













Claims UB-04

2022 Annual IHCP Works Seminar





Agenda

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

MHS Overview

Who is MHS?

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

MHS Products



Claim Submission Process

Medical Claim Submission



Electronic Data Interchange Submission:

- Preferred method of claims submission
- Faster and less expensive than paper submission
- MHS Electronic Payor ID **68069**



Online through the **MHS Secure Provider Portal** at
<https://www.mhsindiana.com/providers.html>



Provides immediate confirmation of received claims and acceptance

- Institutional and Professional
- Batch Claims
- Claim Adjustments/Corrections
- Claim review/Adjustments request



Paper Claims:

Managed Health Services
PO Box 3002
Farmington, MO 63640-3802

Behavioral Health Claim Submission



Electronic Submission:

- Payer ID **68068**
- MHS accepts Third Party Liability (TPL) information via Electronic Data Interchange
- It is the responsibility of the provider to review the error reports received from the Clearinghouse (Payer Reject Report)



Online through the **MHS Secure Provider Portal** at

<https://www.mhsindiana.com/providers.html>

Provides immediate confirmation of received claims and acceptance

- Institutional and Professional
- Batch Claims
- Claim Adjustments/Corrections
- Claim review/Adjustments request




Paper Claims:

- MHS Behavioral Health
PO Box 6800
Farmington, MO 63640-3818

Claim Billing with Ease

NPI, Tax ID, Zip +4

-  This information is necessary for the system to make a one-to-one match based on the information provided on the claim and the information on file with Indiana Medicaid.
- Member Information
 - Newborn's Medicaid Identification number is required for payment

Attachment Forms:

- Required forms need to accompany the claim form

Secondary Claims (TPL):

- Accepted electronically from vendors or via the MHS Secure Provider Portal

Claim Submission




 Contracted or In-Network providers: 90 calendar days from the date of service or discharge date.

Exceptions:





- Newborns (30 days of life or less) – Claims must be received within 365 days from the date of service. Claim must be filed with the newborn's Medicaid Identification number.
- TPL – Claims with primary insurance must be received within 365 days of the date of service with a copy of the primary Explanation of Benefits. If primary EOP is received after the 365 days, providers have *60 days* from date of primary EOP to file claim to MHS. If the third party does not respond within 90 days, claims may be submitted to MHS for consideration. Claims submitted must be accompanied by proof of filing with the patient's primary.

Claim Submission

Claim Acceptance & Adjudication

-  System reviews claim for errors and critical fields (i.e. dates of service, billing/rendering provider, etc.) prior to acceptance.
-  Regulatory requirements (federal and state) mandate certain information to be present in order to accept and pay a claim.
-  National Provider Identifier (NPI) common rejection/denial; provider information on claim **must** match record at IHCP enrollment – a State requirement.

Paper Claim Corrections

-  A corrected claim can be submitted following IHCP claim adjustment processes.
-  A claim adjustment code is required on all claims, based on the type of claim submitted.
 - Example: Frequency 7 entered in Box 22 of the CMS-1500 form.
-  The original claim number must also be listed on the corrected claim.
 - Box 22 on the CMS-1500
 - Remember a rejection, must be submitted as 1st time claim, not as a corrected claim.
-  Handwriting or stamping on a claim will not be accepted as submission of a corrected claim, and will be rejected with code RE.

Transportation Claims



Managed Health Services (MHS) will process all Medicaid emergent and non-emergent ambulance claims, including air ambulance, which would have previously been processed by LCP Transportation.



Claims for the following services should be sent to MHS:

- 911 Transports
- Medically necessary non-emergent hospital transports requiring an ambulance with advanced life support (ALS) or basic life support (BLS).
- Air ambulance



Only providers enrolled with the Indiana Health Coverage Programs (IHCP) are eligible for reimbursement. Claims must be filed within 180 days of the Date of Service (DOS) for non-contracted providers and within 90 days of DOS for contracted providers.



Claims should be submitted to MHS via a CMS-1500 professional claim form. Claims may be submitted via EDI (preferred), MHS web portal or paper.

Transportation Claims




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

For more information on Medicaid ambulance billing guidelines, please visit:




[transportation-services.pdf \(in.gov\)](#)

-  **Claim Inquiries:**
 - Check status online
 - Call Provider Services at 1-877-647-4848

Claim Rejections

-  A rejection is an unclean claim that contains invalid or missing data elements required for acceptance of the claim in the claim process system.
-  Timely filing is not substantiated.
-  Rejected claims need corrected and submitted as a new claim.

Claim Rejections

-  EDI rejections require the provider to contact their clearinghouse and obtain a payer rejection report.
-  Paper to electronic mapping is available on:
<https://www.mhsindiana.com/providers/resources/guides-and-manuals.html>
-  MHS website tools :
 - Reject code listing
 - Refer to Top 10 Rejection Code Help Aid Document
<https://www.mhsindiana.com/content/dam/centene/mhsindiana/medicaid/pdfs/508-Top-10-Rejections-Edu-Doc.pdf>.

Claim Rejections



Medical

- **07** Invalid Subscriber/Member ID
- **09** Member Invalid on Date of Service
- **01** Invalid Provider ID Billing Physician (Provider State Crosswalk File)
- **08** Invalid Member Date of Birth
- **76** Original claim number required
- **40** Diagnosis code is missing
- **90** Invalid or Missing Modifier
- **B5** Missing/incomplete/Invalid CLIA
- **77** Invalid Claim Type
- **A3** Claim exceeded the maximum 97 service line limit







Behavioral Health

- **09** Member Invalid on Date of Service
- **07** Invalid Subscriber/Member ID
- **08** Invalid Member Date of Birth
- **01** Invalid Provider ID Billing Physician (Provider State Crosswalk File)
- **76** Original claim number required
- **40** Diagnosis code is missing
- **31** Invalid Service Procedure code
- **A3** Claim exceeded the maximum 97 service line limit

MHS Provider Claims Issue Resolution Process

Provider Claims Issue Resolution

PROCESS

-  Level 1: Informal Claims Dispute Online or with Medical Claim Dispute/Appeal form
-  Level 2: Formal Claim Dispute –Administrative Claim Appeal Online or with Medical Claim Dispute/Appeal form
-  Level 3: Arbitration
-  Please note, this is different than an Authorization appeal. A claim appeal cannot change a denied authorization status. To change authorization status, you must appeal the denied authorization.

Claim Dispute/Appeal Form – Medical and Behavioral Health



Medical Claims Address:
Managed Health Services
PO Box 3000
Attn: Appeals Department
Farmington, MO 63640-3800



Behavioral Health Claims Address:
Managed Health Services BH
Appeals
PO Box 6000
Attn: Appeals Department
Farmington, MO 63640-3809

<https://www.mhsindiana.com/content/dam/centene/mhsindiana/medical/pdfs/508-MHS-Dispute-Appeal-form.pdf>



DO NOT USE THIS FORM FOR MEDICAL NECESSITY APPEALS.

Medical Claim Dispute/Appeal Form

This form is not required but available to assist in submitting an informal dispute/appeal.

____ 1st Level (Informal Dispute/Reconsideration)
____ 2nd Level (Appeal) – if you are not satisfied with resolution of informal dispute

This form must be completed in its entirety. In order to consider your request, you must provide an explanation of your appeal and submit supporting documentation for the dispute/appeal. Without sufficient documentation, the request cannot be reviewed and the original determination will be upheld.

Provider Name	Provider Tax ID
Provider NPI	Date of last Explanation of Payment
MHS Claim Number *	Dates of Service *
Member Name *	Member ID *

* Required fields

Where more than one of claim number, DOS, member name, or member ID applies for the same appeal reason, please include this information as an attachment.

Reason for the appeal:

- ☐ Claim was denied for no authorization, but authorization number _____ was obtained.
- ☐ Claim was denied for no authorization, but no authorization is required for this service.
- ☐ Claim was denied for no authorization, however authorization was not obtained due to member's eligibility or medical condition.
- ☐ Claims was denied for Member not eligible, but member was eligible on DOS (attach eligibility information).
- ☐ Claim was not paid per the terms of my contract with Managed Health Services (attach relevant reimbursement section).
- ☐ Claim denied as non-covered benefit (attach supporting documentation as proof the service is a covered benefit).
- ☐ Claim was denied "Past Timely Filing" (attach proof of timely filing).
 - ☐ Note: if the past timely filing deadline denial falls on a weekend or a holiday, the provider may request a reconsideration (see Reconsideration Request Form)
- ☐ Claim was paid the incorrect amount (include calculation of expected payment and supporting information).
- ☐ Claim denied based on Managed Health Services Payment policy (attach medical records to support services provided).
 - ☐ Note: Payment policies can be found at <https://www.mhsindiana.com/providers/resources/clinical-payment-policies.html>
- ☐ Other. Please explain (and provide supporting documentation): _____

Please ensure sufficient detail is provided to assist us in the review of your appeal.

Preferred submission via the Provider Portal: Informal disputes – currently available;
2nd level appeal – available online beginning in early 2021

Paper copies of the completed form and all attachments can be sent to:

Medical Claims: Managed Health Services PO Box 3000 Farmington, MO 63640-3800
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Behavioral Health Claims Managed Health Services BH Appeals PO Box 6000 Farmington, MO 63640-3809
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1-877-647-4848 | TTY: 1-800-743-3333 | [mhsindiana.com](https://www.mhsindiana.com)
Allwell from MHS | Ambetter from MHS | Healthy Indiana Plan (HIP) | Hoosier Care Connect | Hoosier Healthwise

1220.OS.PLT 1/21

Informal Claims Dispute or Objection Form

Level 1:



Submit all documentation supporting your objection.





Must be submitted via the Secure Web Portal or in writing within **60 calendar days** of receipt of the MHS Explanation of Payment (EOP) by using the Medical Claim Dispute/Appeal form.

- Requests received after day 60 will not be considered.
- Copies of original MHS EOP showing how the claims in question were processed.
- Copies of any subsequent MHS EOPs or other determinations on the claim(s) in question.
- Documentation of any previous attempt you have made to resolve the issue with MHS.
- Other documentation that supports your request for reprocessing or reconsideration of the claim(s).

Informal Claims Dispute or Objection Form



Level 1:

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


Informal Claims Dispute or Objection Form

Level 1:




Helpful Tips:

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

Provider Services Phone Requests & Web Portal Inquiries


 After the informal claims dispute (Level 1) has been submitted, for assistance or questions the provider can access the Provider Service Phone line, or Web Portal.

Provider Services Phone Requests & Web Portal Inquiries

-  After the informal claims dispute (Level 1) has been submitted, for assistance or questions, the provider can access the Provider Service Phone line or Web Portal. The inquiries will be logged and assigned a ticket number. Please keep this ticket number for your reference.
-  Phone: 1-877-647-4848; Provider Services 8 a.m. to 8 p.m.
-  Provider Web Portal:
<https://www.mhsindiana.com/providers/login.html>
 - Use the Messaging Tool.





Provider Services Phone Requests & Web Portal Inquiries

Helpful Tips:

-  Disputing multiple claim denials:
 - Provide the provider services rep or web portal team member with one claim number as an example of the specific denial.
 - **Communication is Key!**
 - Inform the rep you have a “claims research request” to review all claims for the specific denial reason.
 - State if this denial is happening for one or multiple practitioners within your group or clinic; (if multiple, provide your TIN)
 - Provide the MHS denial code and description found on the EOP.
 - Briefly describe why you are disputing this denial or seeking research.






Formal Claim Dispute - Administrative Claim Appeal

Level 2

-  Level 2 is a Formal Claim Dispute, Administrative Claim Appeal.
-  In the event the provider is not satisfied with the informal claim dispute/objection resolution, the provider may file an administrative claim appeal. The appeal must be filed within 60 calendar days from receipt of the informal dispute resolution notice.
-  An administrative claim appeal must be submitted via the Secure Portal or in writing by using the Medical Claim Dispute/Appeal form with an explanation including any specific details which may justify reconsideration of the disputed claim. The appeal clearly marked on the form as Level 2.
-  See the MHS Provider Manual Chapter 5 Claims Administrative Reviews and Appeals for more information.
<https://www.mhsindiana.com/content/dam/centene/mhsindiana/medicaid/pdfs/508-Provider-Manual-2021.pdf>




Arbitration

Level 3:

-  Level 3 is a part of the formal MHS Provider Claims dispute process.
-  In the event a provider is not satisfied with the outcome of the administrative claim appeal process (Level 2), the provider may request arbitration. Claims with similar issues from the same provider may be grouped together for the purpose of requesting arbitration.
-  To initiate arbitration, the provider should submit a written request to MHS on company letterhead. The request must be postmarked no later than 60 calendar days after the date the provider received MHS' decision on the administrative claim appeal.
-  Arbitration Requests need to be mailed to,
MHS Arbitration
550 N. Meridian Street, Suite 101
Indianapolis, IN 46204
-  See the MHS Provider Manual Chapter 5 Claims Administrative Reviews and Appeals for more information.
<https://www.mhsindiana.com/content/dam/centene/mhsindiana/medicaid/pdfs/508-Provider-Manual-2021.pdf>

Additional Claim Assistance

Provider Relations Regional Mailboxes

-  If all claim denials are upheld after following the dispute processes and the Provider has not received resolution by calling Provider Services or utilizing the secure messaging on the portal, please contact the Provider Relations team through the claim issues mailbox assigned to your region.
-  Issues will be logged by the internal Provider Relations team and providers will receive a response email with next steps and any assigned reference numbers. Response to incoming email can take 2-4 weeks depending on workload.
-  Please do not email your Provider Partnership Associate directly as this may delay the time in getting a response due to their travel.

Provider Relations Regional Mailboxes

Helpful Tips:



Please submit the following information to the provider relations regional mailbox (attach spreadsheet if multiple claims but below fields must be included)

- Issue Reference Number(s)
- TIN
- Group/Facility Name
- Practitioner Name & NPI
- Member Name and RID Number
- Product (Medicaid/Ambetter/Allwell)
- Claim Number(s)
- DOS or DOS Range if multiple denials
- Related Prior Authorization Numbers (this is key if issue involves claims denied for no authorization)
- Provider reason for dispute

Provider Relations Regional Mailboxes




Regional Mailboxes

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

Portal Functionality

Secure Web Portal Login or Registration



[Home](#)
[Find a Provider](#)
[Portal Login](#)
[Events](#)
[Careers](#)
[Contact Us](#)

Contrast ☒ On ☐ Off a a a language

FOR MEMBERS

FOR PROVIDERS

GET INSURED

FOR PROVIDERS

Login

Enrollment and Updates +
Prior Authorization +
Dental Providers
Pharmacy +
Opioid Resources
Behavioral Health Providers +
Provider Resources +
QI Program +
Provider News
Email Sign Up
Coronavirus Information +

Portal Login

Create your own online account today!

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

Creating an account is free and easy.

By creating a MHS account, you can:

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

PORTAL TRAINING GUIDES -

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

Please note that Clear Claim Connection does not provide an all inclusive listing of claim edits. MHS does utilize additional prepayment review edits in keeping with NCCI procedures and guidelines.

Registration Help

If you are having trouble with your registration, you may need to submit a non-par set-up form. Visit our [Become a Provider](#) page to get started. For further assistance, you can call Provider Services at 1-877-647-4848 or see our [Account Registration Guide \(PDF\)](#).

Vision and Dental Providers

[Vision Provider Portal Login](#)
[Dental Provider Portal Login](#)

- Verify member eligibility
- View member benefits

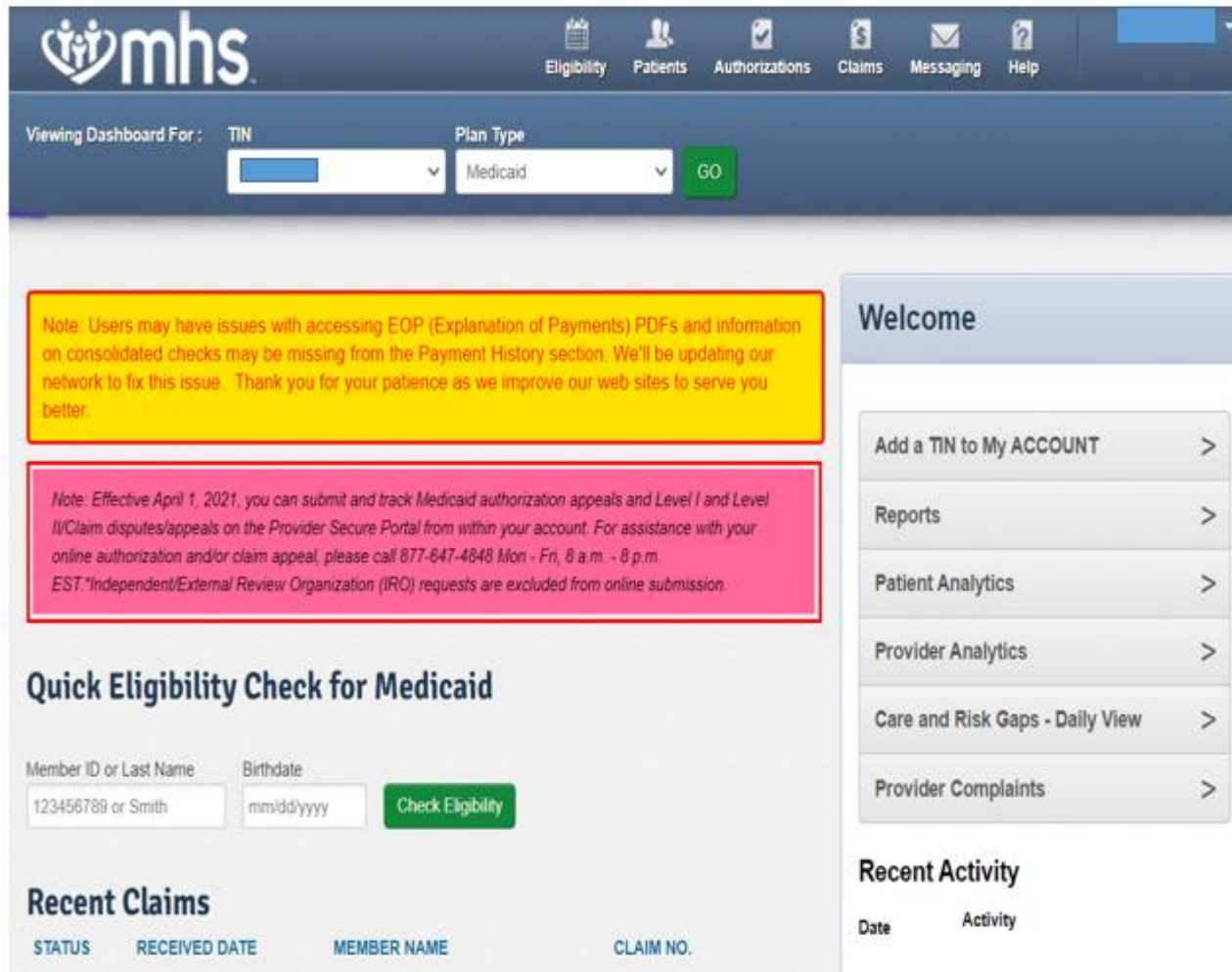
Secure Provider Portal

Login/Register

Provider Email Sign Up

Sign Up

Homepage – MHS (Medicaid)



The screenshot shows the MHS (Medicaid) homepage dashboard. At the top, there is a navigation bar with the MHS logo and several icons for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below the navigation bar, there is a section for "Viewing Dashboard For:" with a TIN dropdown menu and a Plan Type dropdown menu set to "Medicaid". A green "GO" button is next to the Plan Type dropdown.

Below the navigation bar, there are two informational boxes. The first is a yellow box with a red border containing a note about EOP (Explanation of Payments) PDFs. The second is a pink box with a red border containing a note about Medicaid authorization appeals and claim disputes.

Below the informational boxes, there is a section titled "Quick Eligibility Check for Medicaid". It includes a form with fields for "Member ID or Last Name" (containing "123456789 or Smith") and "Birthdate" (containing "mm/dd/yyyy"). A green "Check Eligibility" button is next to the form.

Below the eligibility check section, there is a section titled "Recent Claims". It includes a table with columns for STATUS, RECEIVED DATE, MEMBER NAME, and CLAIM NO.

On the right side of the dashboard, there is a "Welcome" section with a list of links: "Add a TIN to My ACCOUNT", "Reports", "Patient Analytics", "Provider Analytics", "Care and Risk Gaps - Daily View", and "Provider Complaints". Below this is a "Recent Activity" section with columns for Date and Activity.

Quick Links

[Provider Resources](#)

[Member Management Forms](#)

Notification of Pregnancy (NOP): NOP must be accessed through the IHCP Provider Healthcare Portal and electronically submitted. If the member is not enrolled with Medicaid, the NOP option does not display. You must create a login and password in order to access the NOP form through the Provider Healthcare Portal.

Learn more about submitting a NOP through the [IHCP Provider Healthcare Portal](#).

Go to the [IHCP Provider Healthcare Portal](#)

Please note: Claims information is updated every 24 hours.


For HIP Pharmacy information and PDLs, please visit the [Pharmacy](#) page.

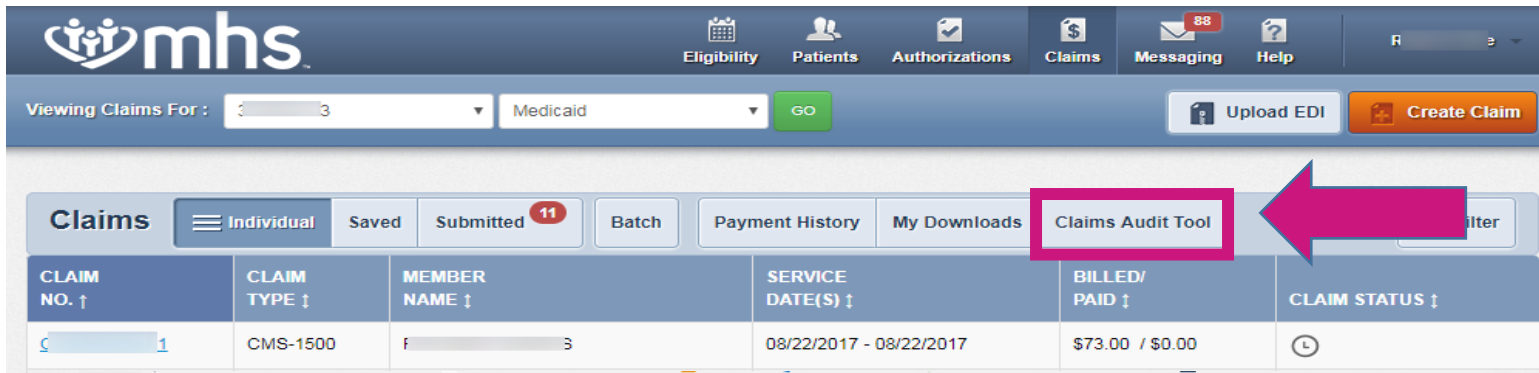
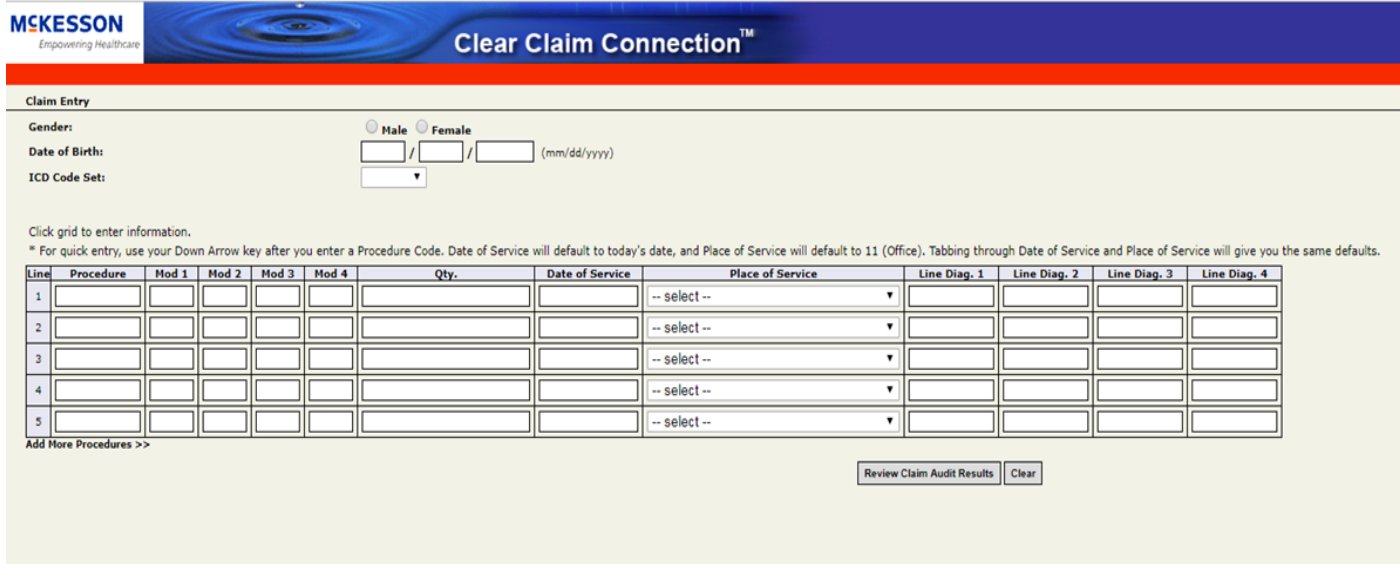
Go Paperless

Empower your practice with electronic settlement.
Now you can receive EFT's and ERA's without investing in new technology and without changes to current systems.

[PlaySpan Site](#)

Claims Audit Tool

 The Clear Claim Connection screen appears, allowing you to enter the Procedure Code, Quantity, Modifiers, Date and Place of Service, and Diagnosis for a claim proactively before you submit or retroactively after you submit.

Claims



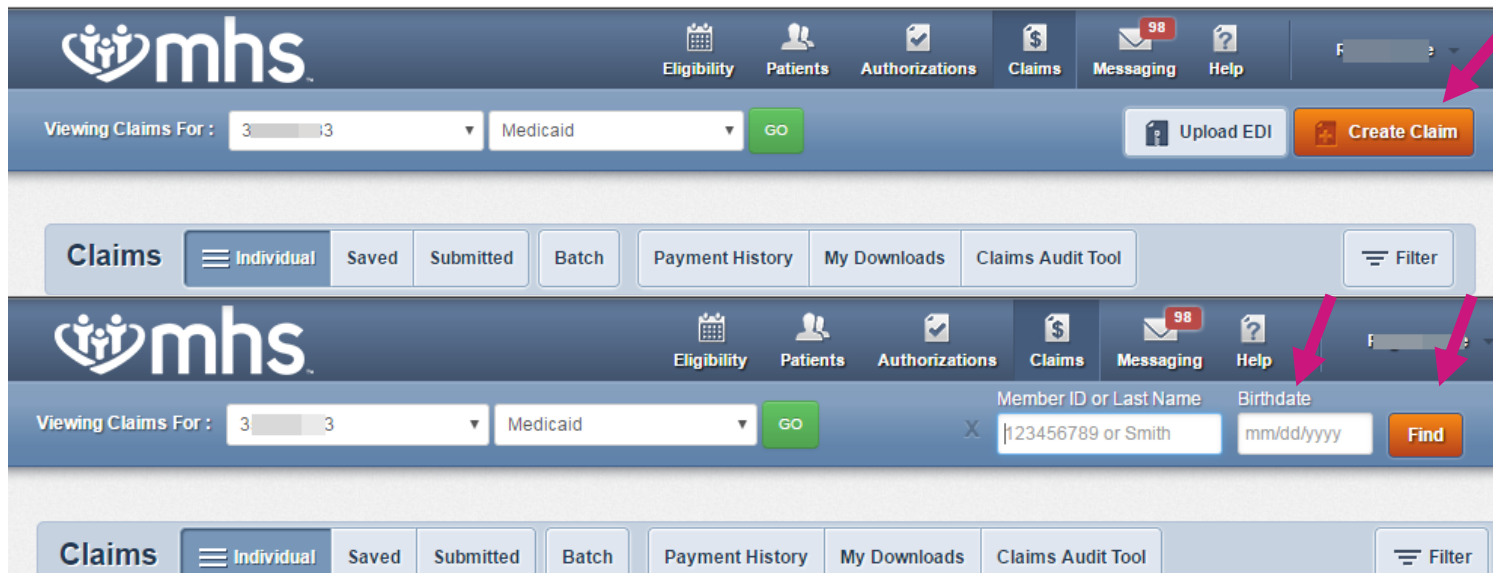
Web Portal Claims Functionalities:

- **Submit** new claim.
- **Review claims** information on file for a patient.
- **Correct** claims.
- **View payment history.**



Submit a New Claim:

- Click **Create Claim** and enter **Member ID** and **Birthdate**

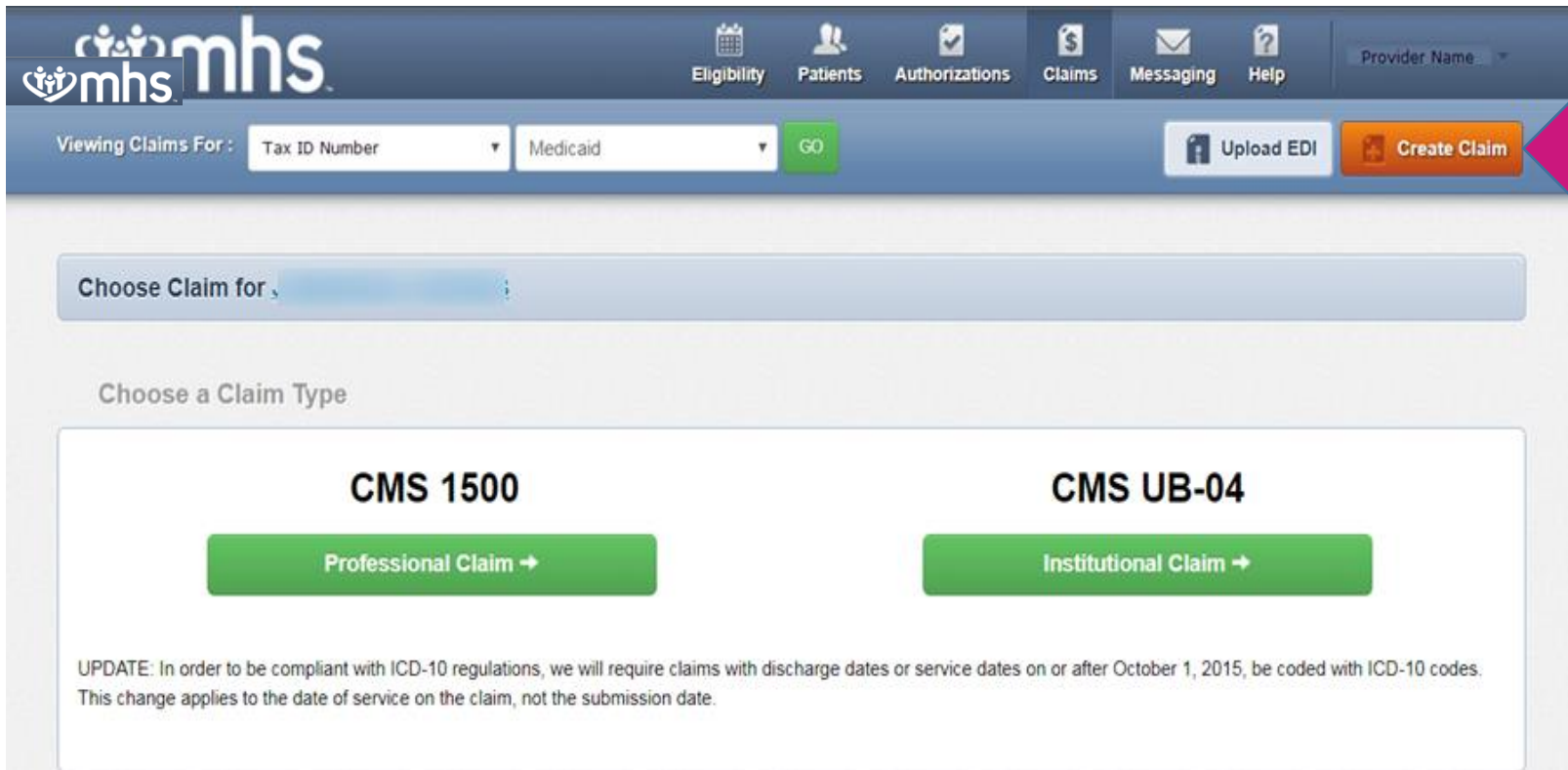


The screenshot displays the mhs web portal interface. At the top, there is a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, Messaging (with a 98 notification), and Help. Below this is a section for 'Viewing Claims For' with a dropdown menu set to '3' and a 'Medicaid' filter,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

Claim Submission

Choose the Claim Type

- **Professional or Institutional** claim submission



The screenshot shows the mhs Claims Submission interface. At the top, there is a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below this, there is a section for "Viewing Claims For:" with dropdown menus for "Tax ID Number" and "Medicaid", and a "GO" button. To the right of this section are buttons for "Upload EDI" and "Create Claim". A large pink arrow points to the "Create Claim" button. Below the navigation bar, there is a section titled "Choose Claim for:" with a dropdown menu. Underneath, there is a section titled "Choose a Claim Type" with two options: "CMS 1500" and "CMS UB-04". Each option has a corresponding green button: "Professional Claim →" for CMS 1500 and "Institutional Claim →" for CMS UB-04. At the bottom, there is an "UPDATE" notice regarding ICD-10 regulations.

Viewing Claims For: Tax ID Number Medicaid GO Upload EDI Create Claim

Choose Claim for:

Choose a Claim Type


CMS 1500
Professional Claim →

CMS UB-04
Institutional Claim →

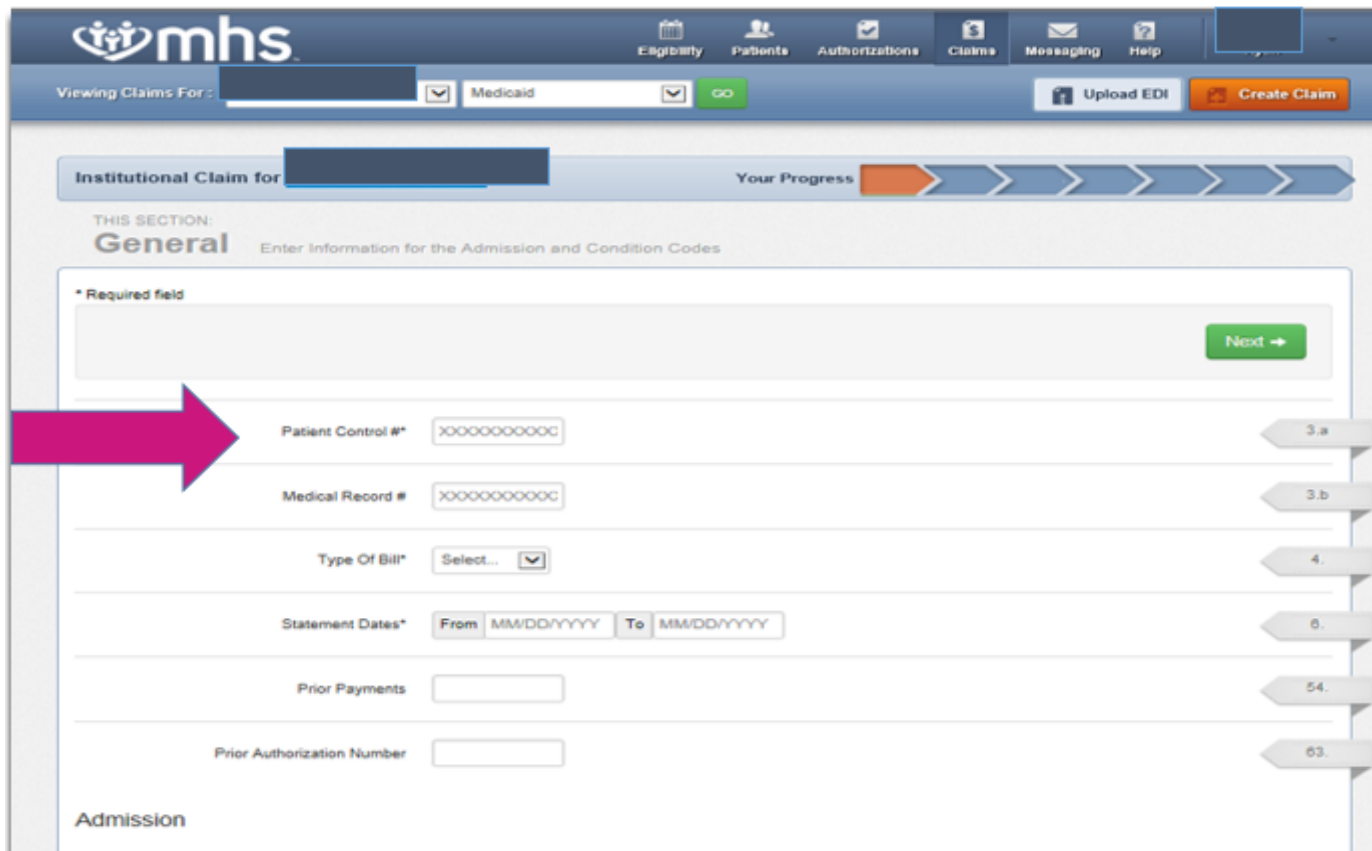
UPDATE: In order to be compliant with ICD-10 regulations, we will require claims with discharge dates or service dates on or after October 1, 2015, be coded with ICD-10 codes. This change applies to the date of service on the claim, not the submission date.

Facility Billing

UB-04 Billing

 In the **General Info** section, populate the **Patient's Control Number** and other information related to the patient's condition by typing into the appropriate fields.


 Click **Next**.

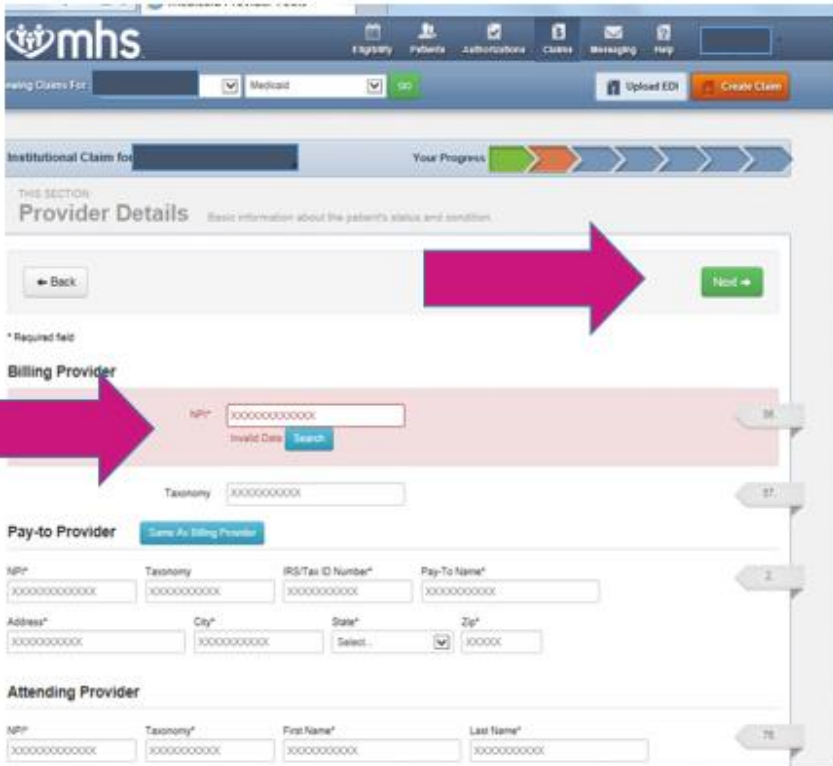


The screenshot shows the mhs UB-04 Billing form. The top navigation bar includes links for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. The main header displays "Viewing Claims For:" followed by a dropdown menu set to "Medicaid" and a "GO" button. To the right are "Upload EDI" and "Create Claim" buttons. Below the header, a progress bar indicates the current step is "General". The "General" section is titled "Enter Information for the Admission and Condition Codes". A large pink arrow points to the "Patient Control #" field, which is marked as a required field. Other fields include "Medical Record #", "Type Of Bill" (a dropdown menu), "Statement Dates" (with "From" and "To" date pickers), "Prior Payments", and "Prior Authorization Number". A "Next" button is located at the top right of the form. On the right side of the form, there are numbered tabs for sections 3.a, 3.b, 4, 6, 54, and 63.

UB-04 Billing

 Add the **provider information**.

 Click **save** and click **next** to proceed



THIS SECTION: Provider Details Basic information about the patient's status and condition.

[← Back](#) [Next →](#)

* Required field

Billing Provider

NPI* Invalid Data [Search](#)

Taxonomy

Pay-to Provider [Same As Billing Provider](#)

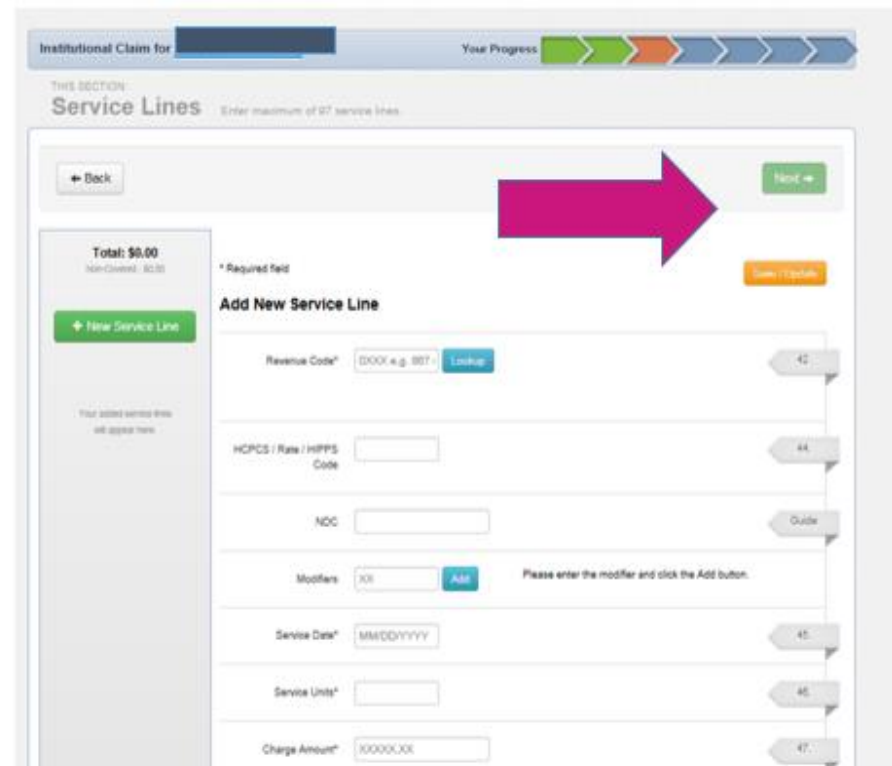
NPI* Taxonomy IRS/Tax ID Number* Pay-To Name*


Address* City* State* Zip*

Attending Provider

NPI* Taxonomy* First Name* Last Name*

 Click **Add New Service Line** and enter the service lines information.



Institutional Claim for **Your Progress** 

THIS SECTION: Service Lines Enter maximum of 27 service lines.

[← Back](#) [Next →](#) [Save / Update](#)

Total: \$0.00
Non-Covered: \$0.00

[+ New Service Line](#)

Your added service lines will appear here.

* Required field

Add New Service Line

Revenue Code* [Lookup](#) 42

HCPCS / Rate / HPPS Code 44

NOC Guide

Modifiers [Add](#) Please enter the modifier and click the Add button.

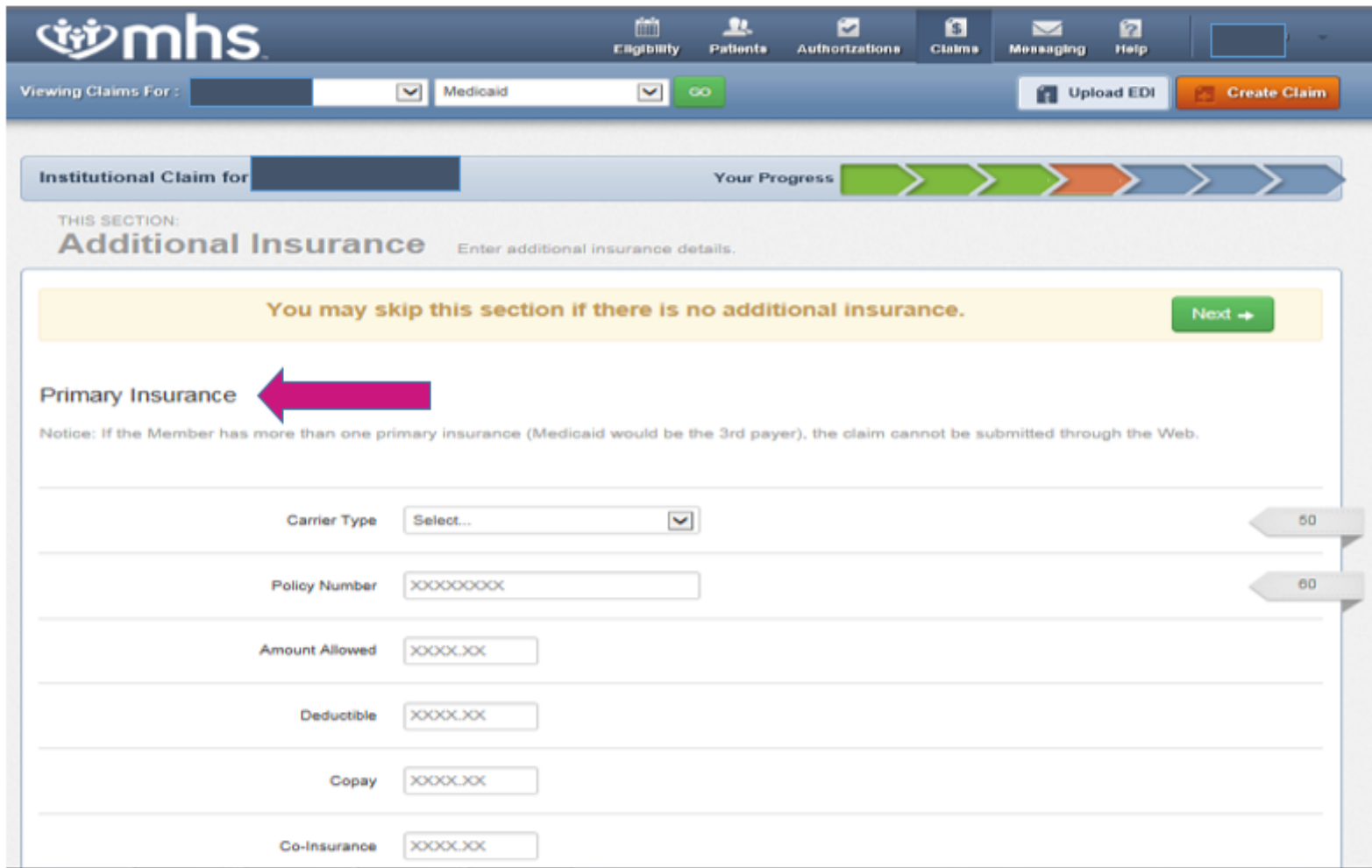
Service Date* 45

Service Units* 46

Charge Amount* 47

UB-04 Billing

Enter Additional Insurance (if applicable)



The screenshot shows the mhs UB-04 Billing interface. At the top, there's a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below this is a header area with a dropdown for 'Viewing Claims For' set to 'Medicaid' and a 'GO' button. To the right are 'Upload EDI' and 'Create Claim' buttons.

The main content area is titled 'Institutional Claim for' followed by a redacted ID. A progress bar shows the current step is 'Additional Insurance'. Below this, the section is titled 'Additional Insurance' with the instruction 'Enter additional insurance details.'.

A yellow banner states: 'You may skip this section if there is no additional insurance.' with a 'Next →' button.

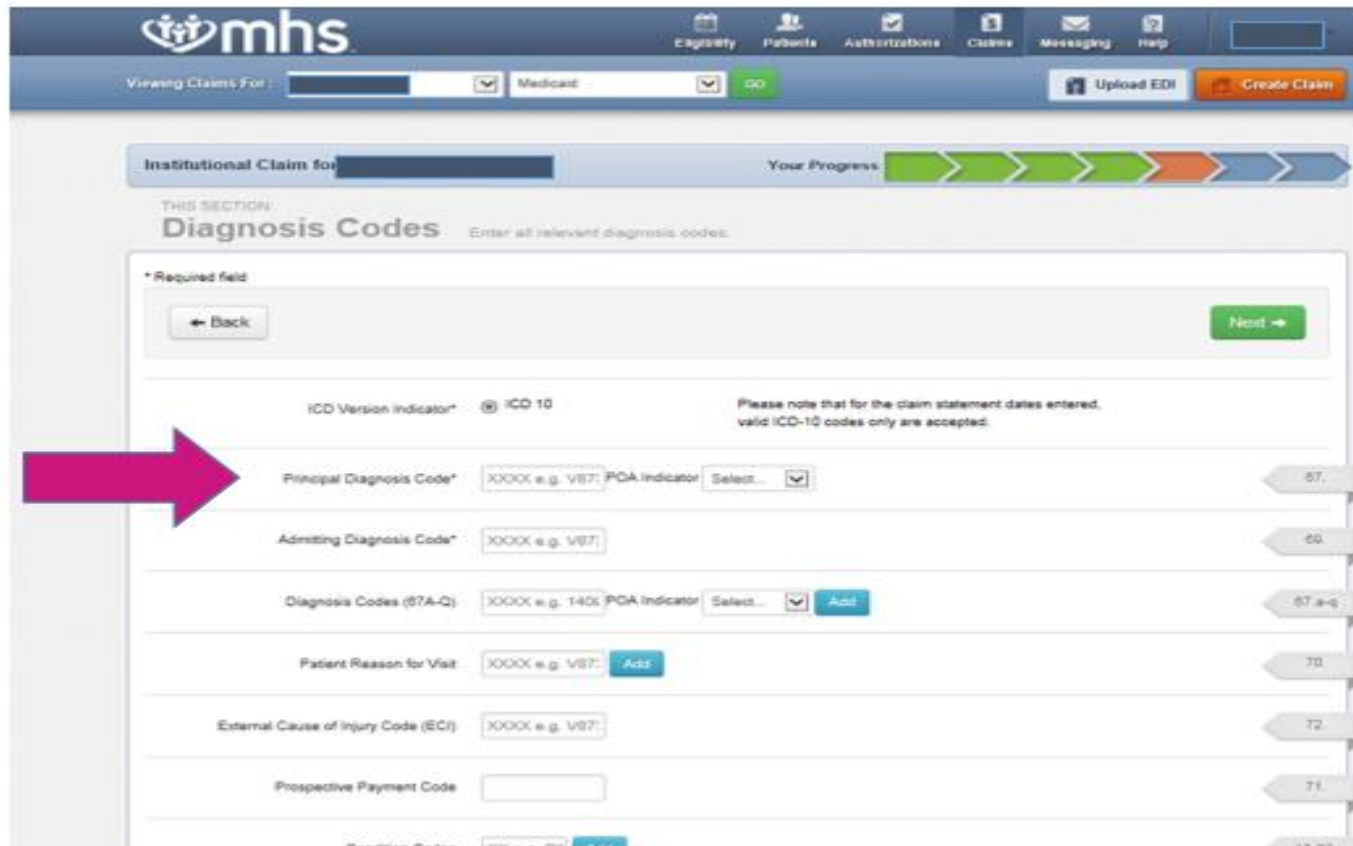
The 'Primary Insurance' section is highlighted with a pink arrow. It includes a notice: 'Notice: If the Member has more than one primary insurance (Medicaid would be the 3rd payer), the claim cannot be submitted through the Web.'.

Below the notice are several input fields for insurance details:

- Carrier Type: Select... (dropdown menu)
- Policy Number: XXXXXXXX
- Amount Allowed: XXXX.XX
- Deductible: XXXX.XX
- Copay: XXXX.XX
- Co-Insurance: XXXX.XX

On the right side of the form, there are two grey tabs labeled '50' and '60'.

Enter Diagnosis Codes (use Add button)



mhs | Eligibility | Patients | Authorizations | Claims | Messaging | Help

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

Institutional Claim for [] Your Progress []

THIS SECTION: **Diagnosis Codes** Enter all relevant diagnosis codes.

* Required field

[Back] [Next]

ICD Version Indicator* [ICD 10] Please note that for the claim statement dates entered, valid ICD-10 codes only are accepted.

Principal Diagnosis Code* [XXXX e.g. V87] POA Indicator [Select...] [BT]

Admitting Diagnosis Code* [XXXX e.g. V87] [BT]

Diagnosis Codes (S7A-Q) [XXXX e.g. 140] POA Indicator [Select...] [Add] [BT]

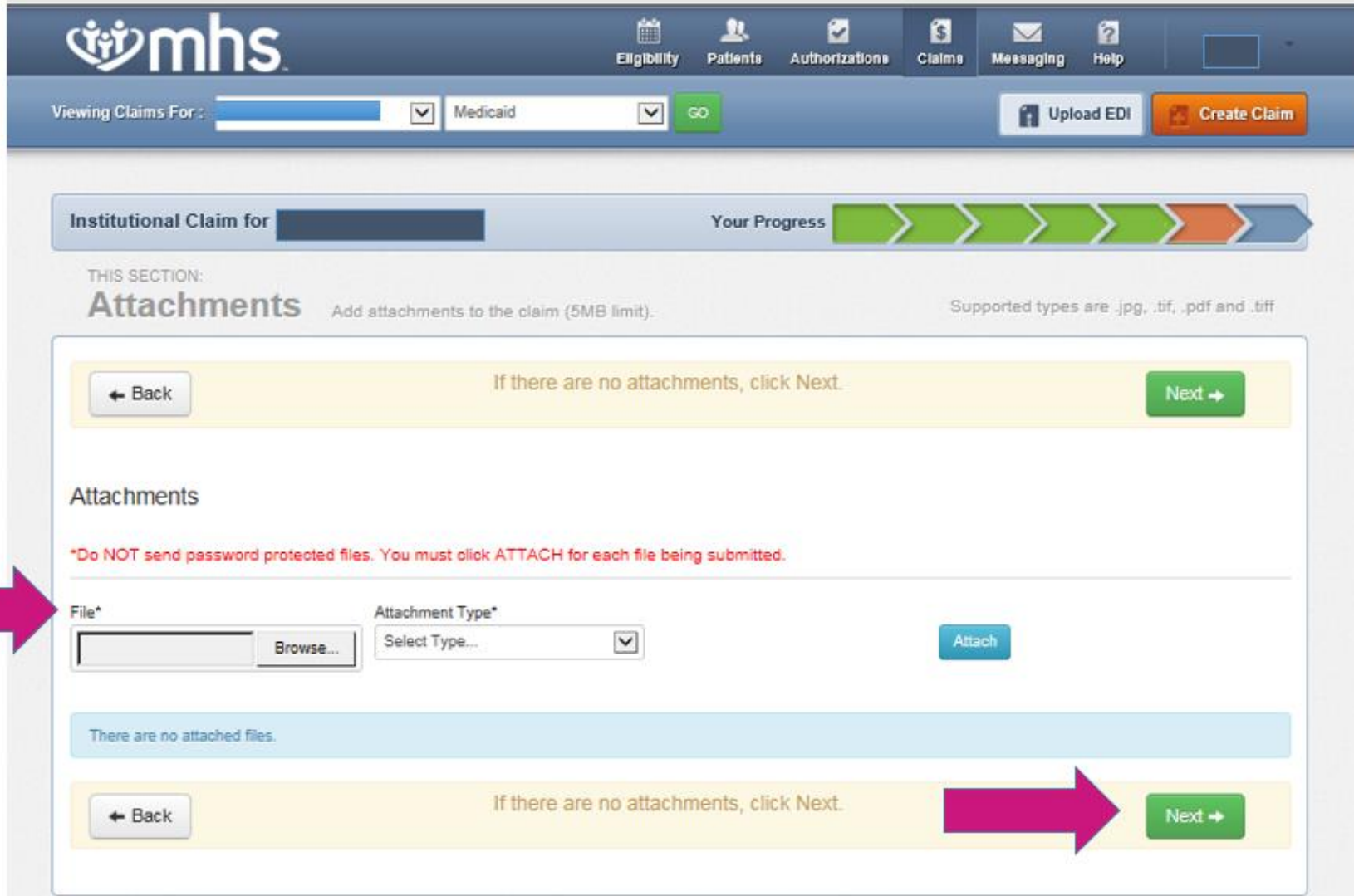
Patient Reason for Visit [XXXX e.g. V87] [Add] [BT]

External Cause of Injury Code (ECI) [XXXX e.g. V87] [BT]


Prospective Payment Code [] [BT]

Position Codes [] [Add] [BT]

Add Attachments (if applicable)



Viewing Claims For: Medicaid

Institutional Claim for Your Progress 

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

← Back If there are no attachments, click Next. Next →

Attachments

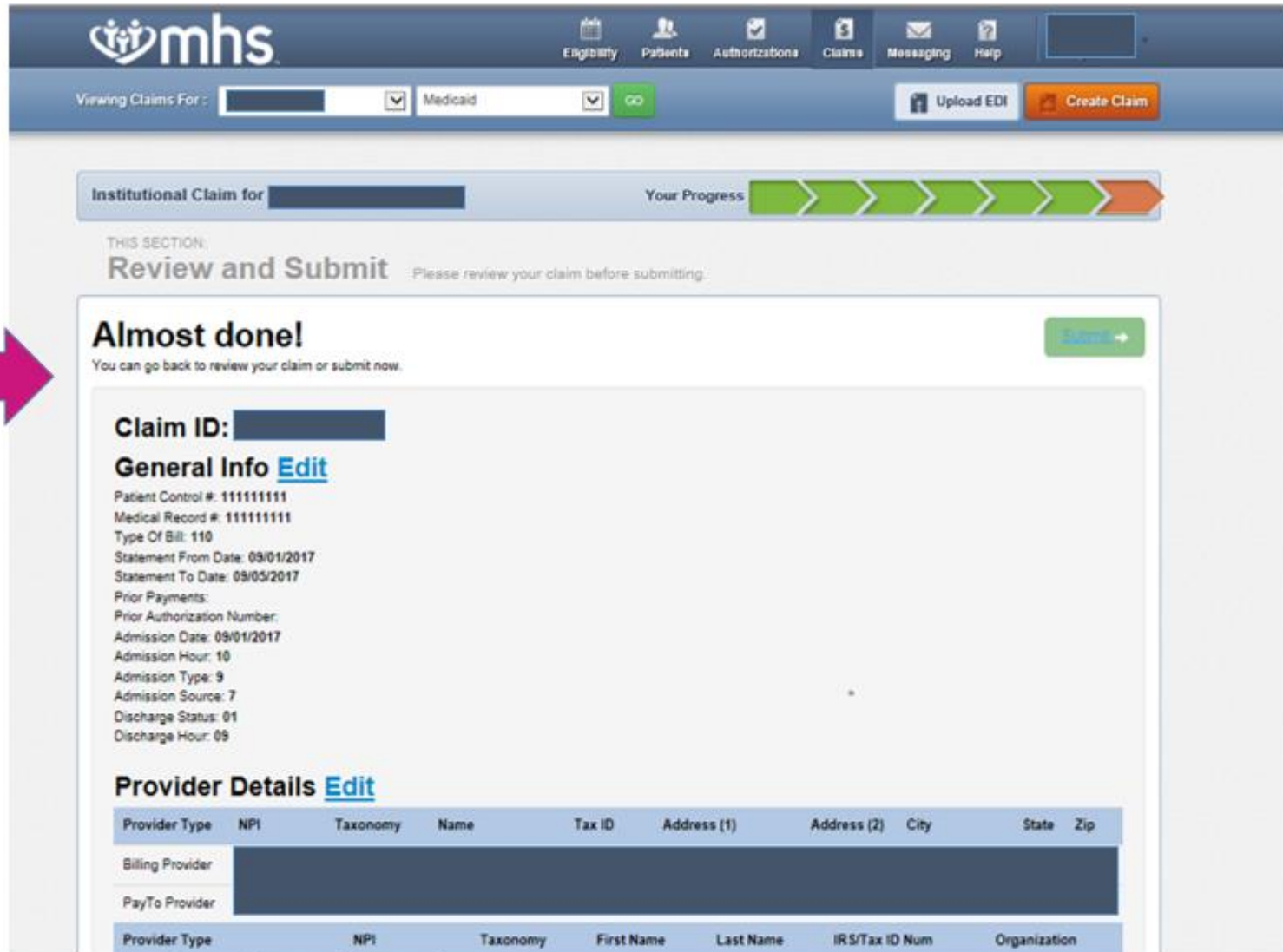
*Do NOT send password protected files. You must click ATTACH for each file being submitted.

File* Browse... Attachment Type*

There are no attached files.

← Back If there are no attachments, click Next. Next →

Review Claim and Submit



Almost done! [Submit](#)

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

Claim ID: [Redacted]

General Info [Edit](#)

Patient Control #: 111111111
 Medical Record #: 111111111
 Type Of Bill: 110
 Statement From Date: 09/01/2017
 Statement To Date: 09/05/2017
 Prior Payments:
 Prior Authorization Number:
 Admission Date: 09/01/2017
 Admission Hour: 10
 Admission Type: 9
 Admission Source: 7
 Discharge Status: 01
 Discharge Hour: 09

Provider Details [Edit](#)

Provider Type	NPI	Taxonomy	Name	Tax ID	Address (1)	Address (2)	City	State	Zip
Billing Provider	[Redacted]								
PayTo Provider	[Redacted]								


Provider Type	NPI	Taxonomy	First Name	Last Name	IRS/Tax ID Num	Organization
[Redacted]						

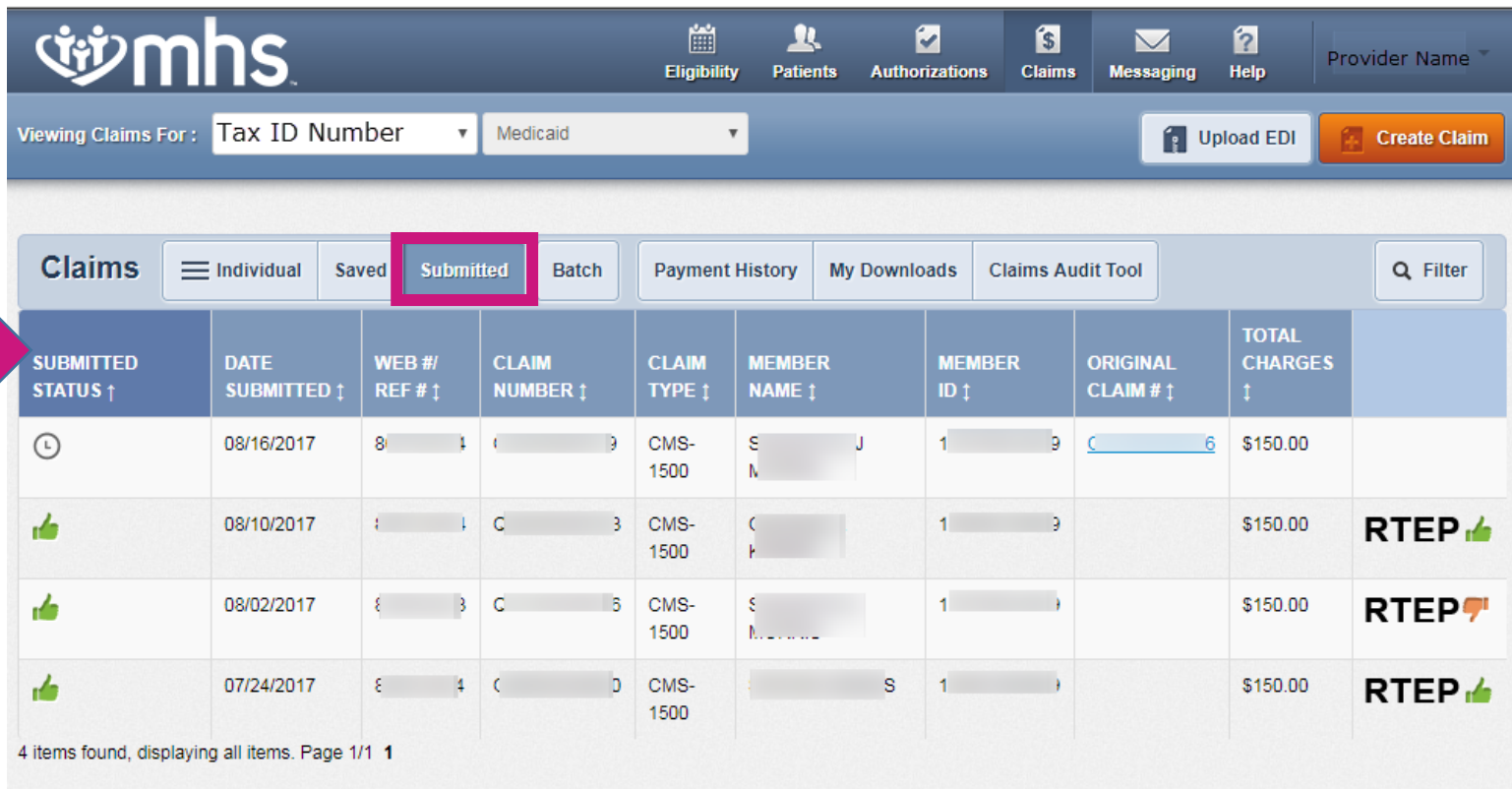
Web Portal Claim and Payment Review

Submitted Claims

 The **Submitted** tab will only display claims created via the MHS portal:

- **Paid** is a **green** thumbs up.
- **Denied** is an **orange** thumbs down.
- **Pending** is a clock.

 **RTEP** claims also show if eligible (i.e. line 3 was submitted, but was not eligible for RTEP).



Viewing Claims For: Tax ID Number Medicaid Upload EDI Create Claim

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

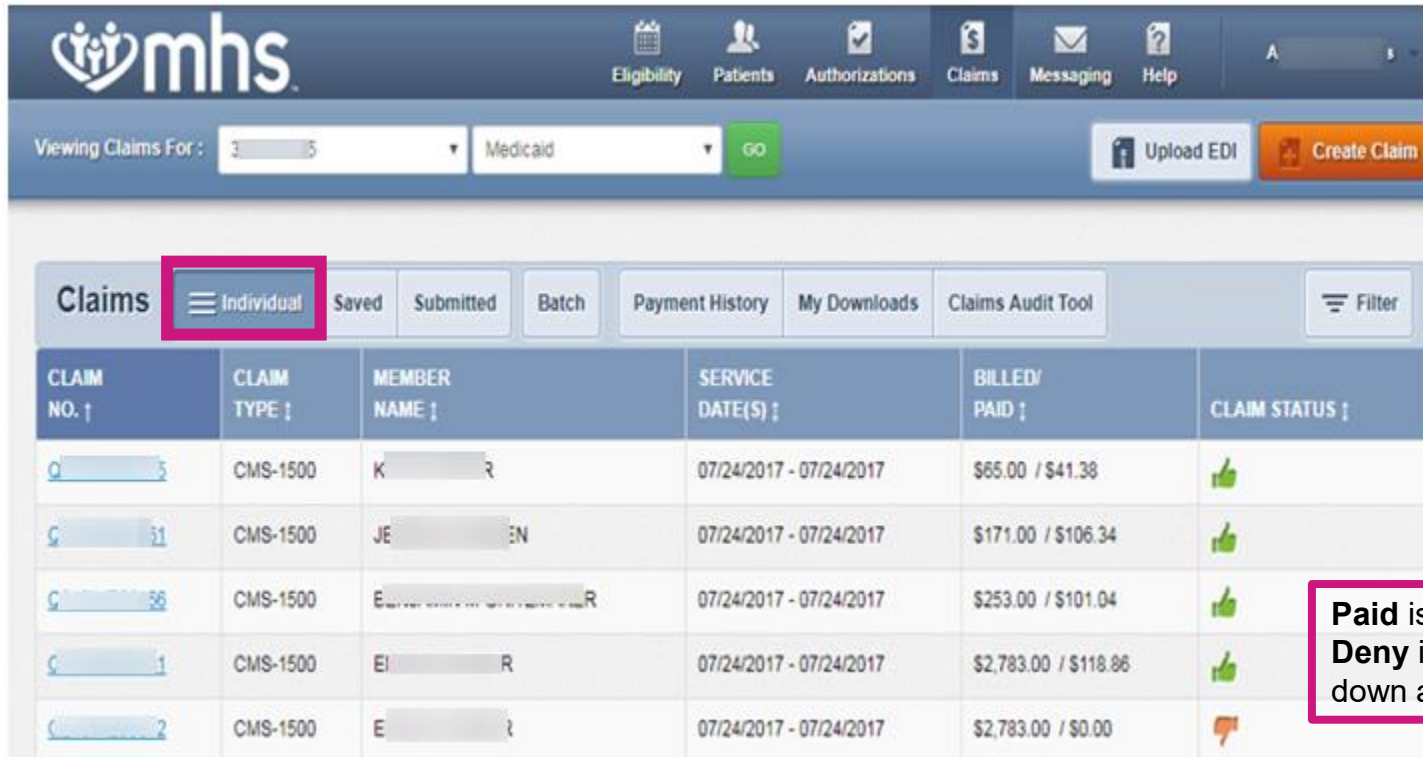
SUBMITTED STATUS ↑	DATE SUBMITTED ↑	WEB #/ REF # ↑	CLAIM NUMBER ↑	CLAIM TYPE ↑	MEMBER NAME ↑	MEMBER ID ↑	ORIGINAL CLAIM # ↑	TOTAL CHARGES ↑	
🕒	08/16/2017	8		CMS-1500	S J	1	6	\$150.00	
👍	08/10/2017		C	CMS-1500	C	1		\$150.00	RTEP 👍
👍	08/02/2017		C	CMS-1500	S	1		\$150.00	RTEP 🗑️
👍	07/24/2017		C	CMS-1500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






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

Individual Claims

 On the **Individual** tab, submitted using paper, portal or clearing house:

- View the Claim No, Claim Type, Member Name, Service Date(s), Billed/Paid, and Claim Status



CLAIM NO. ↑	CLAIM TYPE ↑	MEMBER NAME ↑	SERVICE DATE(S) ↑	BILLED/ PAID ↑	CLAIM STATUS ↑
Q 3	CMS-1500	K R	07/24/2017 - 07/24/2017	\$65.00 / \$41.38	
G 31	CMS-1500	JE EN	07/24/2017 - 07/24/2017	\$171.00 / \$106.34	
G 36	CMS-1500	E R	07/24/2017 - 07/24/2017	\$253.00 / \$101.04	
G 1	CMS-1500	E R	07/24/2017 - 07/24/2017	\$2,783.00 / \$118.86	
G 2	CMS-1500	E	07/24/2017 - 07/24/2017	\$2,783.00 / \$0.00	

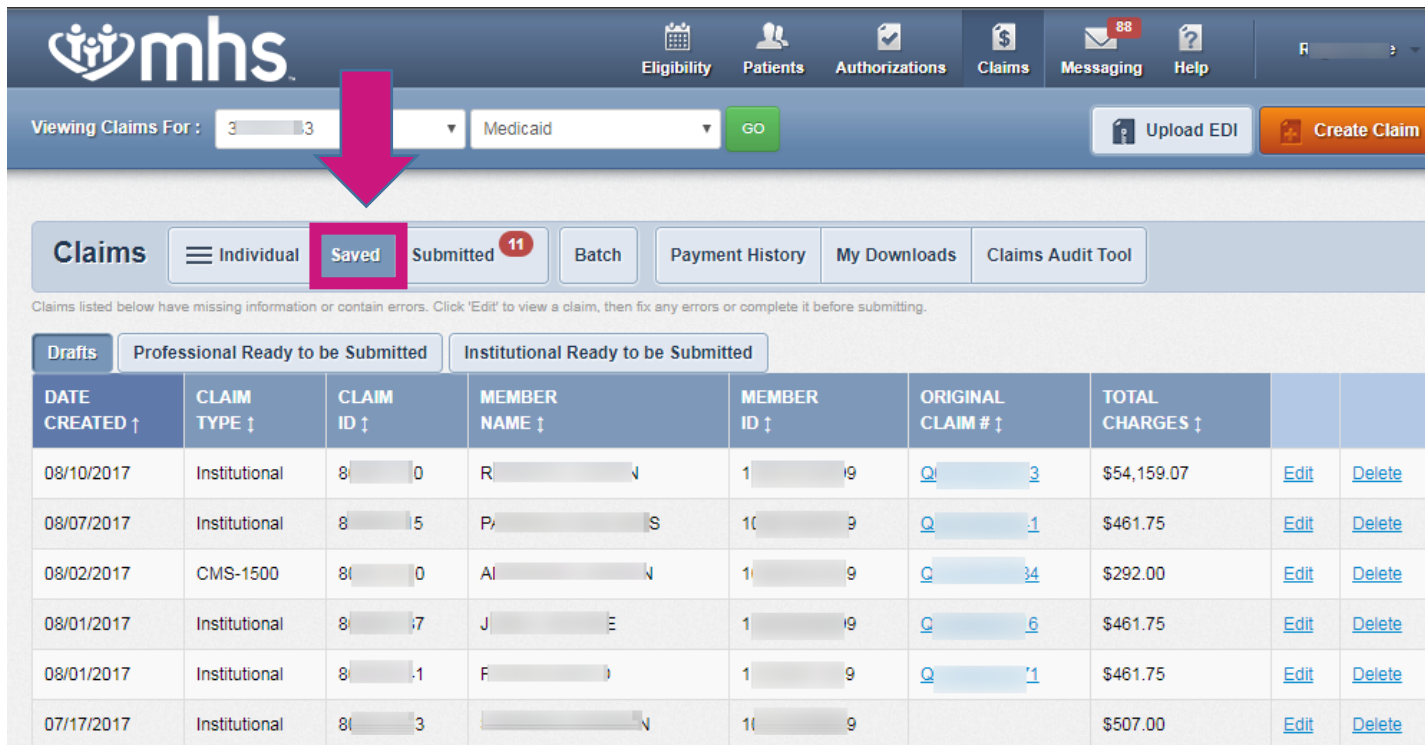
Paid is a green thumbs up,
Deny is an orange thumbs down and a clock is **Pending**.

Saved Claims



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

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



Viewing Claims For : 3 3 Medicaid GO Upload EDI Create Claim

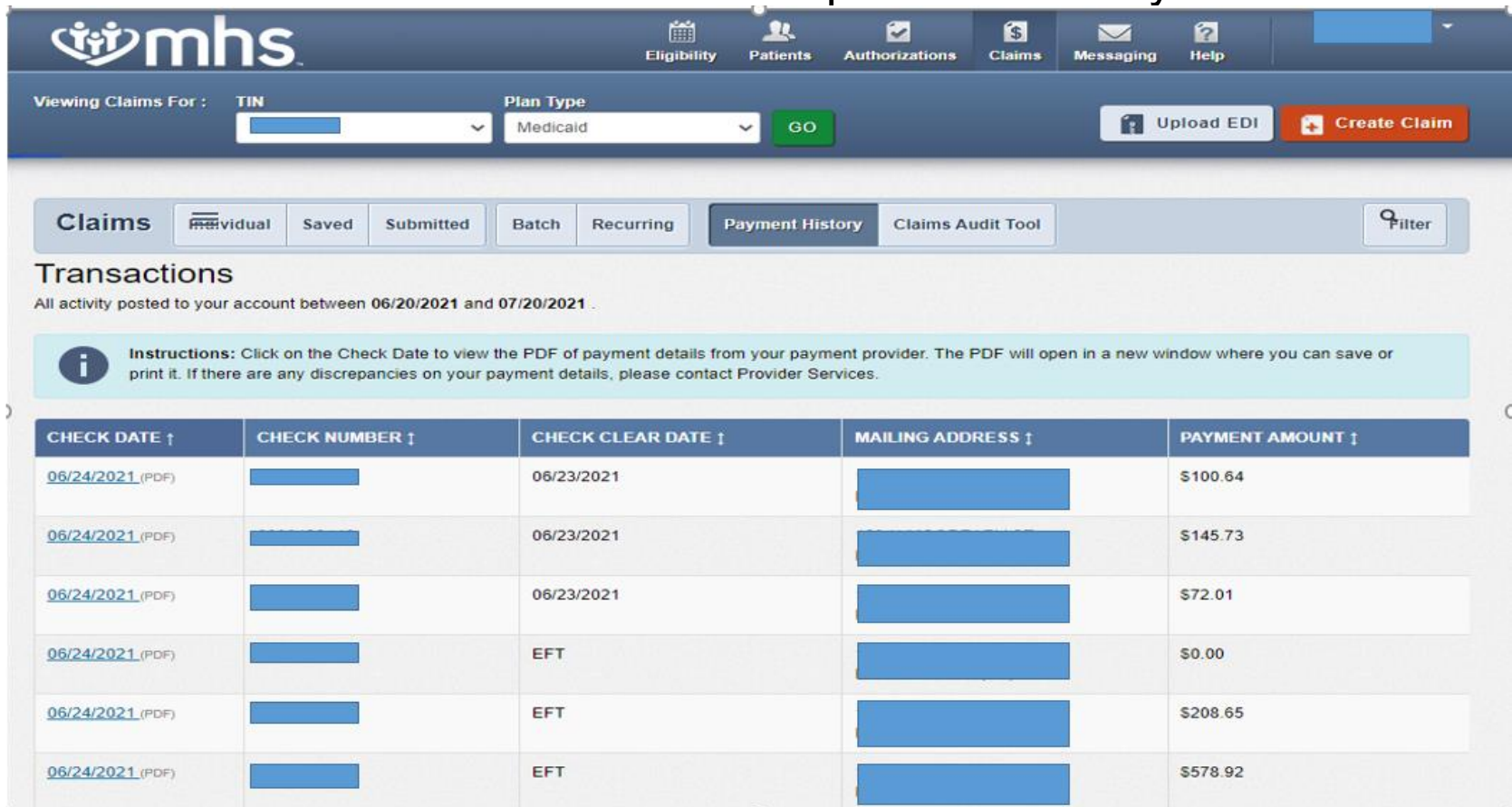
Claims Individual **Saved** Submitted 11 Batch Payment History My Downloads Claims Audit Tool

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

DATE CREATED ↑	CLAIM TYPE ↑	CLAIM ID ↑	MEMBER NAME ↑	MEMBER ID ↑	ORIGINAL CLAIM # ↑	TOTAL CHARGES ↑		
08/10/2017	Institutional	8100	R...	109	Q...3	\$54,159.07	Edit	Delete
08/07/2017	Institutional	815	P...	109	Q...1	\$461.75	Edit	Delete
08/02/2017	CMS-1500	8100	A...	109	Q...34	\$292.00	Edit	Delete
08/01/2017	Institutional	817	J...	109	Q...6	\$461.75	Edit	Delete
08/01/2017	Institutional	811	F...	109	Q...1	\$461.75	Edit	Delete
07/17/2017	Institutional	813	...	109		\$507.00	Edit	Delete

Payment History

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

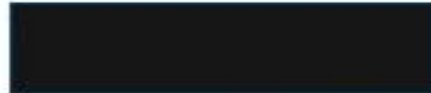


The screenshot shows the MHS web portal interface. At the top, there's a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below this, a section for 'Viewing Claims For:' includes a TIN dropdown, a Plan Type dropdown set to 'Medicaid', and a 'GO' button. To the right are buttons for 'Upload EDI' and 'Create Claim'. A secondary navigation bar contains tabs for 'Claims', 'Individual', 'Saved', 'Submitted', 'Batch', 'Recurring', 'Payment History' (which is selected), and 'Claims Audit Tool'. A 'Filter' button is also present. Below the tabs, the 'Transactions' section displays a message: 'All activity posted to your account between 06/20/2021 and 07/20/2021'. An information box provides instructions: 'Click on the Check Date to view the PDF of payment details from your payment provider. The PDF will open in a new window where you can save or print it. If there are any discrepancies on your payment details, please contact Provider Services.' The main content is a table with five columns: CHECK DATE ↑, CHECK NUMBER ↑, CHECK CLEAR DATE ↑, MAILING ADDRESS ↑, and PAYMENT AMOUNT ↑. The table lists six transactions, all dated 06/24/2021, with varying payment amounts ranging from \$0.00 to \$578.92.



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

Provider EOP

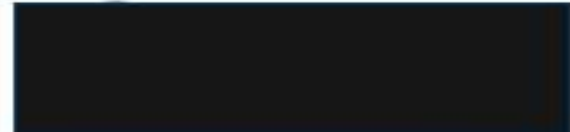
PROBABILITY



Electronic Service Requested



606 0.7648 AV 0.386 5-DIGIT 30374



PROBABILITY



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

STATEMENT TOTAL

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

Remittance Advice and Explanation of Payment

Insured Name: [REDACTED]					Member ID: [REDACTED]					Claim No: [REDACTED]				
Patient Name: [REDACTED]					PCN: [REDACTED]					Carrier: DE		Provider ID: [REDACTED]		
Service Provider: [REDACTED]					LNPI: [REDACTED]					Group: [REDACTED]				
Serv	Dates	Procedure	Modifiers	Days Ctr/Qty	Charged	Allowed	Deduct / Copay	Coinsur/ Discount	Interest	Med Allow/ Med Paid	TPP	Denied	Payment Codes	Payment
0100	[REDACTED]	[REDACTED]	G5	1.00	6388.16	263.75	.00	.00 5.28	.00	.00	.00	.00	A0 SR 30	258.47
0200	[REDACTED]	[REDACTED]	G5	1.00	6388.16	263.75	.00	.00 5.28	.00	.00	.00	.00	A0 SR 30	258.47
0300	[REDACTED]	[REDACTED]	G5	1.00	6388.16	263.75	.00	.00 5.28	.00	.00	.00	.00	A0 SR 30	258.47
0400	[REDACTED]	[REDACTED]	G5	1.00	6388.16	263.75	.00	.00 5.28	.00	.00	.00	.00	A0 SR 30	258.47
0500	[REDACTED]	[REDACTED]	G5	1.00	6388.16	263.75	.00	.00 5.28	.00	.00	.00	.00	A0 SR 30	258.47
0600	[REDACTED]	[REDACTED]	G5	1.00	6388.16	263.75	.00	.00 5.28	.00	.00	.00	.00	A0 SR 30	258.47
0700	[REDACTED]	[REDACTED]	G5	1.00	6388.16	263.75	.00	.00 5.28	.00	.00	.00	.00	A0 SR 30	258.47

EFTs and ERAs

PaySpan Health



Web based solution for:

- Electronic Funds
- Transfers (EFTs) and Electronic Remittance Advices (ERAs)



One year retrieval of remittance advice.





Provided at no cost to providers and allows online enrollment.



Register at [Payspan | Healthcare Payment Reimbursement Solutions](https://payspan.healthcarepaymentreimbursement.com)



For questions call 1-877-331-7154.

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

- Call 1-877-331-7154 for your unique registration code. Then, visit payspanhealth.com and click **Register**.
- Enter your registration code and click **Submit**.
- Enter your PIN, TIN or EIN, and NPI. Then, click **Start Registration**.
- Populate the requested Personal Information. Click **Next**.
- Designate an account for fund transfers by completing the required fields. Click **Next**.
- Verify your information and check the box to agree to the service agreement. Then, click **Confirm**.
- Within a few business days, you will receive a deposit of less than \$1 from PaySpan. Then, follow these steps to complete registration:

 - ▶ Contact your financial institution to obtain the amount deposited by PaySpan.
 - ▶ Log into PaySpan, and click **Payments**.
 - ▶ Click the **Account Verification** link on the left side of the screen.
 - ▶ Enter the amount of the deposit in this format: 0.00.

(The deposit does not need to be returned.)

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

Individual Provider (Healthcare)

Provider Federal Tax Identification Number (TIN) or
Employer Identification Number (EIN)

Enter TIN or EIN (9 digits)

Submit

Org. Code

What is a Org. Code?

Submit

OR

Individual Provider (Healthcare)

Provider Federal Tax Identification Number (TIN) or
Employer Identification Number (EIN)

Enter TIN or EIN (9 digits)

Submit

Account Name

This is the name that will be used to identify this
banking account throughout the PaySpan system.

Financial Institution Routing Number

Provider's Account Number with Financial
Institution

Confirm Provider's Account Number with
Financial Institution

Type of Account at Financial Institution

Business Checking

☒ Enable Electronic Payment

☒ Request Paper Remittance

The Paper does not allow paper remittance.

☒ Assign new or additional Paper to this Banking
Account

Back Next

Provider Contact Name

Administrative Full Name

Email Address

Notification will be sent to this address.

Confirm Email Address

Telephone Number

Please call on this 800-800-0000 Number.

Title

Click Message

Signature

Minimum 40 characters and may include
letters (a-z), numbers (0-9), dashes (-),
underscores (_), apostrophes ('), and spaces

Password

Confirm Password

Challenge Question

What is your favorite color?

Challenge Answer





Submit

mhsindiana.com

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0221.PR.P.FL 2/21

Tips to Remember

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

Online Claim Reconsiderations on the MHS Secure Provider Portal

Summary Of Online Reconsiderations



Skip the phone call.

- Providers can make their case directly on the portal.



Make the case.

- Providers can submit informal dispute/reconsideration comments using expanded text fields.



Add context.


- Providers can easily attach supporting documentation when filing an informal dispute/reconsideration.







Stay current.

- Providers may opt in/out for informal dispute/reconsideration status change emails.
- Providers may also view status online.

Online Reconsiderations

-  Providers are able to:
- Submit informal disputes/reconsiderations on the secure portal
 - Upload/view supporting documents
 - View acknowledgement letters
 - Track real time updates
 - View denial code information.

Online Reconsiderations


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

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


[Back to Claims](#)
Claim Details

Claim #T1234P1235: Denied


[COPY](#)
[DISPUTE](#)



Claim Accepted



In Process



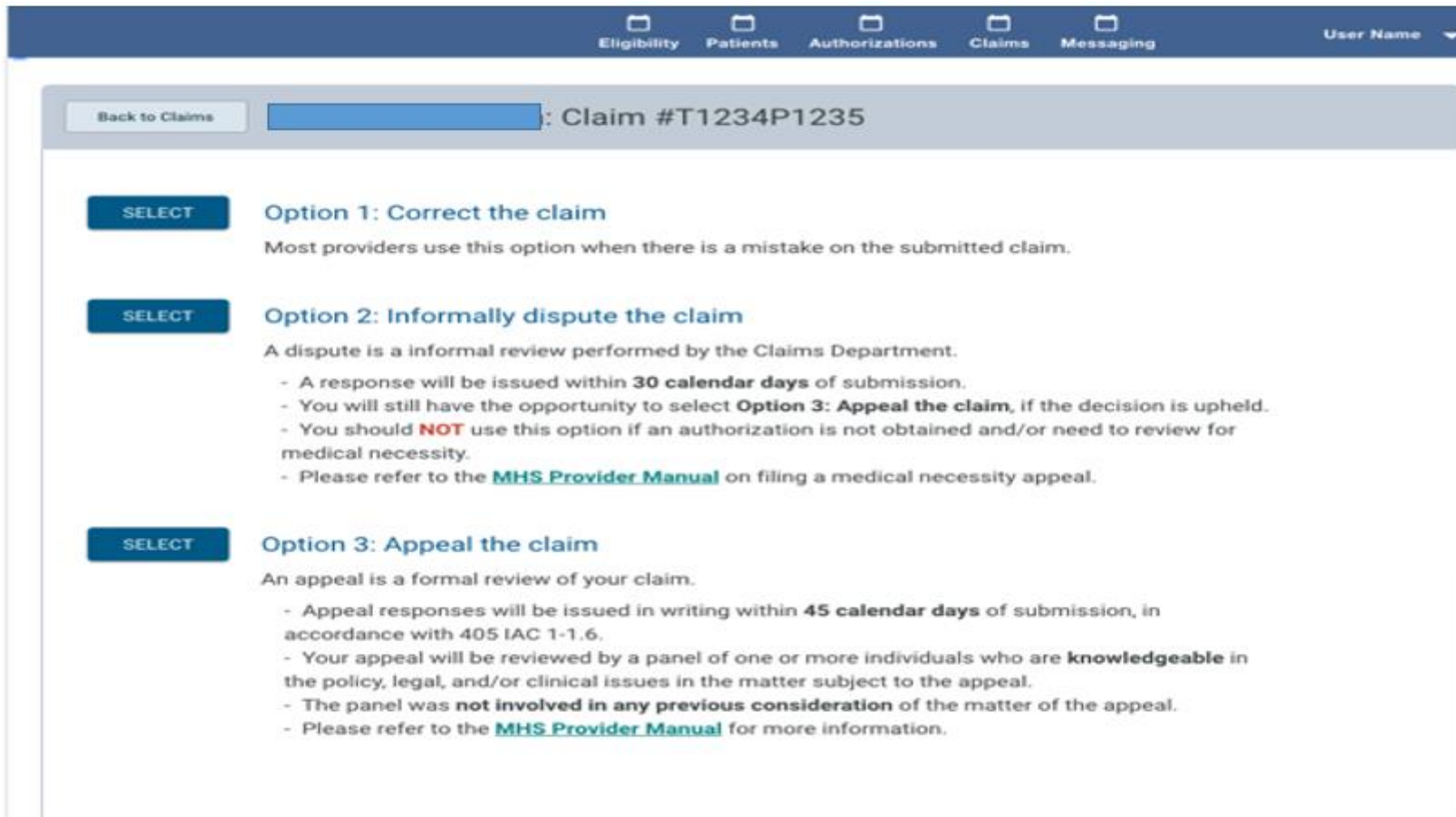
Denied

Participant	Provider	Claim	Most Recent Payment	
Participant Name [Redacted]	Ref/Acct No. 1234567890	DOS Range 08/12/2020 - 08/15/2020	Payment Date —	Paid Claim Amount \$0.00
Member ID ID123459	Servicing Provider [Redacted]	Received Date 09/12/2020	Check/EFT No. —	Total Check Amount —
Member DOB [Redacted]	Servicing NPI [Redacted]	Billed Amount \$6,1234.12	Check Dated —	

Service Lines

Label	Label	Label	Label	Label	Label	Label

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



The screenshot displays the MHS Secure Provider Portal interface. At the top, a navigation bar includes links for Eligibility, Patients, Authorizations, Claims, and Messaging, along with a User Name dropdown. Below this, a header section shows a 'Back to Claims' button and a search bar containing 'Claim #T1234P1235'. The main content area lists three options for handling a claim, each with a 'SELECT' button:

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

Claim Reconsiderations

Enter your explanation for reconsideration and check email updates.

Reconsider Claim✕

Claim No:

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

Reconsideration Type

Denied for Untimely Filing ▾

Notes
Brief Explanation

500 Character Limit

Upload Documents
*Proof of Timely Filing attachment **Required***

Choose Files

Uploaded Files

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

Cancel


Submit Reconsideration →

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

[Back to Claims](#)
Claim Details

Claim #T1234P1235: Denied

[COPY](#)
[DISPUTE](#)



Dispute/Appeal Details

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

Member

Participant Name

[Redacted]

Member ID

ID123459

Member DOB

[Redacted]

Provider

Ref/Acct No.

1234567890

Serving Provider

[Redacted]

Serving NPI

1234567890

Claim

DOS Range

08/12/2020 - 08/15/2020

Received Date

09/12/2020

Billed Amount

\$6,1234.12

Most Recent Payment

Payment Date

Check/EFT No.

Check Dated

Paid Claim Amount

\$0.00

Total Check Amount

Service Lines

Label	Label	Label	Label	Label	Label	Label


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

[Back to Claims](#)





Claim Details




Claim #T1234P1235: Denied

[COPY](#)
[DISPUTE](#)



Dispute/Appeal Details

Created Date	Type	Current Status	Reference No.	Tools
2/15/2021	Appeal - Claim Paid at the Incorrect Amount	In Progress	ABCDE1234567	 
1/26/2021	Dispute - Claim Paid at the Incorrect Amount	Resolved	U026IA1234566	 

Member	Provider	Claim	Most Recent Payment
Participant Name 	Ref/Acct No. 1234567890	DOS Range 08/12/2020 - 08/15/2020	Payment Date ---
Member ID ID123459	Servicing Provider 	Received Date 09/12/2020	Paid Claim Amount \$0.00
Member DOB 	Servicing NPI 1234567890	Billed Amount \$6,1234.12	Check/EFT No. ---
			Total Check Amount ---
			Check Dated ---

Service Lines

Label	Label	Label	Label	Label	Label	Label

Coordination of Benefits

 This screen shows if a member has other insurance.

[Back to Patient List](#)
Member Name

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

Prior Authorization

Authorizations

 View previously submitted or **Create a New Authorization.**

[Back to Patient List](#)

Member Name

Overview

Cost Sharing

Assessments

Health Record

Care Plan

Authorizations

Referrals

Coordination of Benefits

Claims

Document Resource Center

Notes

Authorizations

STATUS	AUTH NBR	FROM DATE	TO DATE	DIAGNOSIS	AUTH TYPE	SERVICE
APPROVE	C	02/06/2018	05/06/2018	M51.36	OUTPATIENT	Office Visit
APPROVE	C	03/14/2017	01/05/2018	G89.4	OUTPATIENT	Office Visit

Create a New Authorization

Click on **AUTH NBR** above

Auth Status: APPROVE
Auth Nbr: C
Service: Office Visit
Provider of Service(s):
Diagnosis Code(s): M51.36

Explanation: Pay
Auth Type: OUTPATIENT
From Date: 02/06/2018
To Date: 05/06/2018
Procedure Code(s): 99214
Notes & Attachments: [View](#)

Line Item	Service type	Start Date	End Date	Units Req.	Units Apprd	Servicing Provider	Location	Status	Medical Necessity	Decision Date
1	Office Visit	02/06/2018	05/06/2018	3	3		Office	APPROVE	Met as requested	01/31/2018

Authorization Considerations



Need to know what requires Authorization:

- Quick Reference Guides (QRG)
- Pre-Authorization tool



How to obtain Authorization:

- Online
- Phone
- Fax



Authorizations do not guarantee payment

Prior Authorization

Is Prior Authorization Needed?

- Provider Quick Reference Guide

<https://www.mhsindiana.com/content/dam/centene/mhsindiana/mediacaid/pdfs/508-Provider-QRG-2021.pdf>

- Pre-AuthTool

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



PROVIDER Quick Reference Guide
Effective June 2021

Applies to all Hoosier Healthwise (HHW), Healthy Indiana Plan (HIP) and Hoosier Care Connect (HCC) packages.
For an Ambetter Provider Quick Reference Guide, please visit ambetter.mhsindiana.com. Coverage is subject to specific benefit package of member.

1-877-647-4848
TTY/TDD: 1-800-743-3333
mhsindiana.com

GENERAL OFFICE HOURS:
8 a.m. to 5 p.m., EST, closed holidays

MEMBER SERVICES AND PROVIDER SERVICES:
8 a.m. to 8 p.m.

REFERRALS AND AUTHORIZATIONS:
8 a.m. to 5 p.m., closed 12 p.m. to 1 p.m.

CASE MANAGEMENT:
8 a.m. to 5 p.m.

AFTER-HOURS:
MHS' 24/7 Nurse Advice Line for members is available to answer calls for emergent authorization needs. Or, you may leave a message on our after-hours recording system. Messages are returned within one business day.

MANAGED HEALTH SERVICES (MHS)

ELECTRONIC PAYER ID:
68069

BEHAVIORAL HEALTH PAYER ID:
68068

MEDICAL CLAIMS ADDRESS:
Managed Health Services
P.O. Box 3002
Farmington, MO 63640-3802

Claims sent to MHS' Indianapolis address will be returned to the provider.

MEDICAL NECESSITY APPEALS ONLY ADDRESS:
ATTN: APPEALS
P.O. Box 441567
Indianapolis, IN 46244

MEDICAL CLAIMS APPEALS ADDRESS:
Managed Health Services
P.O. Box 3000
Farmington, MO 63640-3800

Providers have 60 calendar days from the date of the Explanation of Payment to file an adjustment, rebuttal, or appeal a decision. Failure to do so within the specified timeframe will waive the right for reconsideration.

MEDICAL CLAIMS REFUNDS:
To refund claims overpayment, please send check and documentation to:
Coordinated Care Corporation
75 Remittance Dr., Suite 6446
Chicago, IL 60675-6446

MHS FAX NUMBERS

MEDICAL APPEALS: 1-866-714-7993

CASE MANAGEMENT: 1-866-694-3853
Ex. Member Referrals to CCM/DH

REFERRALS AND AUTHORIZATIONS: 1-866-912-4345

MHS WEBSITE: MHSINDIANA.COM

mhsindiana.com/providers Latest MHS provider updates and news, as well as online provider enrollment, office and billing address change forms, quality and care gap tools, forms, manuals, guides, online PA tool and tutorials.

mhsindiana.com/health MHS' Health Library. Click on "KRAMER Health Library" for free print-on-demand patient health fact sheets on over 4,000 topics, available in English and Spanish.

mhsindiana.com/login MHS' Secure Provider Portal lets you submit prior authorization appeals, level 1 and level 2 claim disputes and appeals, claims, claim adjustments, and view your panel's medical records and care gaps.

mhsindiana.com/transactions Information for electronic processing and payment of claims with MHS.

OTHER RESOURCES
paypanhealth.com MHS is pleased to partner with Paypan to provide an innovative web-based solution for Electronic Funds Transfers (EFTs) and Electronic Remittance Advices (ERAs). This service is provided at no cost to providers and allows online enrollment at paypanhealth.com.

You can find out more about the information in this Guide in the MHS Provider Manual, online at mhsindiana.com/providers/resources, or by contacting MHS at 1-877-647-4848.

0700.PB.FSL 3.1/1/20

Prior Authorization



[Home](#)
[Find a Provider](#)
[Portal Login](#)
[Events](#)
[Careers](#)
[Contact Us](#)

search

Contrast ☒ On ☐ Off a a a language+

FOR MEMBERS

FOR PROVIDERS

GET INSURED

FOR PROVIDERS

Login

Enrollment and Updates +

Prior Authorization -

Medicaid Pre-Auth

Ambetter Pre-Auth

Medicare Pre-Auth

Dental Providers

Pharmacy +

Opioid Resources

Behavioral Health Providers +

Provider Resources +

QI Program +

Provider News

Email Sign Up

Coronavirus Information +

Medicaid Pre-Auth

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

Vision services need to be verified by [Envolve Vision](#).
 Dental services need to be verified by [Envolve Dental](#).
 Ambulance and Transportation services need to be verified by [LCP Transportation](#).
 Musculoskeletal services need to be verified by [TurningPoint](#).
 Complex imaging, MRA, MRI, PET, CT scans, PT, ST, and OT need to be verified by [NIA](#).

Non-participating providers must submit Prior Authorization for all services.
 For non-participating providers, [join our network](#).

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

☐ Yes ☒ No

Types of Services

YES NO

Is the member being admitted to an inpatient facility?

☐ YES ☒ NO

Are services other than lab, radiology, domiciliary visits DME, Orthotics, or Prosthetics being rendered in the home?

☐ YES ☒ NO

Are anesthesia services being rendered for pain management?

☐ YES ☒ NO

Are services for infertility?

☐ YES ☒ NO

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

58270

Check



Yes

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

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

MHS Team

MHS Provider Network Territories

Indiana

NORTHEAST REGION

For claims issues, email:
MHS_ProviderRelations_NE@mhsindiana.com
Chad Pratt, Provider Partnership Associate
1-877-647-4848, ext. 20454

NORTHWEST REGION

For claims issues, email:
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Candace Ervin, Provider Partnership Associate
1-877-647-4848, ext. 20187

NORTH CENTRAL REGION

For claims issues, email:
MHS_ProviderRelations_NC@mhsindiana.com
Natalie Smith, Provider Partnership Associate
1-877-647-4848, ext. 20127

CENTRAL REGION

For claims issues, email:
MHS_ProviderRelations_C@mhsindiana.com
Mona Green, Provider Partnership Associate
1-877-647-4848, ext. 20080

SOUTH CENTRAL REGION

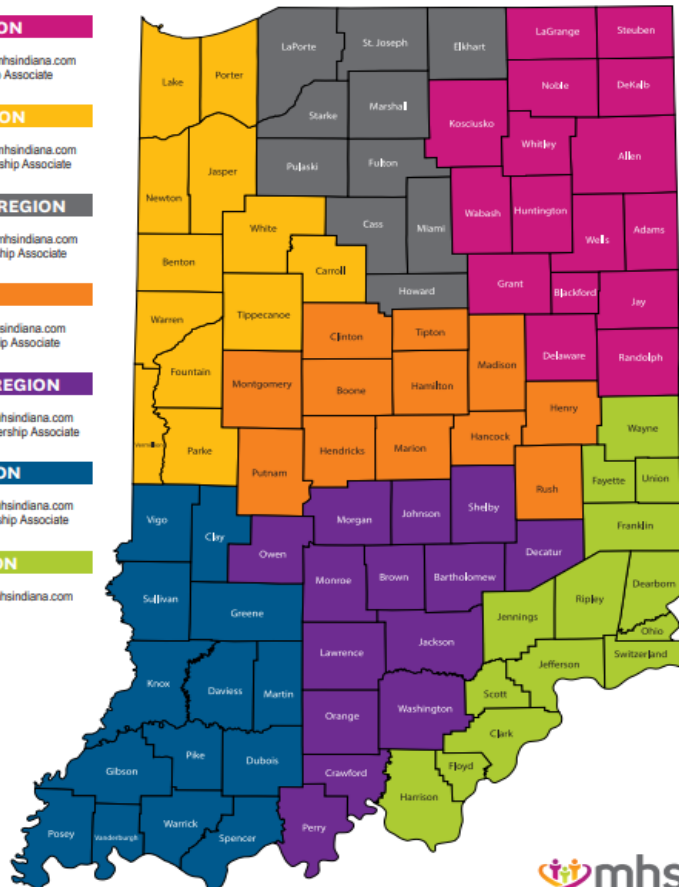
For claims issues, email:
MHS_ProviderRelations_SC@mhsindiana.com
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SOUTHWEST REGION

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SOUTHEAST REGION

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Available online:

https://www.mhsindiana.com/content/dam/centene/mhsindiana/medicaid/pdfs/ProviderTerritory_map_2021.pdf

MHS Provider Network Territories

TAWANNA DANZIE

Provider Partnership Associate II
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tdanzie@mhsindiana.com

PROVIDER GROUPS

Beacon Medical Group
Franciscan Alliance
HealthLinc
Heart City Health Center
Indiana Health Centers
Lutheran Medical Group
Parkview Health System
South Bend Clinic

JENNIFER GARNER

Program Manager,
Provider Engagement
1-877-647-4848 ext. 20149
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PROVIDER GROUPS

American Health Network of Indiana
Columbus Regional Health
Community Physicians of Indiana
HealthNet
Health & Hospital Corporation of
Marion County
Indiana University Health
St. Vincent Medical Group

ENVOLVE DENTAL, INC.

THOMAS “TONY” SMITH

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

ENVOLVE VISION, INC.

CHANTEL MCKINNEY

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Network Leadership

NETWORK LEADERSHIP

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Questions?

**Thank you for being our
partner in care.**