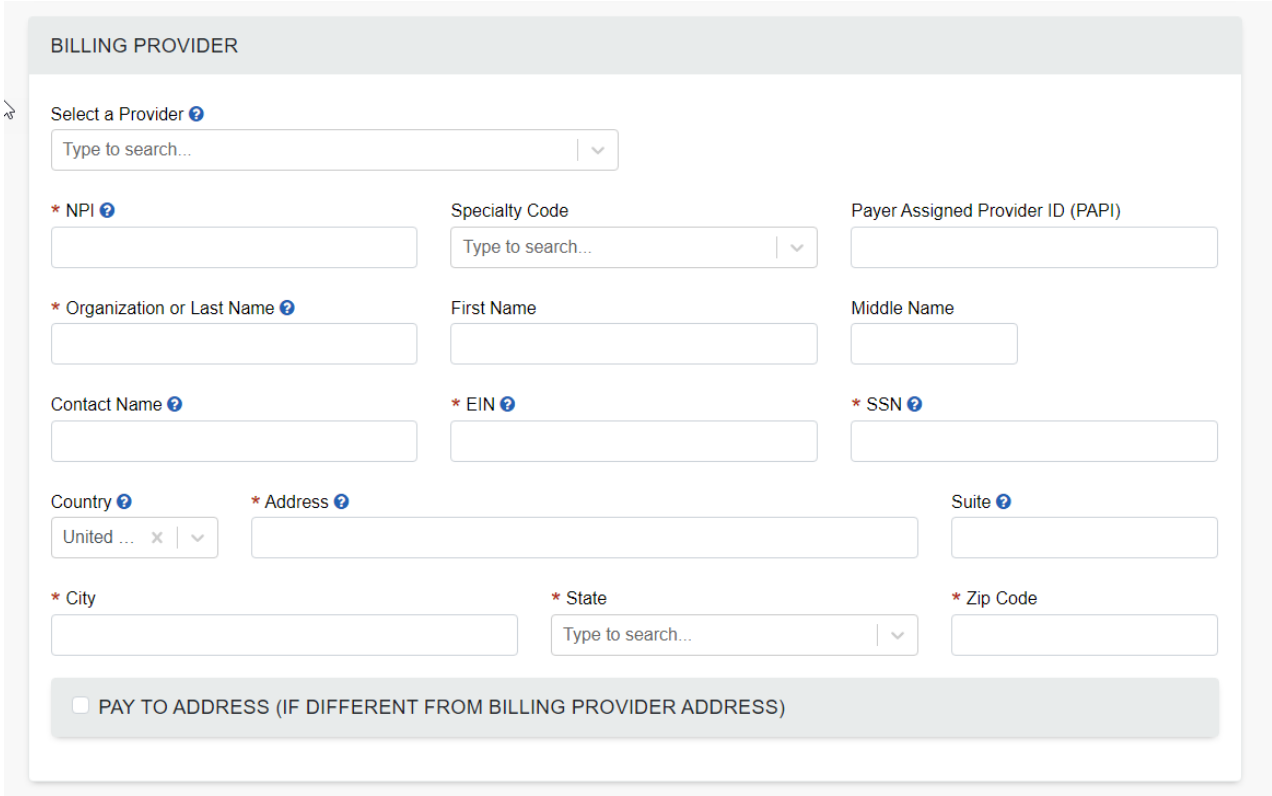
When entering the subscriber ID, be sure to enter the prefix YRH or YRK, MID.

- Starting *[January 1, 2023]*, the prefix will not be required.



Claim form (cont.)

The provider's billing information goes into this field.

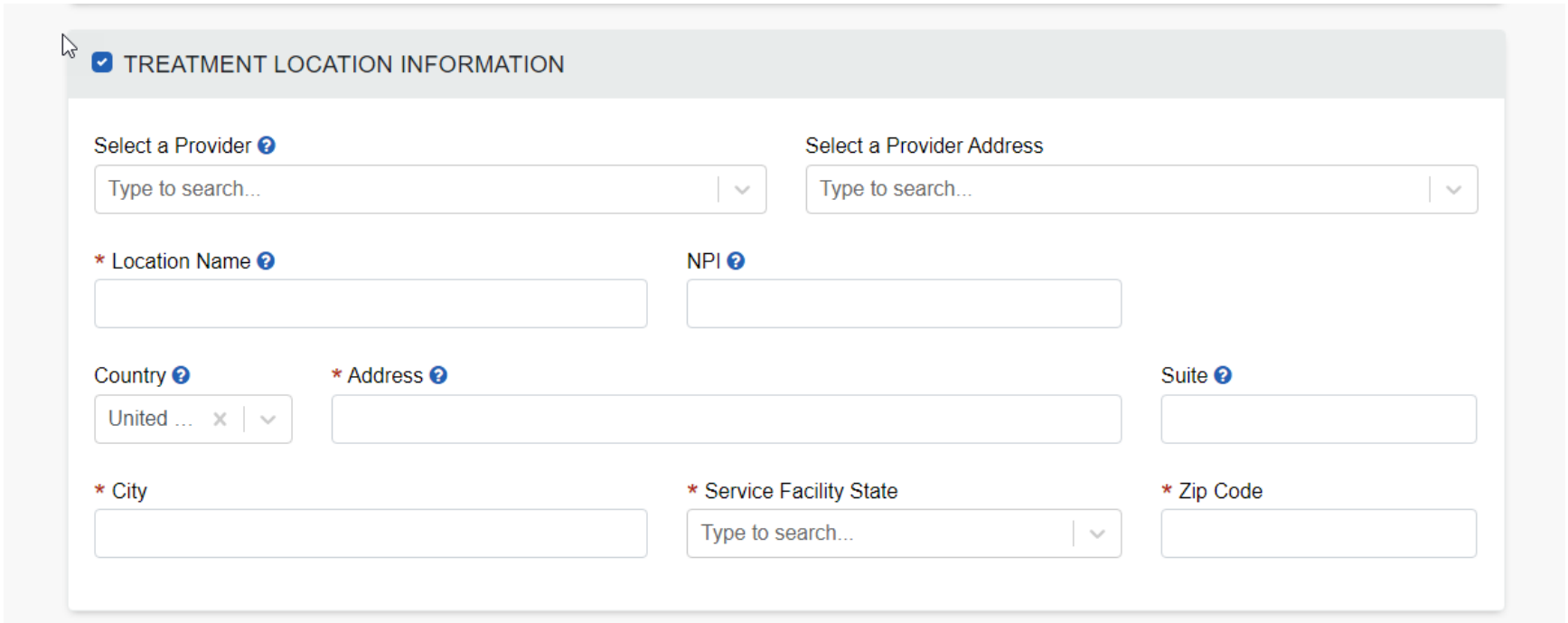


Claim form (cont.)

The following slides will show what each of these fields looks like in detail. If you select the box, it will expand for you to fill out the information.

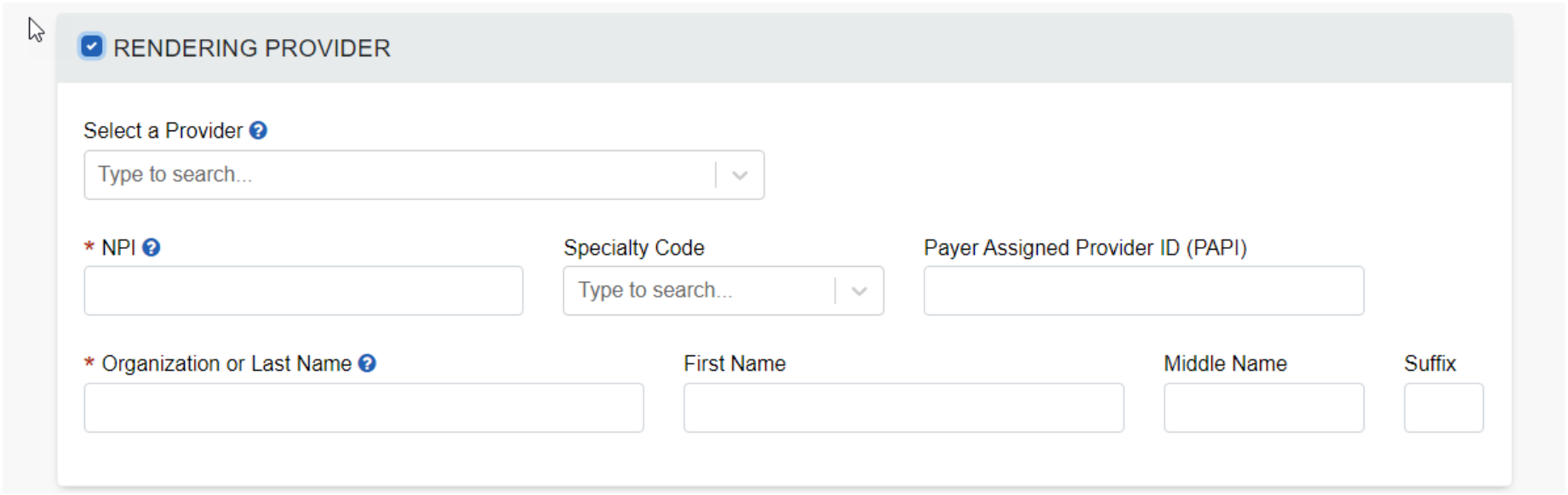
Claim form (cont.)

Enter the provider's service location information here.



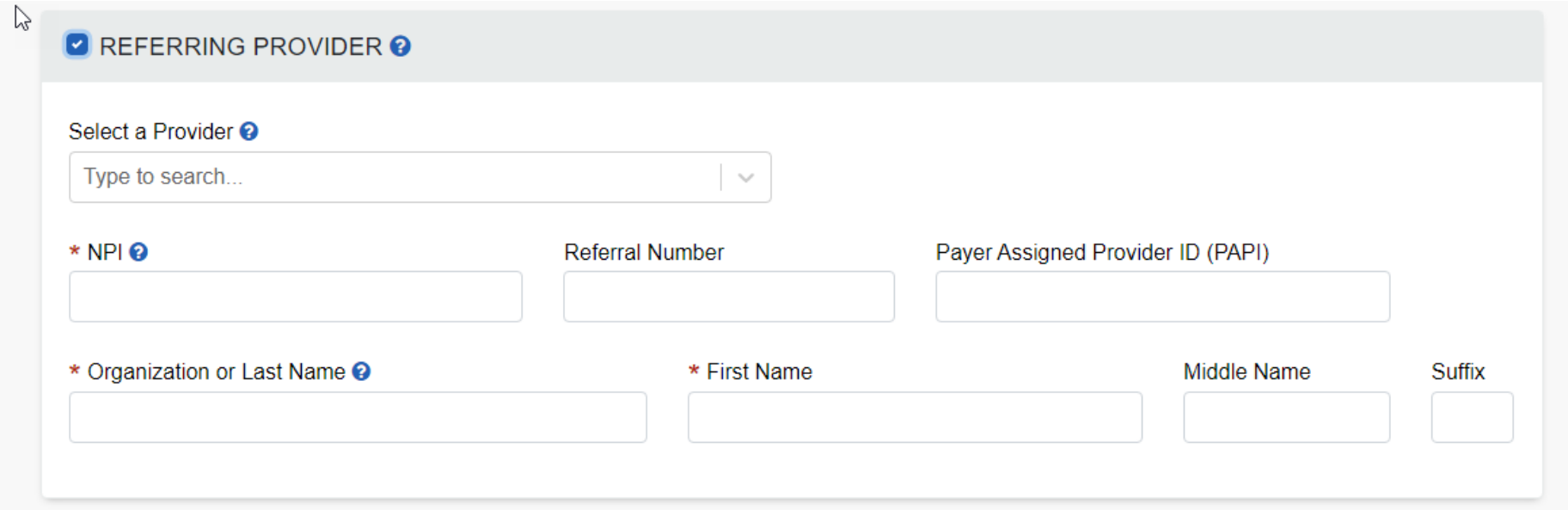
Claim form (cont.)

Enter the rendering provider's information here.



Claim form (cont.)

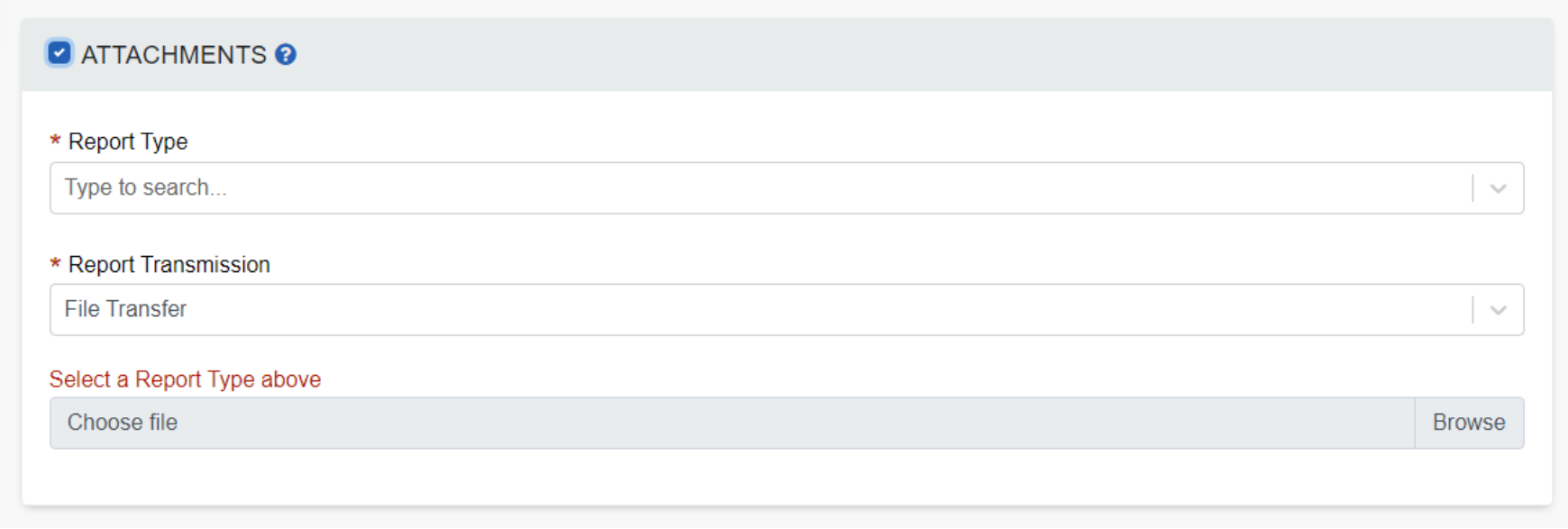
Enter the referring provider's information here.



Claim form (cont.)

In this field you can add attachments to your claim:

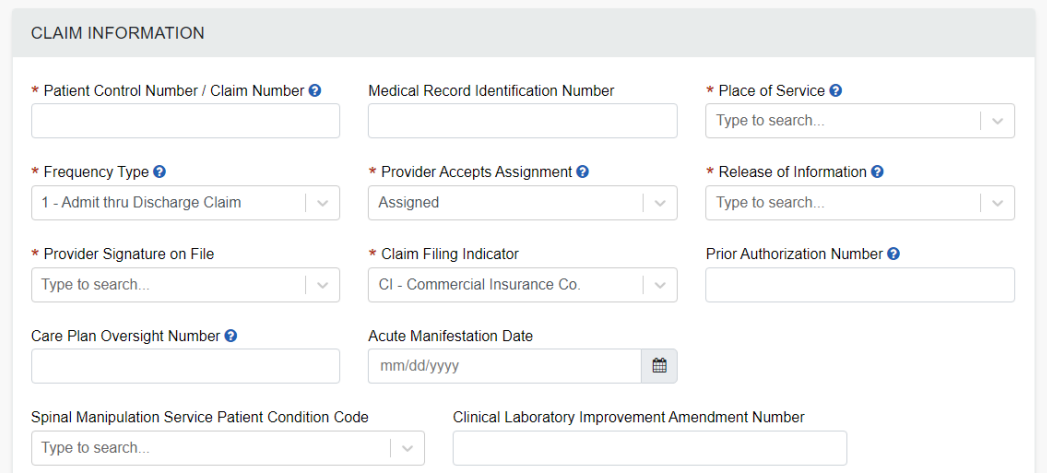
- Under *Report Type*, providers can select what type of information is being attached such as a primary Explanation Of Benefits, consent form, or medical records.
- The bottom field is where providers can upload attachments.



Claim form (cont.)

The required fields here are:

- **Patient Control Number:**
  - Enter your patient account number.
- **Place of Service:**
  - This dropdown will provide the place of service code.
- **Frequency Type:**
  - *1 - Admit thru Discharge Claim*
  - *7 – Replacement of Prior Claim***
  - *8 – Void/Cancel of Prior Claim***
- Select the *Claim Filing Indicator.*

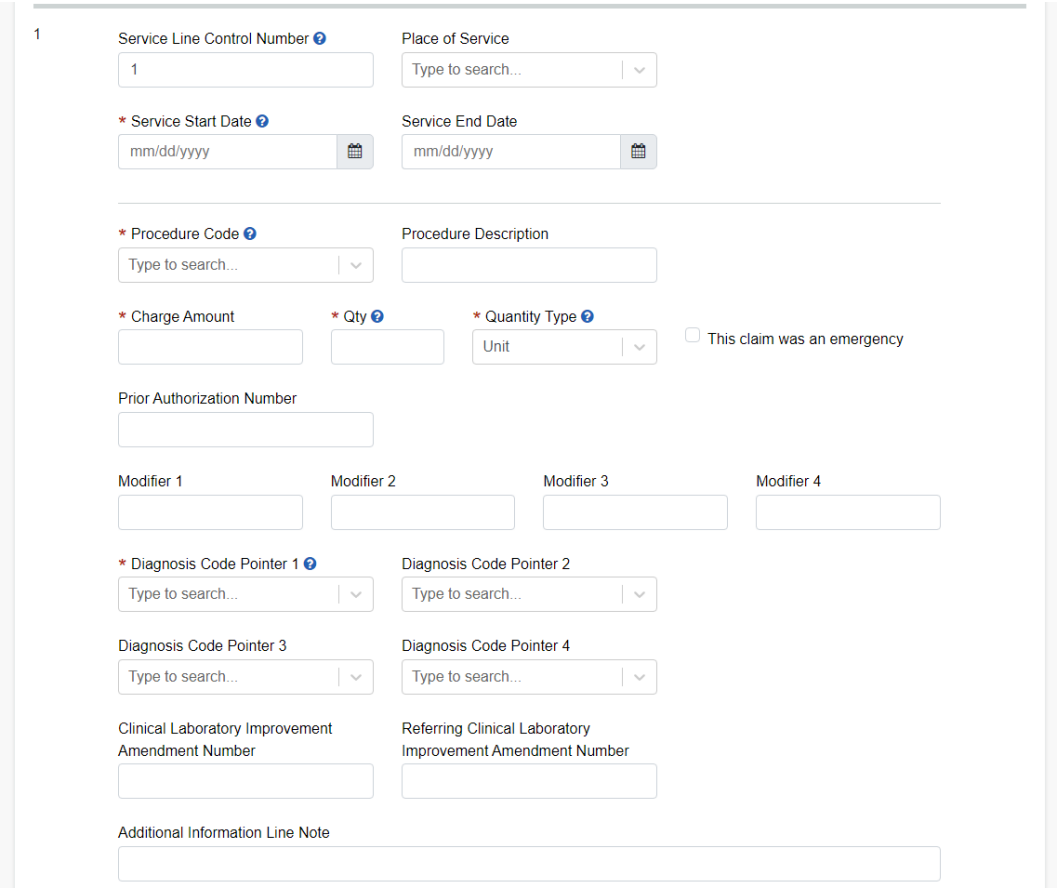


** If these fields are selected, a field will pop up for the original claim number.

Claim form (cont.)

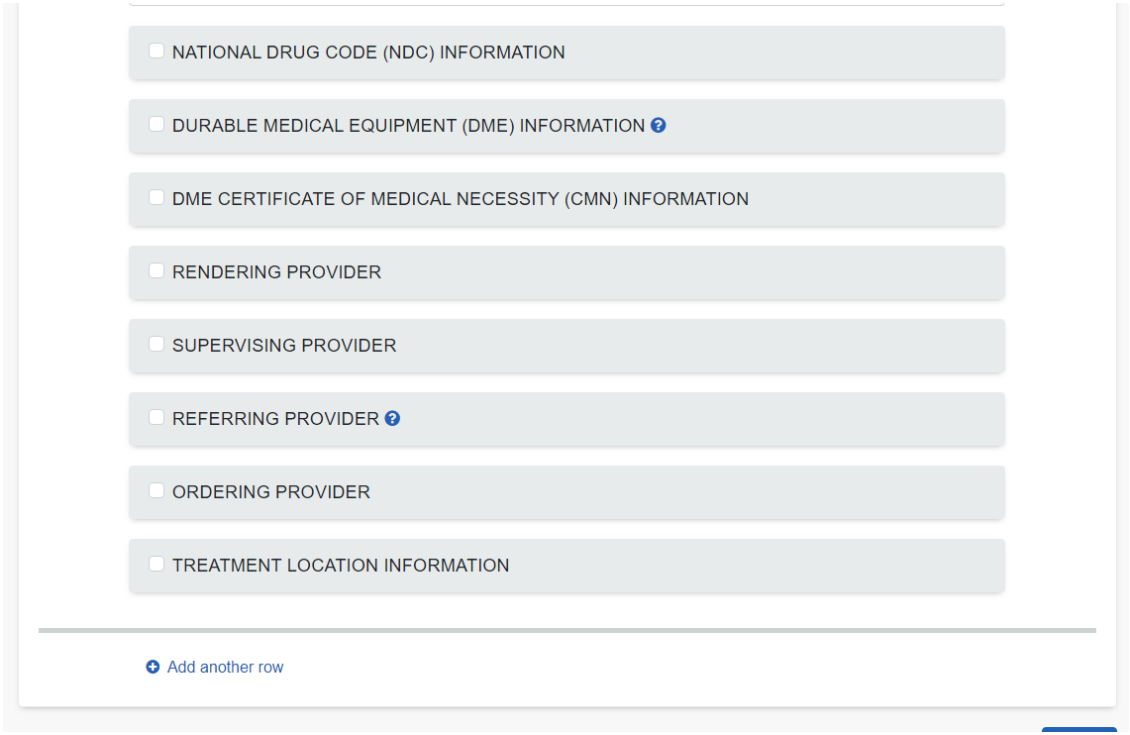
Enter claim service line information here:

- Select your **Place of Service.**
- Providers will need to enter:
  - **Service Start Date**
  - **Procedure Code**
  - **Charge Amount**
  - **Quantity**
  - **Quantity Type**
  - **Prior Authorization number (if required)**
  - **Any modifiers**
  - **Diagnosis Pointer (up to 4)**
  - **CLIA information (if required)**



Claim form (cont.)

These fields are the continuation of the claim service lines.



Claim form (cont.)

NATIONAL DRUG CODE (NDC) INFORMATION

* National Drug Code

Type to search...

* National Drug Unit Count

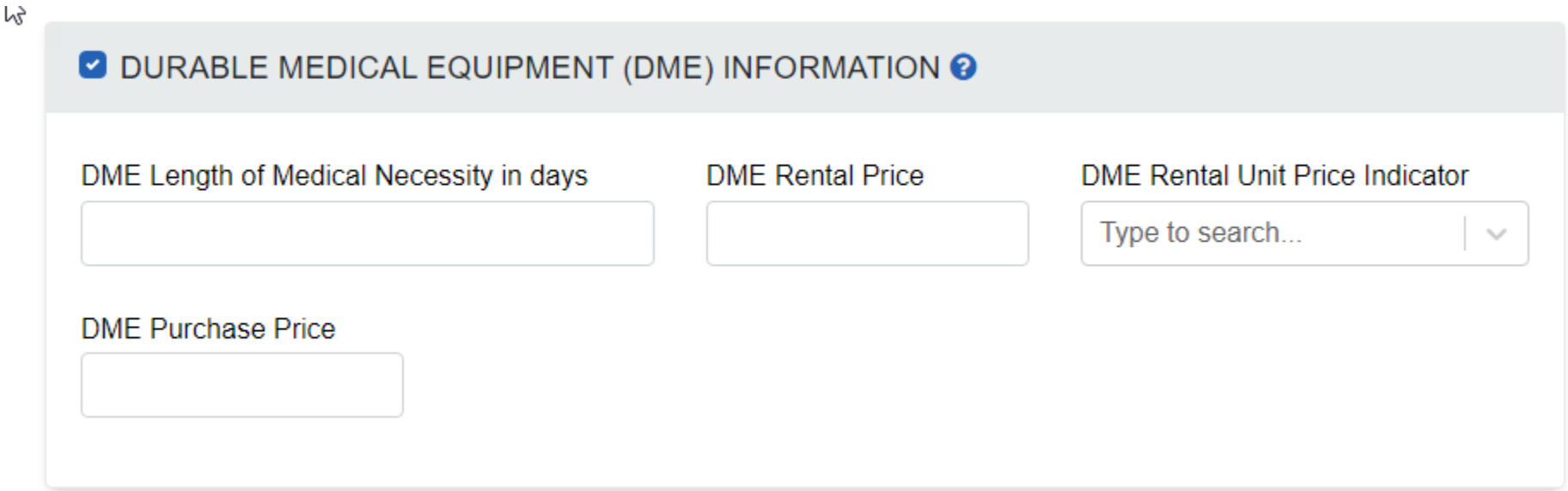
* Drug Quantity Unit Code Qualifier

Unit

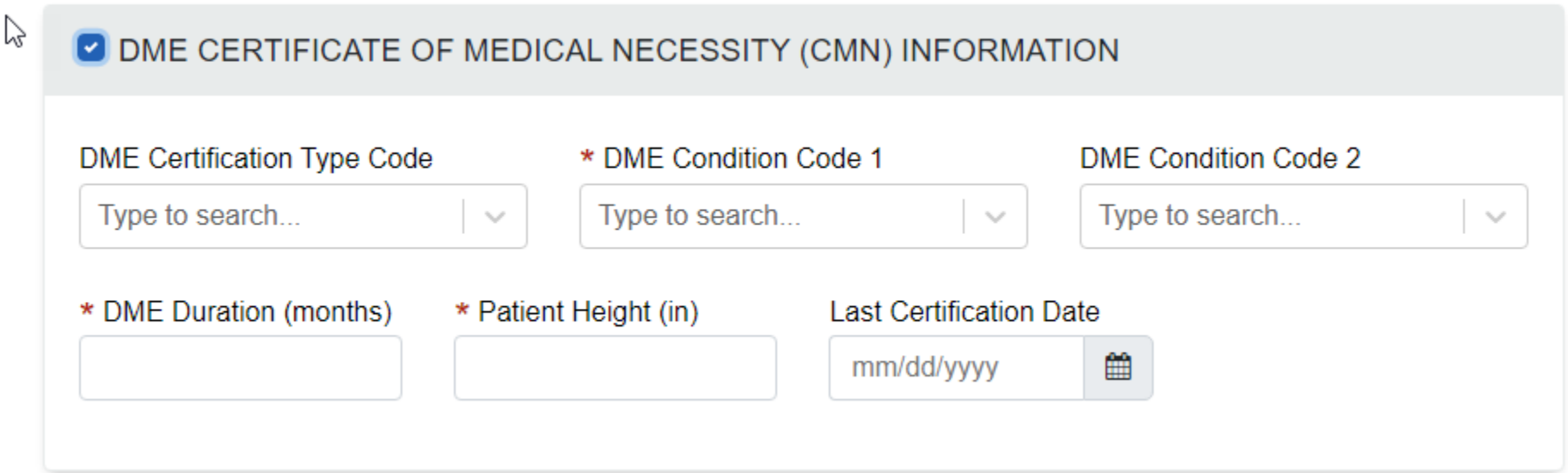
Prescription Number Type

Type to search...

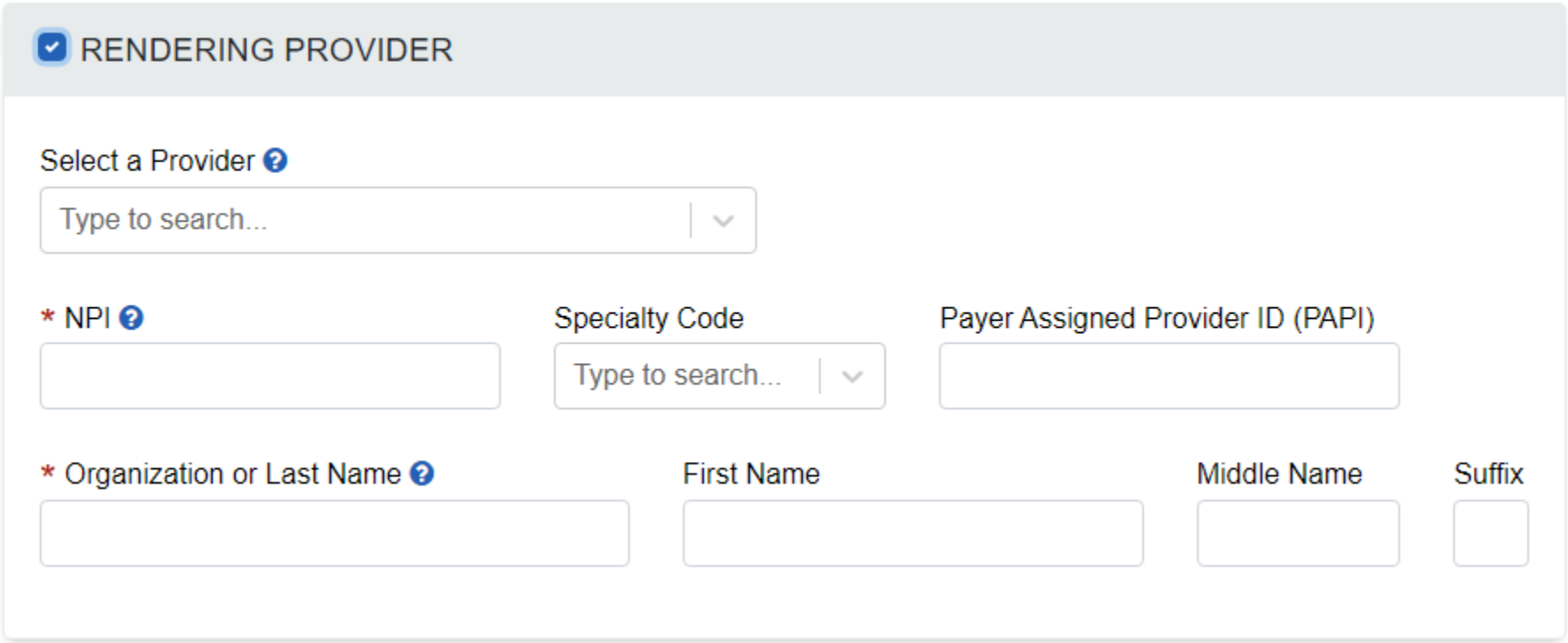
Claim form (cont.)



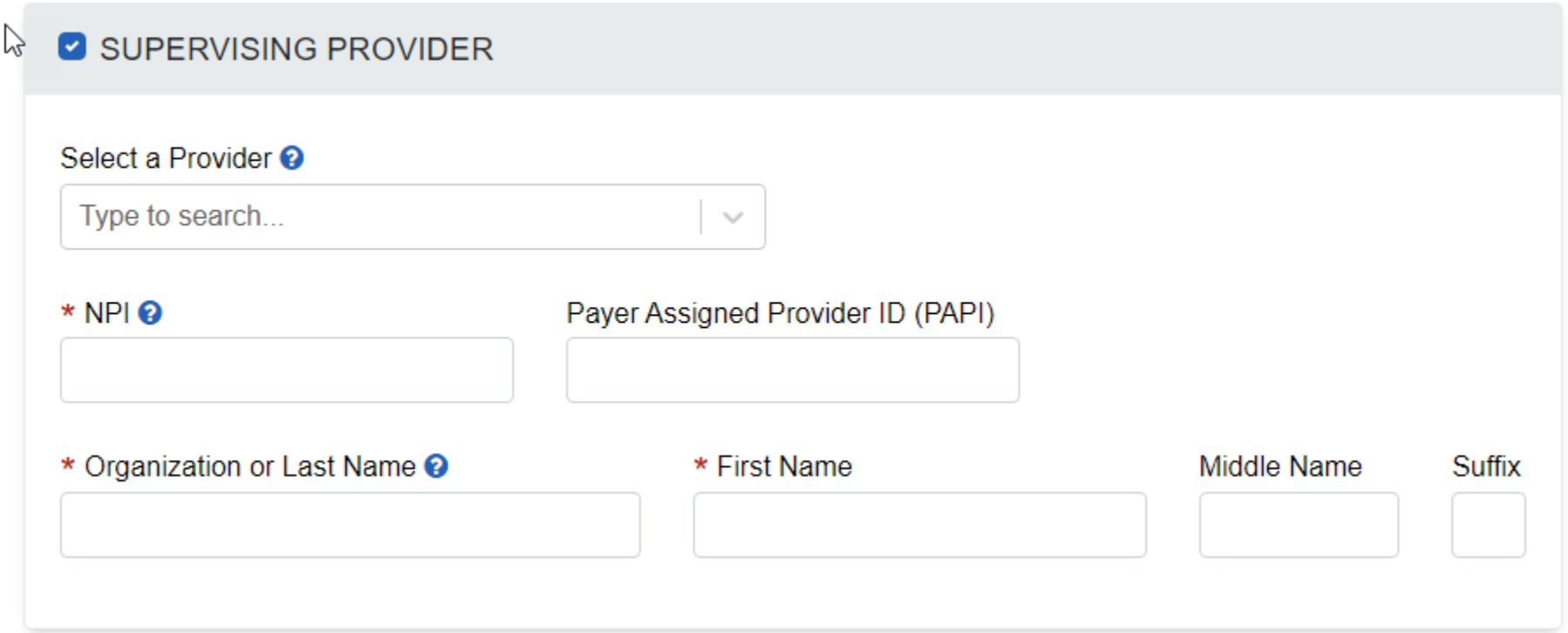
Claim form (cont.)



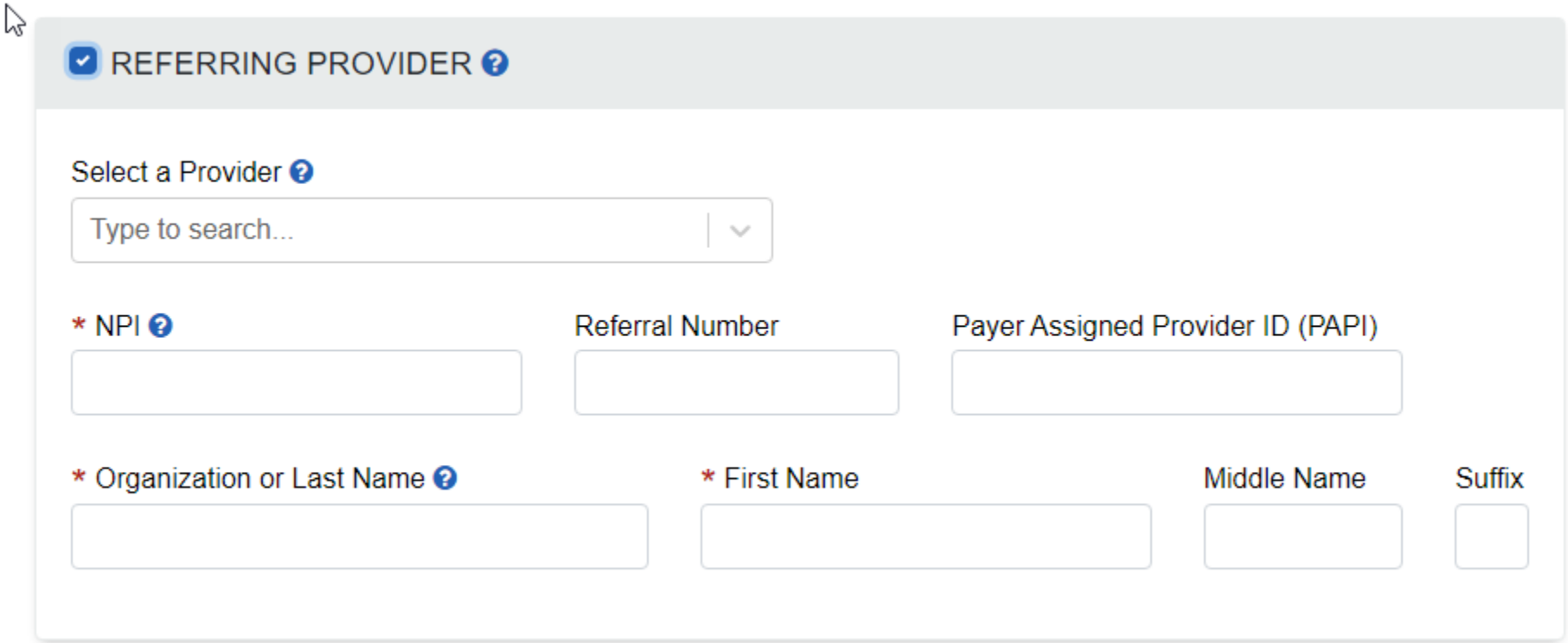
Claim form (cont.)



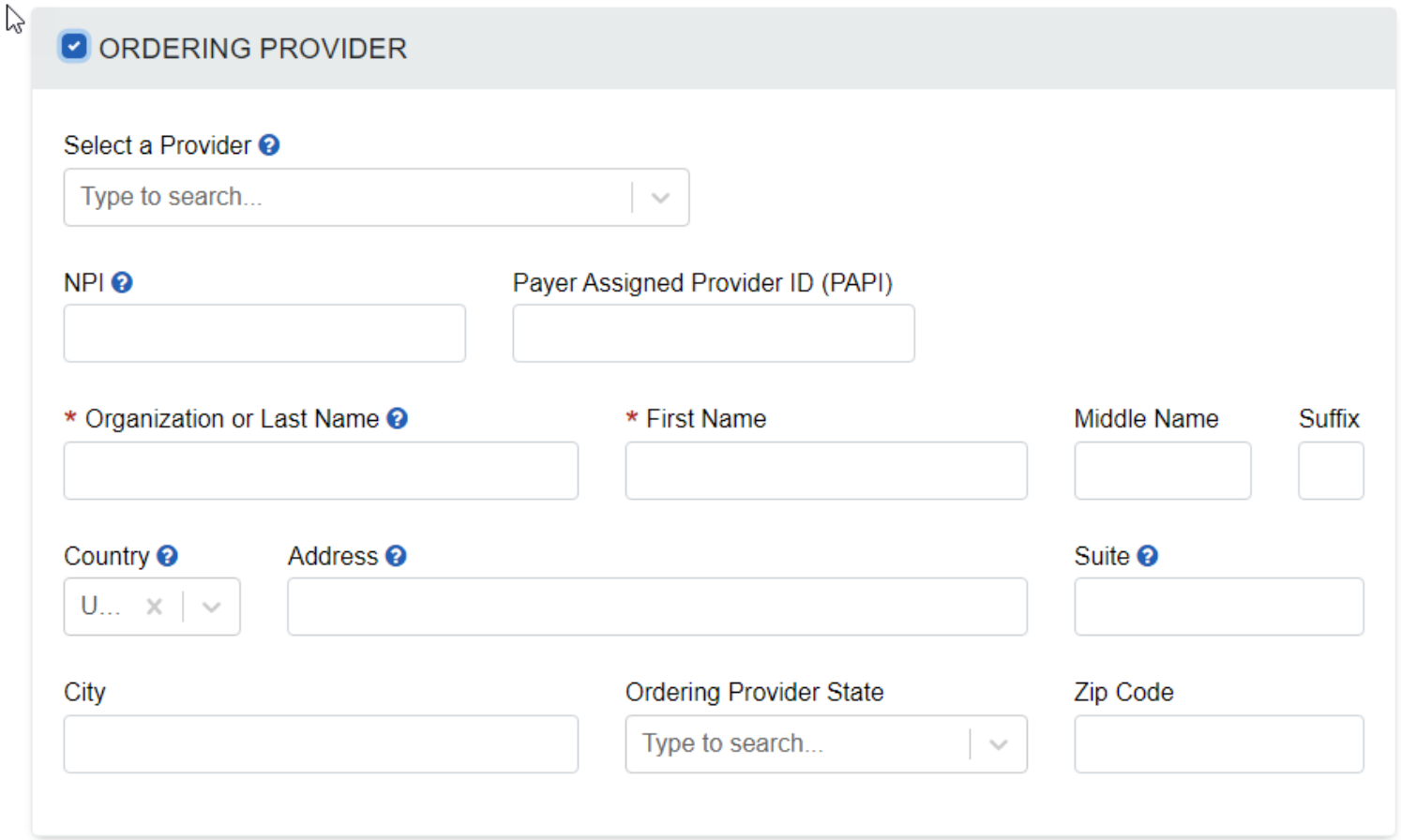
Claim form (cont.)



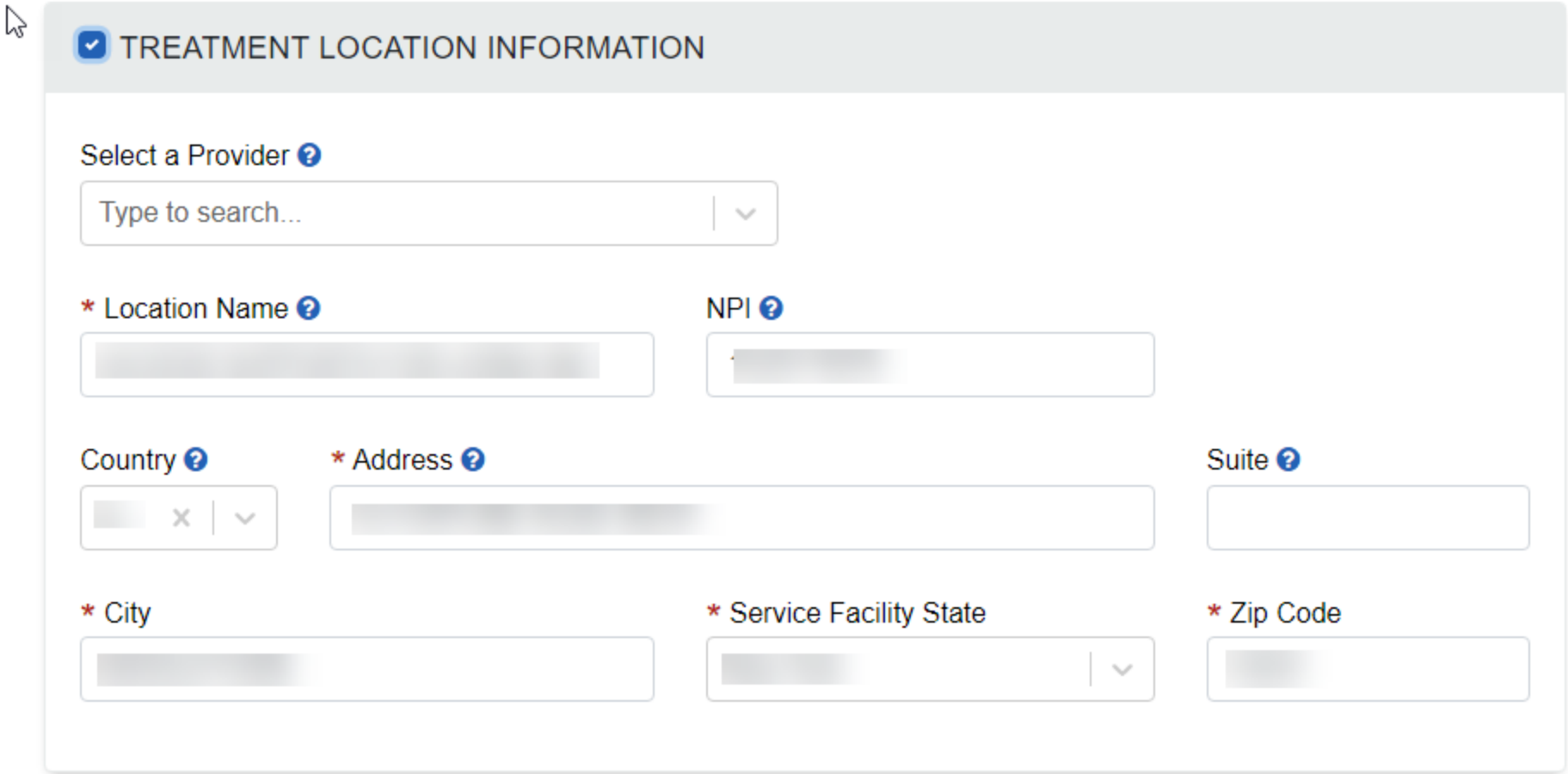
Claim form (cont.)



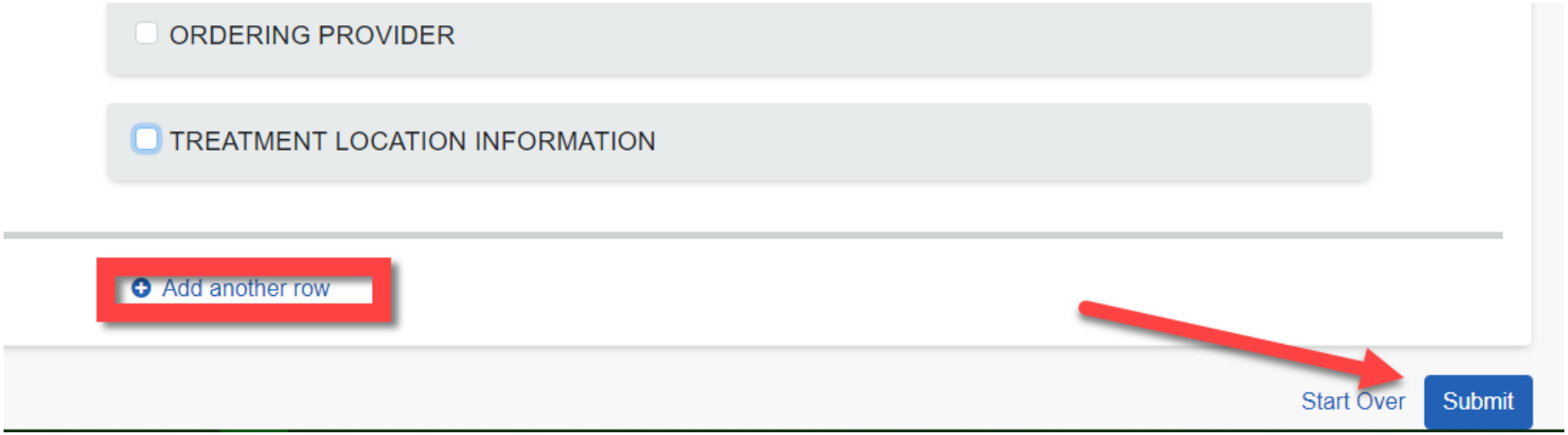
Claim form (cont.)



Claim form (cont.)



Claim form (cont.)



When you reach the bottom of the claim service lines, you have the option to add additional rows or submit.

Claim turnaround

Processing time:

- 21 days for electronic clean claims
- 30 days for paper clean claims

If the claim isn’t showing in our processing system, ask the Provider Services representative to verify if the claim is in imaging. **Do not resubmit if the claim is on file in the processing or image system.**

COB

COB is when a member shows to have primary insurance:

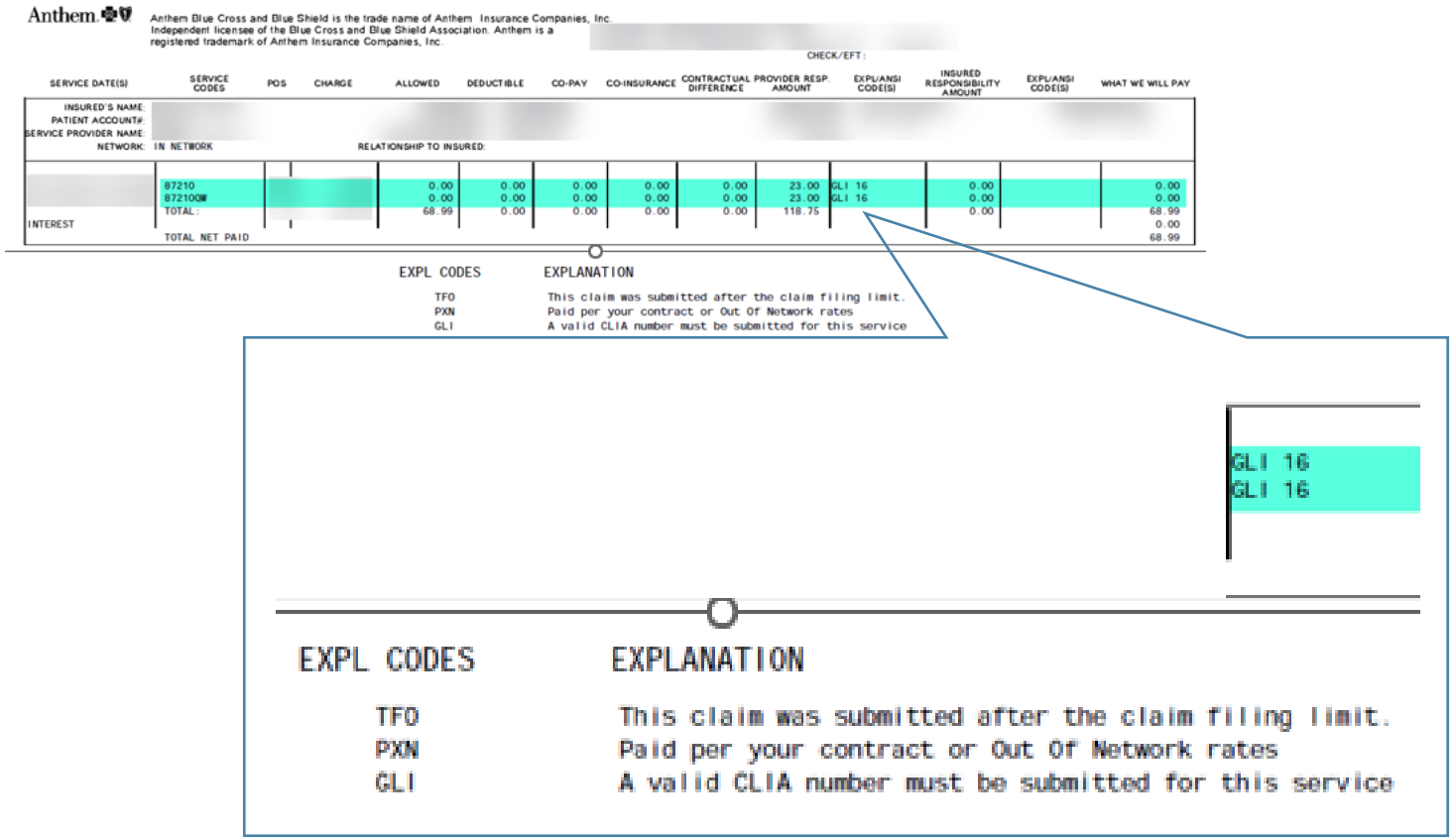
- Claims must be filed to Anthem within 90 days of the date on the primary *Explanation of Payment (EOP)*.

If the primary carrier pays more than the Medicaid allowable, no additional money will be paid.

- **Example one:** Primary pays $45 for a 99213 and you bill Medicaid as secondary. The Medicaid fee schedule is $31.96. No additional money would be paid.
- **Example two:** Primary allows $45 for a 99213 but applies it all towards a deductible and you bill Medicaid as secondary. Medicaid will pay the $31.96 since primary applied all to the deductible.

Note: Bill all secondary claims, even if we will not pay additional money; this will assist in the HEDIS® data review.

Identifying denials on the *EOP*



Anthem

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Independent licensee of the Blue Cross and Blue Shield Association. Anthem is a
registered trademark of Anthem Insurance Companies, Inc.

CHECK/EFT:

SERVICE DATE(S)	SERVICE CODES	POS	CHARGE	ALLOWED	DEDUCTIBLE	CO-PAY	CO-INSURANCE	CONTRACTUAL DIFFERENCE	PROVIDER RESP. AMOUNT	EXPL/ANSI CODE(S)	INSURED RESPONSIBILITY AMOUNT	EXPL/ANSI CODE(S)	WHAT WE WILL PAY
INSURED'S NAME:													
PATIENT ACCOUNT#:													
SERVICE PROVIDER NAME:													
NETWORK: IN NETWORK			RELATIONSHIP TO INSURED:										
	87210			0.00	0.00	0.00	0.00	0.00	23.00	GLI 16	0.00		0.00
	87210QW			0.00	0.00	0.00	0.00	0.00	23.00	GLI 16	0.00		0.00
	TOTAL:			68.99	0.00	0.00	0.00	0.00	118.75		0.00		68.99
INTEREST													0.00
	TOTAL NET PAID												68.99

EXPL CODES	EXPLANATION
TFO	This claim was submitted after the claim filing limit.
PXN	Paid per your contract or Out Of Network rates
GLI	A valid CLIA number must be submitted for this service

GLI 16
GLI 16

EXPL CODES EXPLANATION

TFO This claim was submitted after the claim filing limit.
PXN Paid per your contract or Out Of Network rates
GLI A valid CLIA number must be submitted for this service

Professional claims – top 5 denials

1. Billing NPI not registered with the state – Z33
2. Submitted after plan filing limit – TF0
3. Deny – prior auth not obtained – Y40
4. *EOB* required from the primary carrier – QA0
5. Rendering NPI not registered with the state – Z34

Billing NPI not registered with the state – Z33

- Z33 refers to the provider NPI in field 33a of the CMS-1500/837P claim form
- Billing providers must be actively enrolled with the state to receive reimbursement from Anthem
- There must be a one-to-one match between the data submitted on the claim and the State Assigned Provider ID file received from the state
  - NPI, taxonomy, zip+4 = 1 State Provider ID = Match
  - NPI, taxonomy, zip+4 = 2+ State Provider IDs = No Match, Z33 denial

Submitted after plan filing limit – TF0

- In-Network Providers = 90 days from the last date of service on the claim
- Out-of-Network Providers = 180 days from the last date of service on the claim
- Auto-denial in our system
- Filing limit can be extended
  - Other primary insurance – 90 days from the date of the primary *EOB*
  - Member retroactive eligibility
  - Delay/error loading a prior authorization
  - Other administrative delays
- Submit dispute and include documentation that clearly identifies the reason for the filing delay

Prior authorization not obtained – Y40

- Claims denied for Y40 may be submitted as a dispute with documentation demonstrating the medical necessity and an explanation of the failure to obtain authorization in the required time frame
- If the authorization was requested but denied:
  - Reconsideration — within seven business days of a denial date
  - P2P — within seven business days of a denial date (initial or reconsideration)
  - Appeals — within 60 calendar days of a denial date

EOB required from the primary carrier – CBP/ QA0

- Medicaid is the payer of last resort
- If the member has other insurance, the provider must submit the claim to the other payer prior to billing Anthem.
- The member is responsible for notifying Anthem if a primary policy is updated or terminates
- Data mining, provider updates
- Other payer information is available via Availity during the eligibility verification process
- Anthem coordinates payment up to the provider’s contract allowable. Any remaining amount is a contractual adjustment and cannot be billed to the member.

EOB required from the primary carrier – CBP/ QA0 (cont.)

- Per IHCP Third Party Liability Module, page 14: “When a provider submits a claim to the IHCP for the difference between the amount billed and the primary insurer’s payment, the IHCP pays the difference, up to the IHCP allowable charge. If the primary insurer payment is equal to or greater than the IHCP-allowable charge, no payment is made by the IHCP.” Providers cannot bill members for any balance.

Rendering NPI not registered with the state – Z34

- Z34 refers to the NPI in field 24J of the CMS-1500/837P claim form
- Claims billed by provider groups must contain a rendering NPI
- Servicing provider must be enrolled as a rendering provider with the state
- Billing entities (hospitals, DME, ambulance, etc.) are not required to include a rendering provider NPI on the claim
- Anthem matches the NPI with the State Assigned Provider ID file received from the state

Claims resolution process

Follow-up guidelines

Use the Availity Portal to check claim status online. You can also call the appropriate helpline:

Plan	Phone number
HIP	**844-533-1995**
Hoosier Care Connect	**844-284-1798**
Hoosier Healthwise	**866-408-6132**

It is the provider’s responsibility to follow up timely and ensure claims are received and accepted.

Claims resolution process (cont.)

Corrected claims submission guidelines

Submit a corrected claim when the claim is denied or only paid in part due to an error on the original claim submission.

When submitting corrected claims, follow these guidelines:

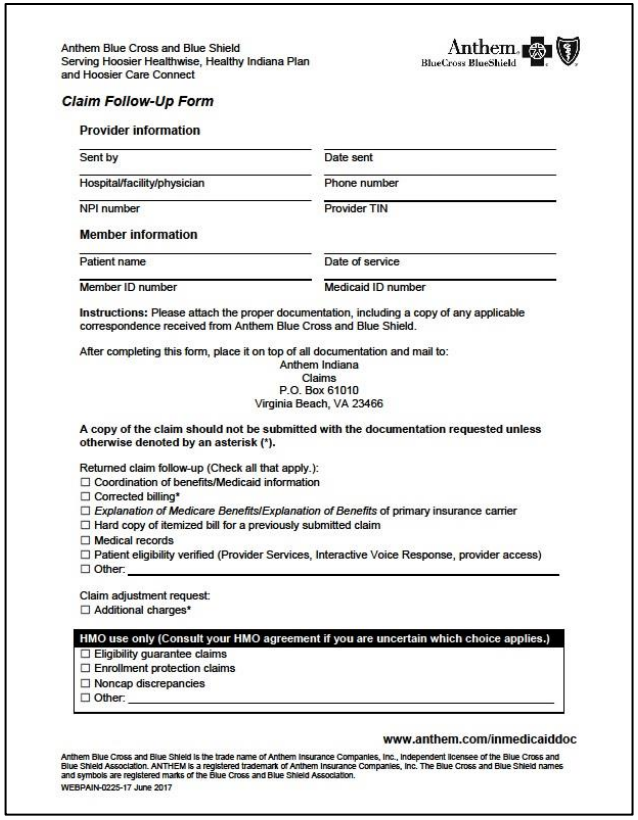
- Submit the corrected claim no later than 60 calendar days from the date of our letter or remittance advice (RA).
- Corrected claims can be submitted by paper, electronically through your clearinghouse, or through the Availity Portal.

Claims resolution process (cont.)

Send corrected paper claims to:

Anthem Blue Cross and Blue Shield
Corrected Claims and Correspondence Department
P.O. Box 61599
Virginia Beach, VA 23466

The *Claim Follow-Up Form* is available at www.anthem.com/inmedicaiddoc > Resources > Forms > Claims and Billing.



Anthem Blue Cross and Blue Shield
Serving Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect

Anthem BlueCross BlueShield

Claim Follow-Up Form

Provider information

Sent by | Date sent

Hospital/facility/physician | Phone number

NPI number | Provider TIN

Member information

Patient name | Date of service

Member ID number | Medicaid ID number

Instructions: Please attach the proper documentation, including a copy of any applicable correspondence received from Anthem Blue Cross and Blue Shield.

After completing this form, place it on top of all documentation and mail to:
Anthem Indiana
Claims
P.O. Box 61010
Virginia Beach, VA 23466

A copy of the claim should not be submitted with the documentation requested unless otherwise denoted by an asterisk (*).

Returned claim follow-up (Check all that apply.):
☐ Coordination of benefits/Medicaid information
☐ Corrected billing*
☐ *Explanation of Medicare Benefits/Explanation of Benefits* of primary insurance carrier
☐ Hard copy of itemized bill for a previously submitted claim
☐ Medical records
☐ Patient eligibility verified (Provider Services, Interactive Voice Response, provider access)
☐ Other: _____

Claim adjustment request:
☐ Additional charges*

HMO use only (Consult your HMO agreement if you are uncertain which choice applies.)
☐ Eligibility guarantee claims
☐ Enrollment protection claims
☐ Noncap discrepancies
☐ Other: _____

www.anthem.com/inmedicaiddoc

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Claims resolution process (cont.)

Claims dispute and appeal process

The dispute process is if a provider disagrees with full or partial denial on the claim:

- There is a 60-calendar day time limit from the date on the remittance advice (RA) in which to dispute any claim.
- Disputes and appeals that are not filed within the defined time frames will be denied without a review for merit.

Claims resolution process (cont.)

The claims dispute process is as follows:

1. **Claims reconsideration** — must be received within 60 calendar days from the date on the RA. Disputes can be done verbally through provider services, in writing, or online through the Availity Portal. Submit a claims reconsideration if you disagree with full or partial claim rejection or denial, or the payment amount.
2. **Claim payment appeal** — if you are not satisfied with the reconsideration, you may submit a claim payment appeal. We must receive this appeal within 60 calendar days from the date of the claim reconsideration. This can be done via the Availity Portal or by mail.

Important contact information

Important contact information

Provider Services:

- Hoosier Healthwise: **866-408-6132**
- HIP: **844-533-1995**
- Hoosier Care Connect: **844-284-1798**

Member Services and 24/7 NurseLine:

- Hoosier Healthwise and HIP: **866-408-6131**
- Hoosier Care Connect: **844-284-1797**

Important contact information (cont.)

PA requests:

- HIP: **844-533-1995**
- Hoosier Care Connect: **844-284-1798**
- Hoosier Healthwise: **866-408-6132**
- Fax: **866-406-2803**

Provider Experience physical health zone map

Physical health Provider Experience managers

Zone 1/Beacon Health Systems

Jessi Earls
Jessica.Wilkerson-Earls@anthem.com
317-452-2568

Zone 2/Ascension St. Vincent

Angelique Jones
Angelique.Jones@anthem.com
317-619-9241

Zone 3

Jamaal Wade
Jamaal.WadeSr@anthem.com
317-409-7209

Zone 4/Deaconess

Jonathan Hedrick
Jonathan.Hedrick@anthem.com
317-601-9474

Zone 5/Parkview

David Tudor
David.Tudor@anthem.com
317-447-7008

Zone 6/IU Health; St. Joseph Regional Medical Health Center; Home Health and Hospice

Matt Swingendorf
Matthew.Swingendorf@anthem.com
317-306-0077

Zone 7/Baptist Health

Sophia Brown
Sophia.Brown@anthem.com
317-775-9528

Zone 8/Eskenazi

Marvin Davis
Marvin.Davis@anthem.com
317-501-7251

Zone 9/Out-of-state providers, Franciscan, Community Health Network

Nicole Bouye
Nicole.Bouye@anthem.com
317-517-8862

Dir, Provider Experience
Jacquie Marsalis
Jacqueline.Marsalis@anthem.com

https://providers.anthem.com/docs/gpp/IN_CAID_PU_NetworkRelationsMap.pdf?v=202110061311

Provider Experience behavioral health subject matter experts

Statewide behavioral health (BH) subject matter experts (SME)

Acute hospitals
Tish Jones, Provider Experience Manager
Latisha.Willoughby@anthem.com
317-617-9481

Community mental health centers/federally qualified health centers/rural health clinics
Matthew McGarry, Provider Experience Manager
Matthew.McGarry@anthem.com
463-202-3579

Substance use disorder (SUD)/Opioid treatment program (OTP)
Alisa Phillips, Provider Experience Manager, Sr.
Alisa.Phillips@anthem.com
317-517-1008

SME — SUD/OTP
Michele Weaver, Provider Experience Manager
Michele.Weaver@anthem.com
317-601-3031

Solo BH and applied behavior analysis providers

Zones 1, 2, 5, 6
Ashley Holmes
Ashley.Holmes@anthem.com
317-315-0623

Zones 3, 4, 7, 8
Whit'ney McTush
Whitney.McTush@anthem.com
317-519-1089

Questions?

Thank you for your participation in serving our members enrolled in Hoosier Healthwise, HIP, and Hoosier Care Connect!

Serving Hoosier Healthwise, Healthy Indiana Plan
and Hoosier Care Connect

* Availity, LLC is an independent company providing administrative support services on behalf of Anthem Blue Cross and Blue Shield.

https://providers.anthem.com/in

Providers who are contracted with Anthem Blue Cross and Blue Shield to serve Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect through an accountable care organization (ACO), participating medical group (PMG) or Independent Physician Association (IPA) are to follow guidelines and practices of the group. This includes but is not limited to authorization, covered benefits and services, and claims submittal. If you have questions, please contact your group administrator or your Anthem network representative.

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