Prior Authorization: Simplifying Prior Authorization for Better Patient Care

2025 Indiana Health Coverage Programs (IHCP) Annual Works Seminar

Agenda

- Medical Prior Authorization (PA)
- Need to Know
- Web Portal
- Fax Authorizations
- Prior Authorization and Medical Necessity Appeals
- Prior Authorization Denials and Appeal Process
- Behavioral Health (BH) PA Updates
- Fax Request
- Pertinent Information
- BH Prior Authorizations Denials
- BH Prior Authorizations and Appeals
- MHS Network Team
- Questions and Answers

Medical Prior Authorization (PA)

Medical Prior Authorization

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

- Emergency Room (ER) services do not require PA.
  - Admission must be called into the MHS Prior Authorization Department within two business days. Please contact 1-877-647-4848
- Urgent concurrent = Emergent inpatient admission. Determination timeline within 24 hours of receipt of request.

PA Guidelines for Medical and Behavioral Health

MHS adheres to the following timelines for PA decisions:

- Up to 48 hours for standard PA decisions.
- Within 24 hours for urgent PA decisions.
- Concurrent review request within 48 hours.

Possible Reasons for Delayed Decisions:

- Incomplete or insufficient information submitted with the request.
- Requests requiring review by the Medical Director.
- If the provider requests an inpatient level of care for a covered/eligible condition, but the procedure and documentation support an outpatient/observation level of care, the case will be sent for Medical Director review.

Important Note: The Medical Management team does not verify member eligibility or benefit limitations. It is the provider's responsibility to confirm eligibility and verify benefit coverage is assigned to MHS.

Medical Prior Authorization

MHS Medical Management will review State guidelines and clinical documentation.

- If the provider requests an inpatient level of care for a covered or eligible condition, but procedure and documentation supports an outpatient or observation level of care, MHS will send the case for Medical Director review.
- Elective procedures that require PA must be submitted to MHS at least two business days prior to the date of service.

***Authorizations do not guarantee payment.**

Transfer Prior Authorization Requests

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

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

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

Ways to Obtain a Prior Authorization

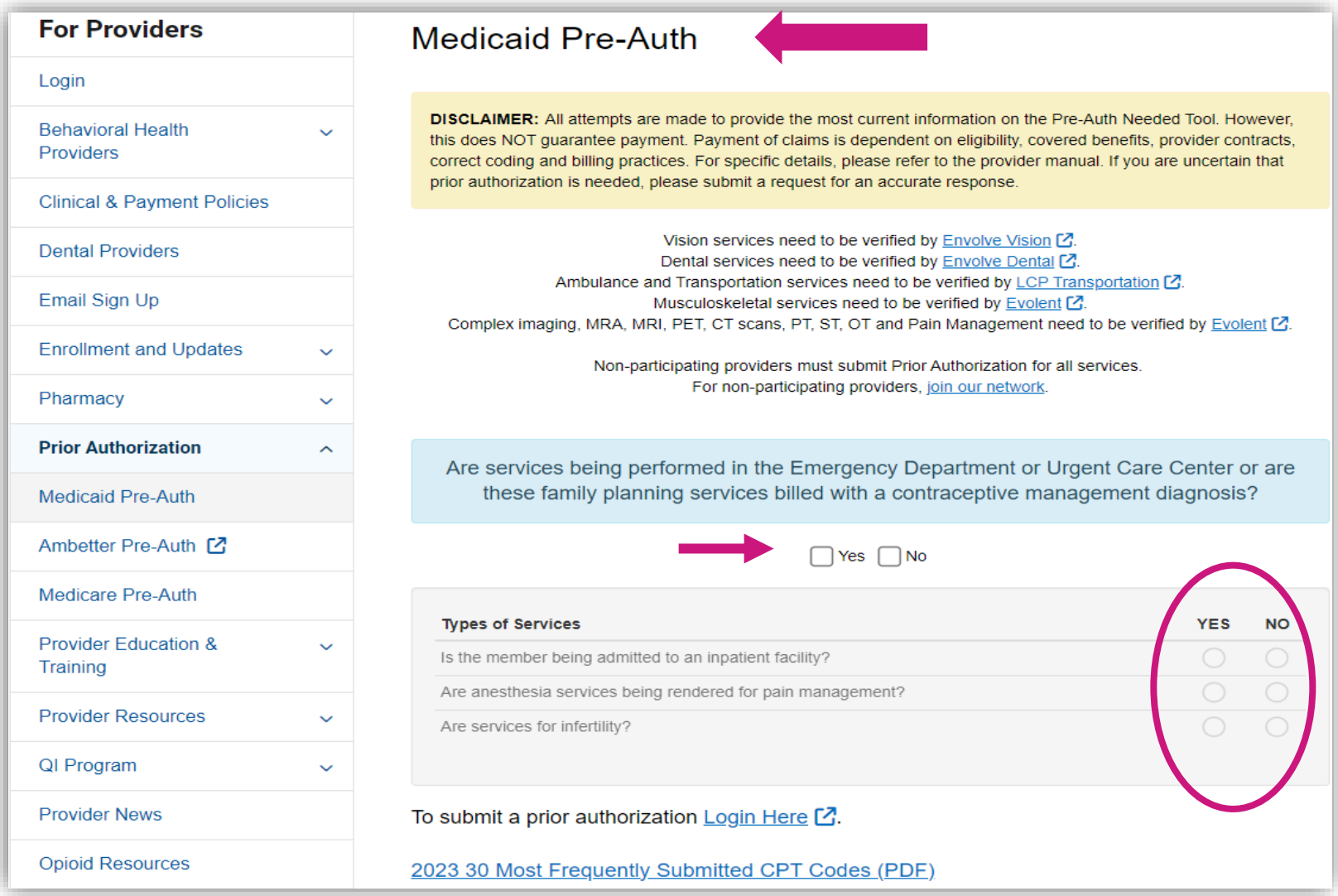
- Check to see if a Medicaid Pre-Authorization is necessary by using our online tool. If an authorization is needed, you can access our **MHS Provider Portal** to submit a request online.

- The **Prior Authorization** link will take you to the Medicaid Pre-Auth page.

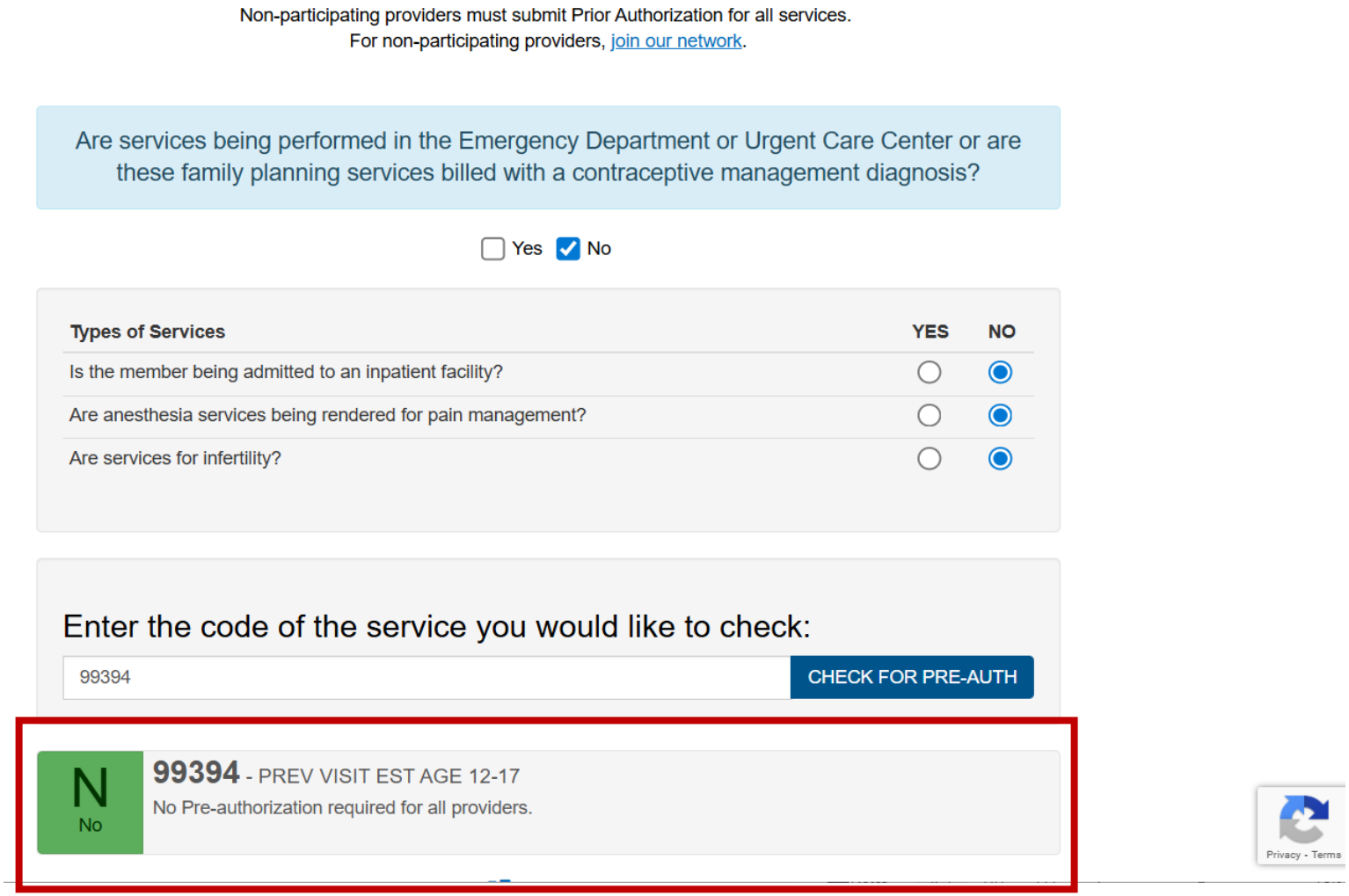
- For imaging, outpatient surgeries and testing, requests for services may be obtained via:

Phone: 1-877-647-4848
Fax: 1-866-912-4245
Online: **MHS Provider Portal**

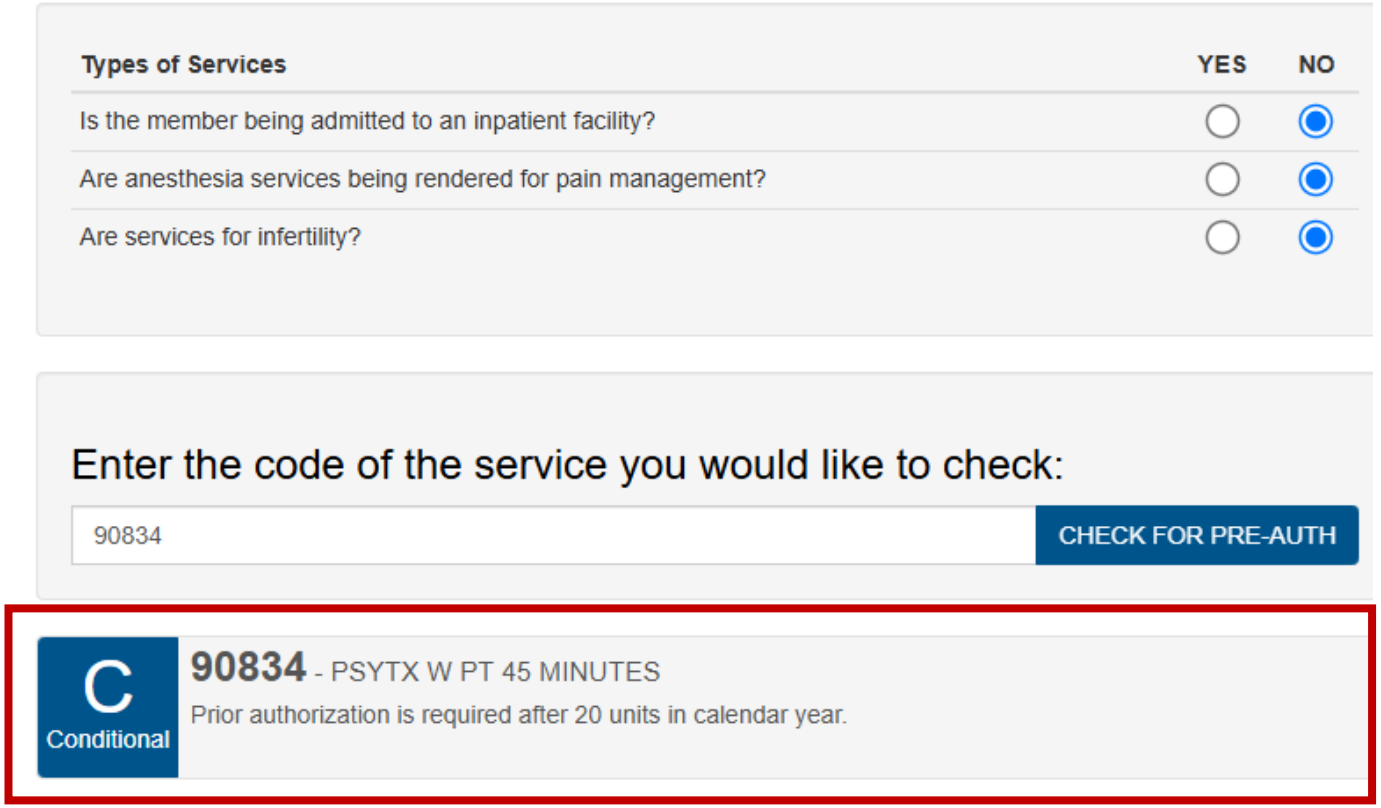
How to Obtain a Prior Authorization



Prior Authorization Web Tool – No

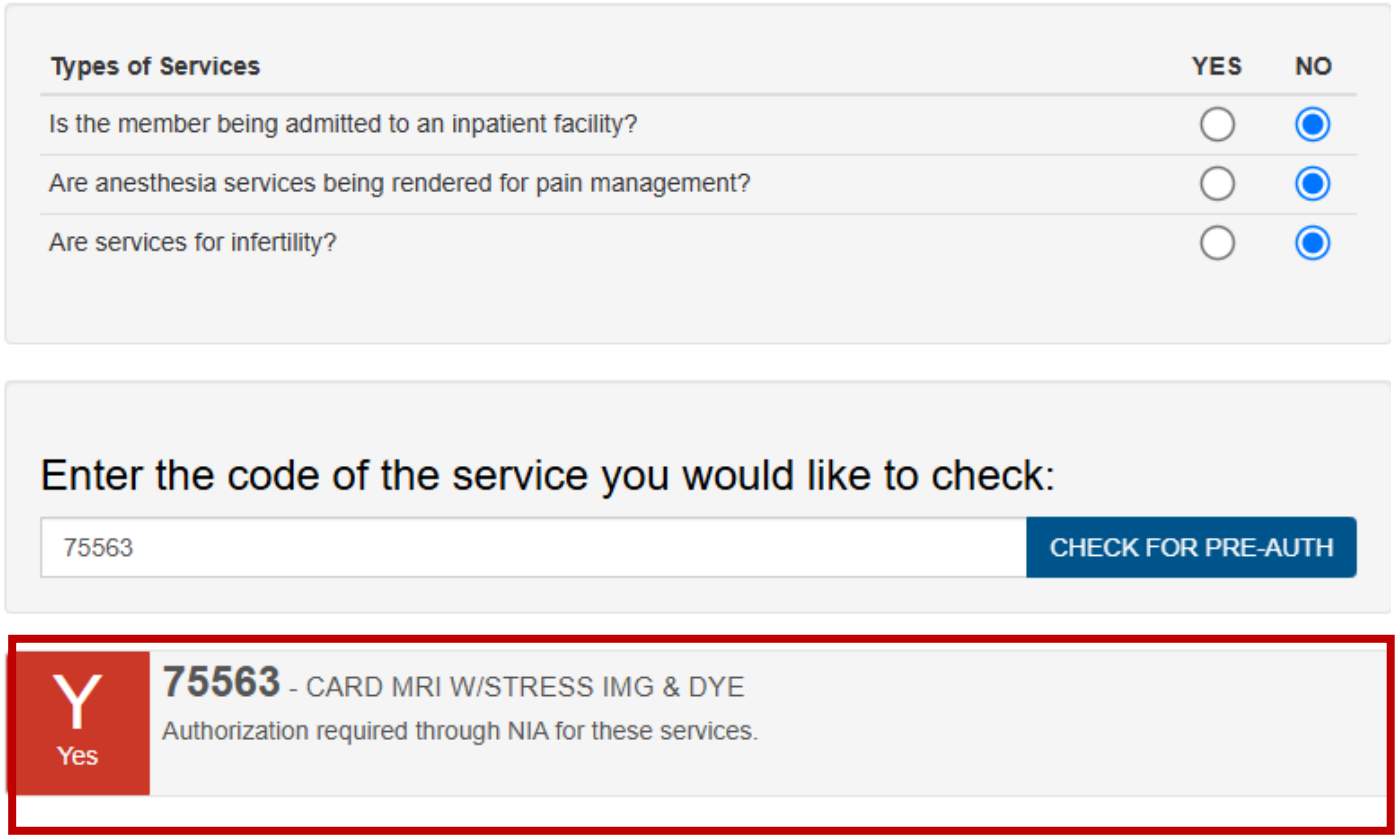


Prior Authorization Web Tool - Conditional



Log into the **MHS Provider Portal** to submit a Prior Authorization

Prior Authorization Web Tool - Yes



Log into the **MHS Provider Portal** to submit a Prior Authorization

Information Needed For Prior Authorization

Information Needed to Complete All Prior Authorization Request:

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

Prior Authorization Update Requests

- Providers can update previously approved PA within 90 calendar days of the original date of service prior to claim denial for changes to:
  - Dates of service
  - CPT/HCPCS codes
  - Provider demographic changes

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

Continuity of Care Prior Authorization Requests

- MHS will honor pre-existing authorizations from any other Indiana Medicaid payor following the below mentioned guidelines:
  - During the first 90 calendar days during member enrollment, or up to the expiration date of the previous authorization, whichever occurs first, and upon notification of transition to MHS.
  - Providers must include the approval from the prior payor and Fee-for Service (FFS), once the member transfers to MHS.

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

Sub-Acute Care Prior Authorization Requests

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

Sub-Acute Care

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

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

Inpatient Prior Authorization Requests

- Notification of an inpatient admission and any clinical information may be submitted for medical necessity review via:
  - **MHS Provider Portal**, using the **IHCP Universal PA Form**
  - Via fax 1-866-912-4245
- Phone notifications of admission and submission of clinical information for members enrolled in Hoosier Healthwise, the Healthy Indiana Plan (HIP), or Hoosier Care Connect will not be accepted.

Need to Know

Outpatient Radiology Prior Authorization Request

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

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

Evolent

Physical, Occupational and Speech Therapy

- Utilization management of these services is managed by Evolent for Medicaid.
- All Health Plan approved training/education materials are posted on the Evolent website, **RadMD**, under the Resources tab. For new users to access these web-based documents, a RadMD account ID and password must be created.
- Chiropractors rendering therapy services are exempt from the Evolent program.

Evolent – Cardiac Services

Cardiac Services

Evolent manages prior authorizations for the cardiac services below:

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

Telephonic Intake: Direct:1-574-784-1005 | Toll Free:1-855-415-7482
Facsimile Intake: 1-463-207-5864

***This is not an all-inclusive list.**

Durable & Home Medical Equipment (DME/ HME)

- Non-Participating DME providers require prior authorization on all services. Prior Authorization requests must be submitted by the ordering physician. All requests should be faxed directly to MHS
- Orders are sent directly to and coordinated by MHS and delivered to the member.
- Does not apply to items provided by and billed by physician office.
- To initiate a prior authorization:

  Log into the **MHS Provider Portal** click on “Create Authorization.” Choose DME and you will be directed to the DME portal for order entry.
- **Fax Number:** 1-866-912-4245 **Phone Number:**1-844-218-4932.

Ambulance Coverage

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

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

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

Please contact for our transportation vendor for prior authorization request

Pharmacy Requests

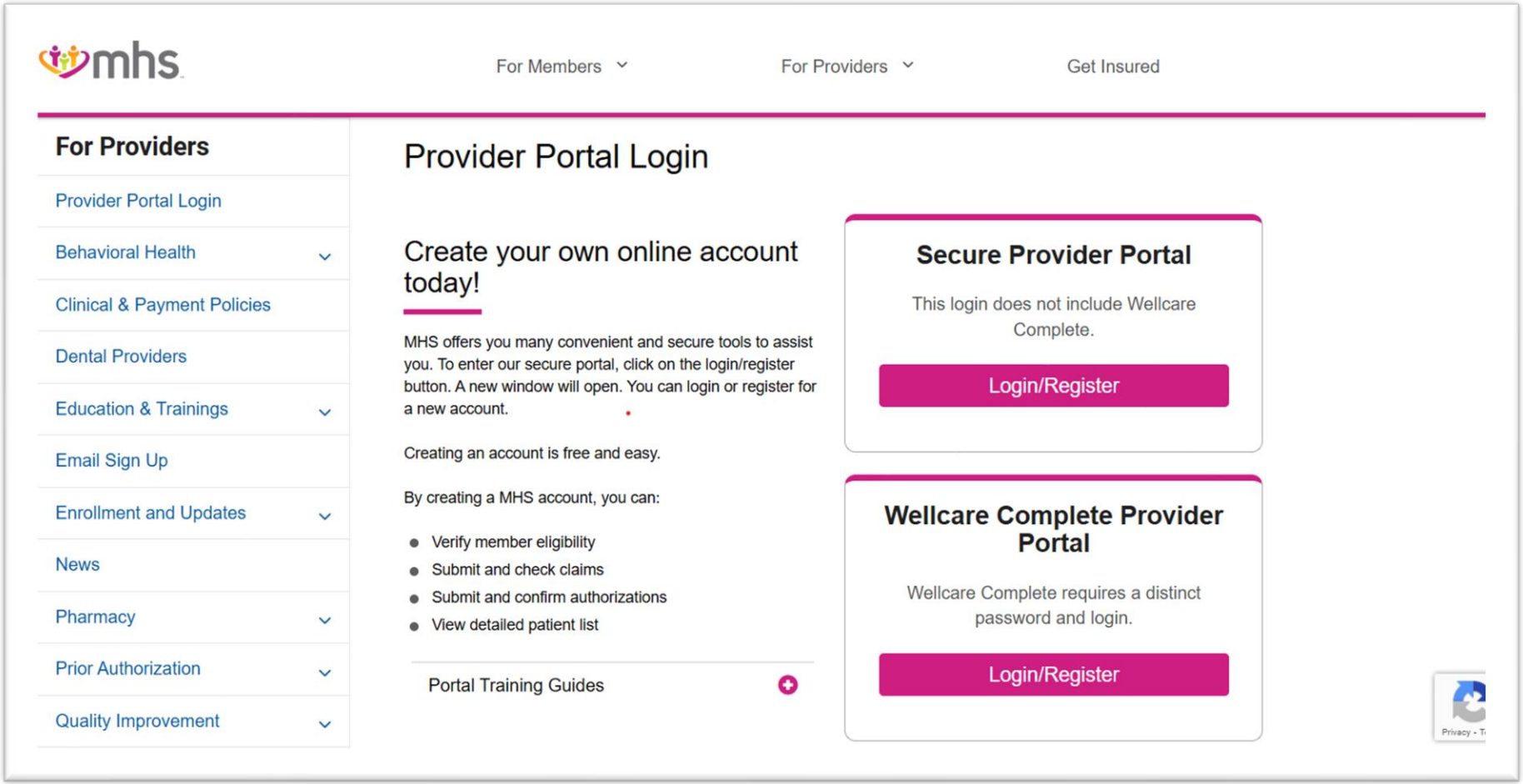
MHS Pharmacy Benefit Manager is Express Scripts, Inc. (ESI)

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

Web Portal

Secure Portal Registration or Login

Sign up or log into the **MHS Provider Portal**



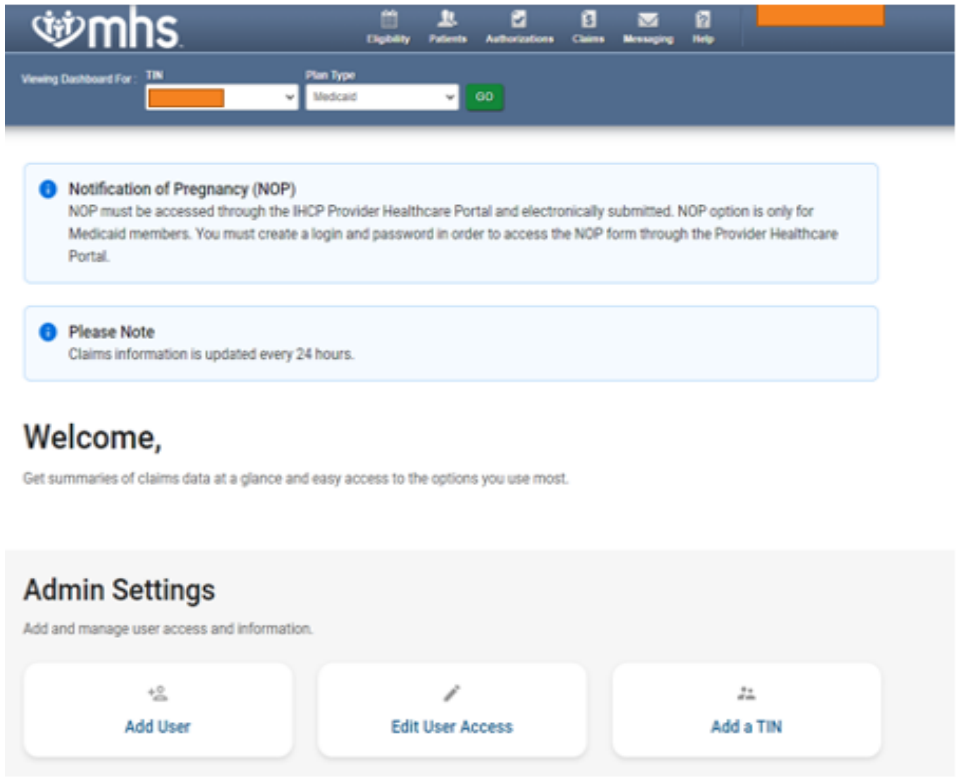
Web Authorization

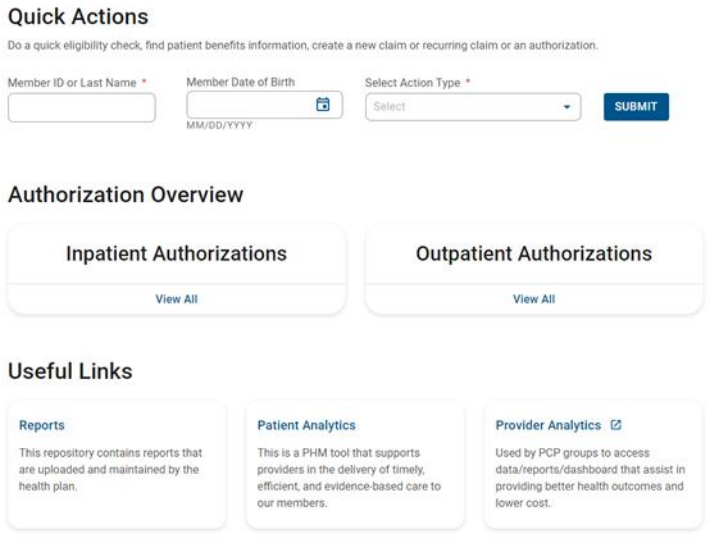
- Providers can submit PAs online via the MHS Secure Provider Portal.
- When using the portal, providers can upload supporting documentation directly.
- Providers can check the authorization status on the portal.
- Same steps for Behavioral Health (BH) and Medical using appropriate links.

<u>Exceptions</u>: Must submit Hospice, Home Health, and biopharmaceuticals PA requests via fax at 1-866-912-4245.

Homepage - MHS (Medicaid)

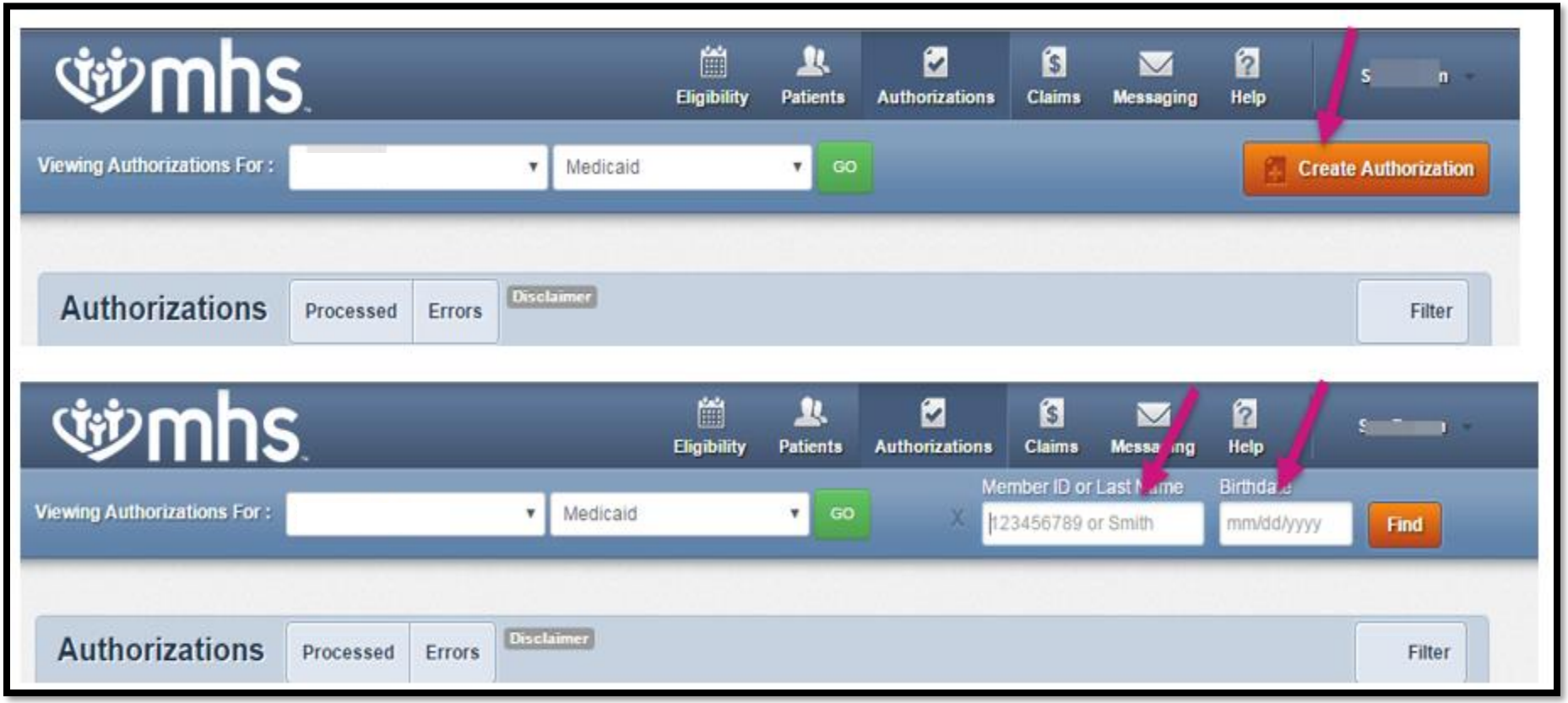
After logging into the **MHS Provider Portal** this homepage will appear that allows providers to access information





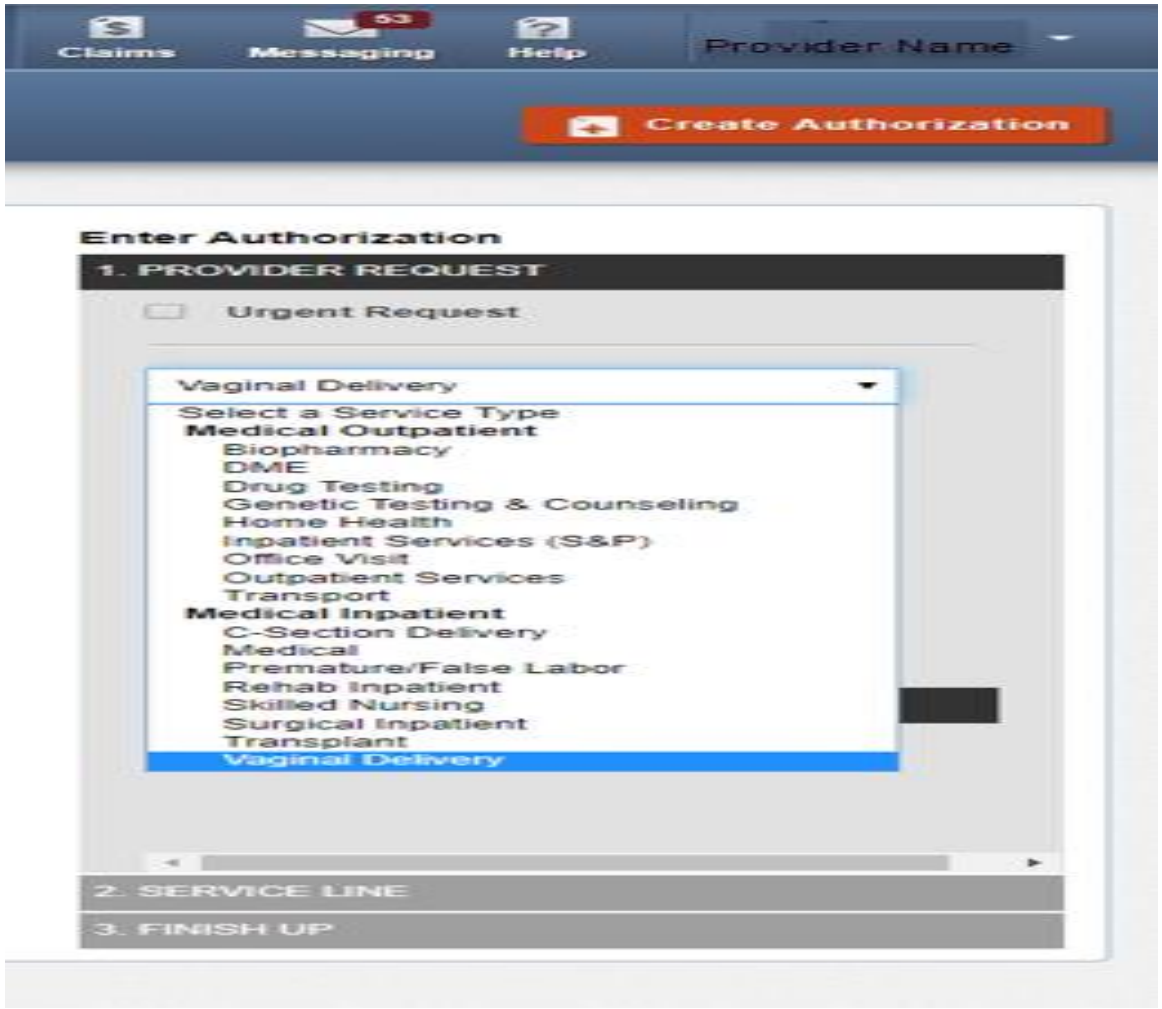
Creating a New Authorization

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



Creating a New Authorization

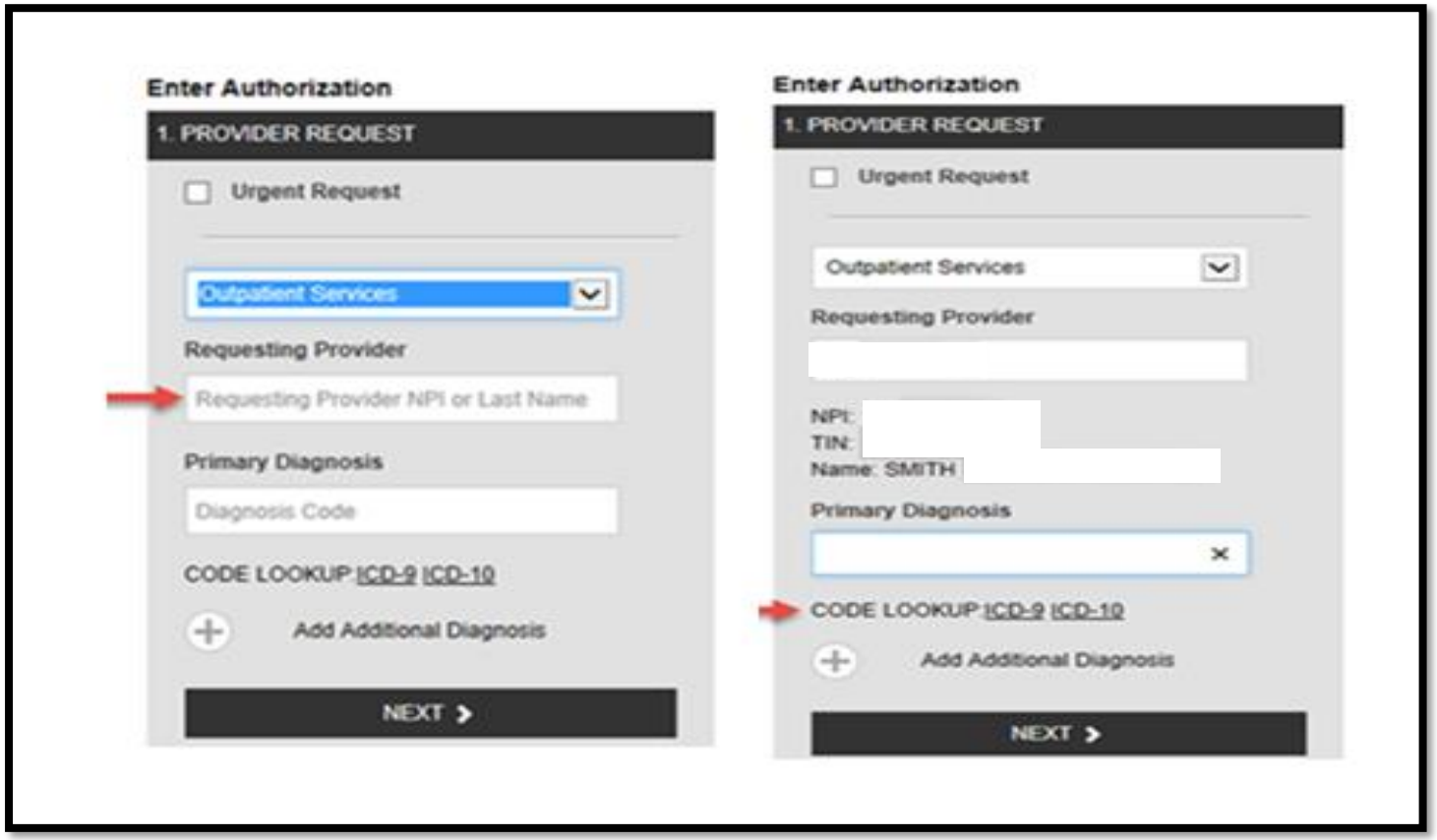
- Select a Service Type.



Adding Information for Authorization

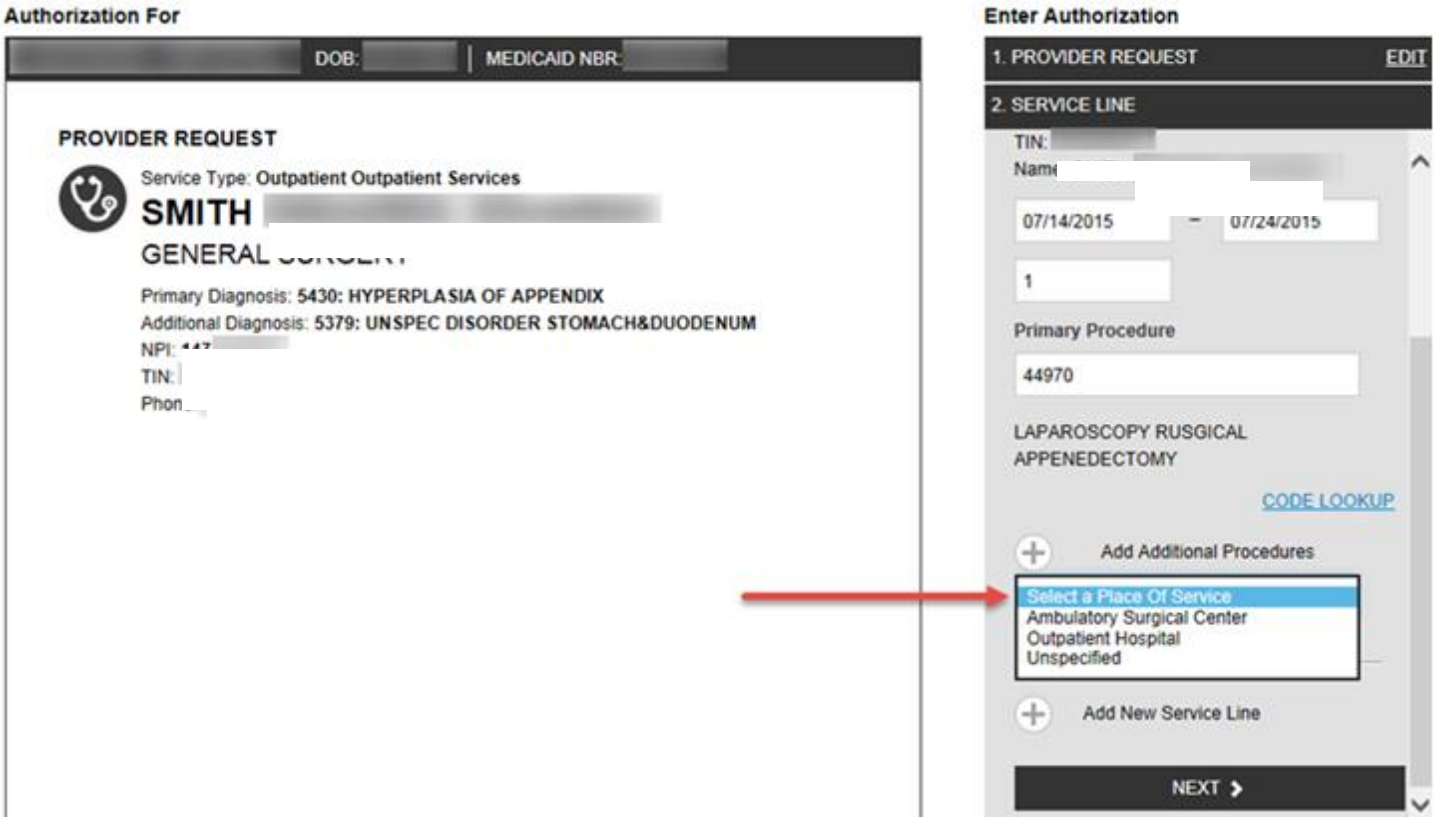
Select Provider NPI.

Add Primary Diagnosis.



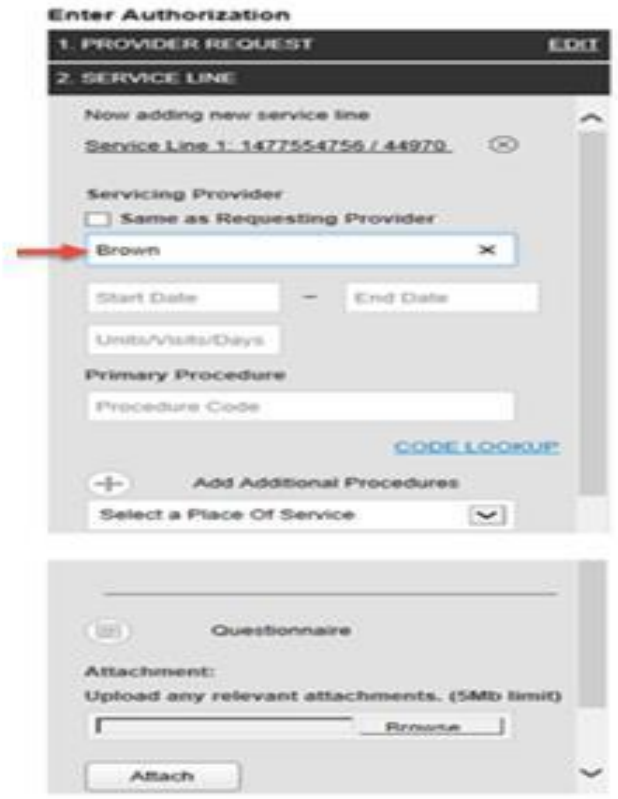
Adding Procedure

Add Additional Procedures (if applicable).



Creating a New Authorization

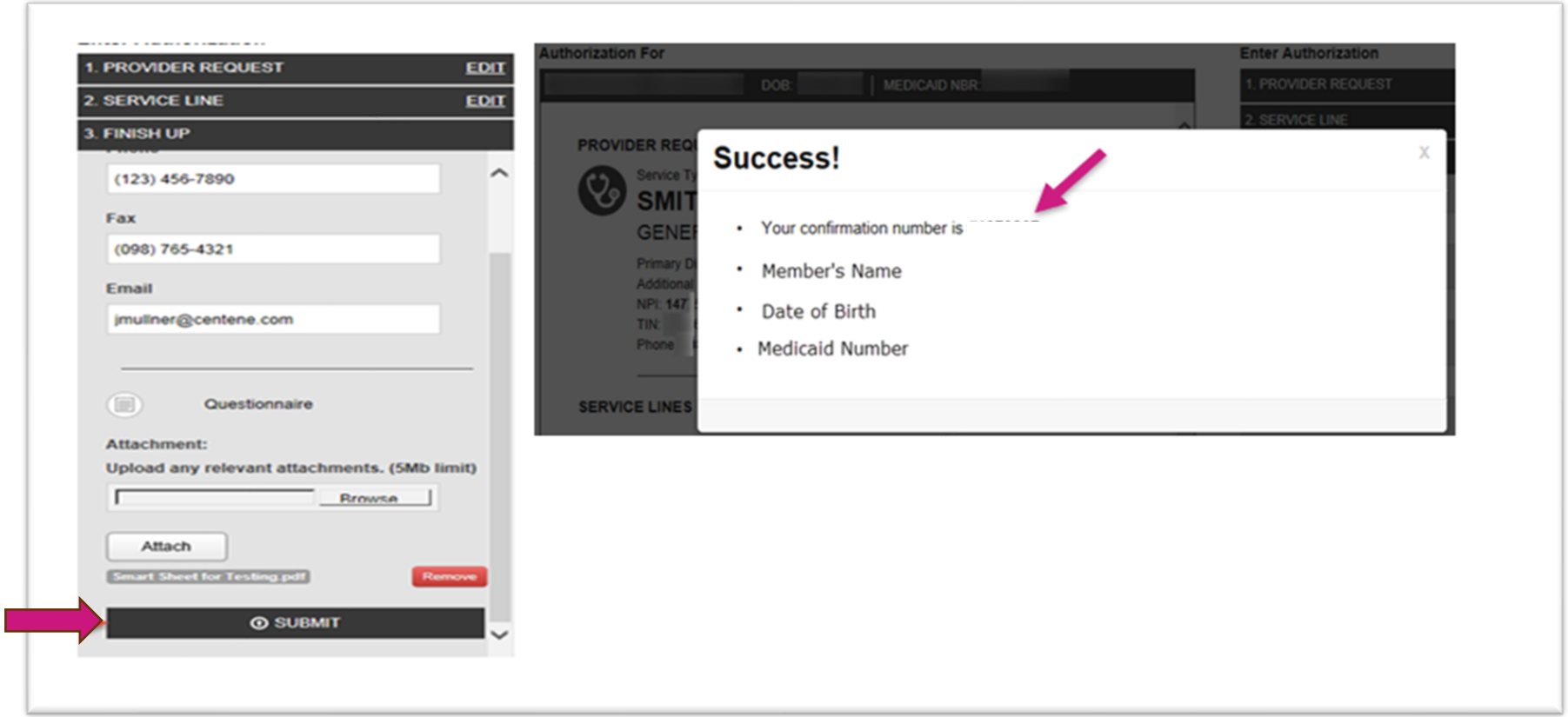
Service Line Details:



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

Creating a New Authorization

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



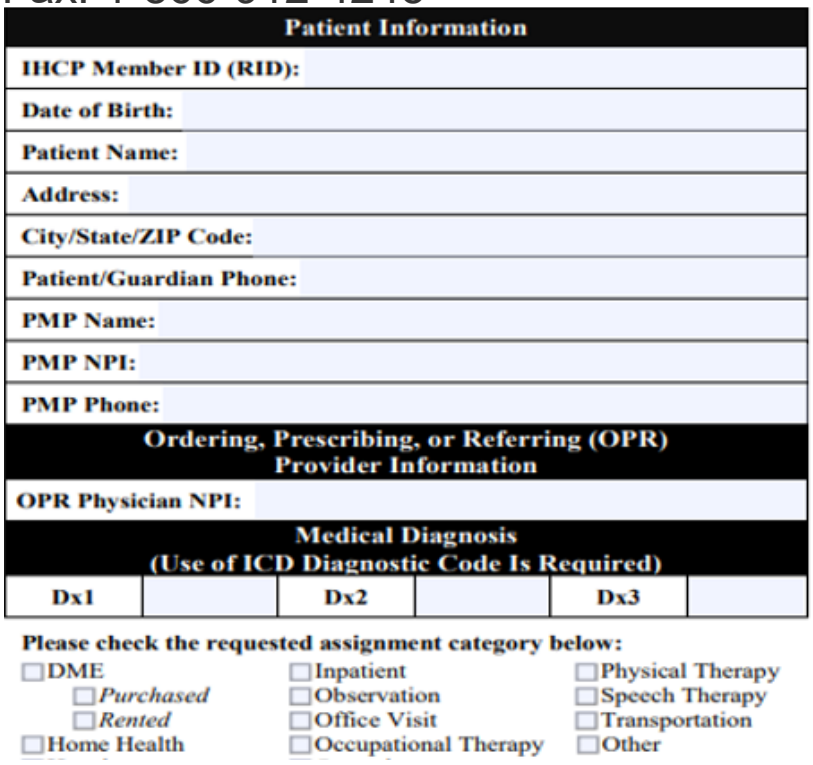
Fax Authorizations

Fax Authorizations

MHS Medical Management Department

Prior Authorization

Fax: 1-866-912-4245



Patient Information	
IHCP Member ID (RID):	
Date of Birth:	
Patient Name:	
Address:	
City/State/ZIP Code:	
Patient/Guardian Phone:	
PMP Name:	
PMP NPI:	
PMP Phone:	
Ordering, Prescribing, or Referring (OPR) Provider Information	
OPR Physician NPI:	

Medical Diagnosis (Use of ICD Diagnostic Code Is Required)					
Dx1		Dx2		Dx3	

Please check the requested assignment category below:

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

Member ID, DOB, Patient Name required.

Medical Diagnosis code(s) required.

Check Service category.

PA Forms can be found on the website

Fax Authorizations- Pertinent Information

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

Enter the **Requesting** provider's information

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

Fax Authorization

Fax Authorizations – Procedures

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

Please complete all fields to ensure the PA request will be processed accurately.

Prior Authorization and Medical Necessity Appeals

Prior Authorization/Medical Necessity Appeals

- Appeals must be initiated within 48 hours of the denial to be considered.
- Members may continue to receive benefits while the appeal is pending but may be liable for the costs if the decision is unfavorable. Determination will be communicated to the provider within 48 hours of the receipt.
- Decisions regarding expedited appeals are made no later than 24 hours.
- Peer-to-Peer (P2P) requests must be within 48 hours of the adverse determination.

Prior Authorization Submission

- Prior Authorization/Medical Necessity Appeals may be submitted to MHS in the following ways:
  - Web: **Secure Provider Portal**
  - Call: Medicaid: 1-877-647-4848
    Monday - Friday 8:00 a.m. to 5:00 p.m. EST.
  - Email: **Appeals@mhsindiana.com**
  - Fax: Medicaid: 1-866-714-7993
  - Mail: MHS Grievance & Appeals
    P.O. Box 441567
    Indianapolis, IN 46244

Prior Authorization Denial and Appeal Process

Prior Authorization Denial and Appeal Process

- **If MHS denies the requested service:**
  - And the member is still receiving services; you have the right to an expedited appeal. The attending physician must request the expedited appeal.
  - Or if the member already has been discharged, the attending physician must submit an appeal in writing within 60 calendar days of the denial.
  - The attending physician has the right to a P2P discussion with an MHS physician.
    - Providers initiate P2P discussions and expedited appeals by calling an MHS Appeals Coordinator at 1-877-647-4848.

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

Peer to Peer

P2P Discussion

- The Indiana MHS Medicaid P2P Schedulers report to Dr. Erwin, Chief Medical Officer.
- You must request P2P within 48 hours of the adverse determination.

***A PA appeal is different than a claim appeal request.**

PA Denial and Appeal Process

- PA and appeals can be completed through our Secure Web Portal: **MHS Secure Portal**

- Appeals can also be mailed to:
  Authorization/Medical Necessity
  Managed Health Service
  Attn: Appeals Coordinator
  P.O. Box 441567
  Indianapolis, IN 46244

- To check status of an Appeal or Grievance email:
  Appeal status inquiries should be sent to MHS Indy Appeals: **appeals@mhsindiana.com**
  Grievance status inquiries should be sent to MHS Indy Compliance Outreach: **compliance_outreach_in@centene.com**

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

Behavioral Health PA Updates

Behavioral Health Authorization continued

Facility Services:

- Inpatient Admissions
- Intensive Outpatient Treatment (IOT)
- Outpatient (may be different timeframes depending on codes billed)
- Partial Hospitalization
- Substance Use Disorder (SUD) Residential Treatment

***Authorizations do not guarantee payment.**

Behavioral Health Authorization continued

Professional Services:

- Psychiatric Diagnostic Evaluation
- Behavioral Health Outpatient Therapy (BHOP Therapy)
- Electroconvulsive Therapy
- Psychological Testing (unless for autism, then no authorization is required)
- Developmental testing, with interpretation and report {(non-Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)}
- Neurobehavioral status exam, with interpretation and report
- Neuropsychological testing per hour, face-to-face:
    - Unless for autism, then no authorization is required
- Applied Behavior Analysis (ABA) Services – are approved by units
- Non-participating providers only

***Authorizations do not guarantee payment.**

Behavioral Health Authorization continued

- Please visit our Behavioral Health Forms page to access the complete list of forms required for prior authorization submissions:

BH Forms

Inpatient and Residential Treatment for Substance Use Disorder (SUD)

- Discharge Consultation Documentation (PDF)
- Initial Assessment Form for Substance Use Disorder Treatment Admission
- Reassessment Form for Continued Substance Use Disorder Treatment
- Residential/Inpatient Substance Use Disorder Treatment Prior Authorization Request Form

Outpatient Treatment Request (OTR) Form

- Applied Behavioral Analysis Treatment OTR (PDF)
- IN Medicaid ABA Provider Request Tip Sheet (PDF)
- Intensive Outpatient Day Treatment Form (PDF)
- HHW/HIP Outpatient Treatment Request (OTR) Form (PDF)

- When submitting a prior authorization request for Behavioral Health Services, ensure all sections are filled out accurately, including service details, provider information, and member details.

Behavioral Health Authorization

When submitting a prior authorization request for Behavioral Health Services, please include the following documents as applicable:

Type of Document	Supporting Documents
Member Treatment Summary (Narrative)	A written summary detailing the member's treatment history and current care plan.
Assessment Findings	Results from clinical evaluations, diagnostic tests, or any behavioral health assessments.
Prescribed Medications	Include a list of current medications along with dosages and duration of use.
Psychotherapy Documentation	Specify prescribed therapy, goals, objectives, and the member's individualized care plan.
Diagnoses	Clearly document all relevant behavioral health and physical diagnoses.
Treatment Plan	Include measurable goals, timelines, and strategies to address the member's specific needs.
Supporting Medical Records	Relevant clinical notes, progress reports, or prior treatment outcomes.
Service Request Details	Provide details regarding requested services (e.g., frequency, duration, and intensity).
Additional Documentation	Any other pertinent information or supporting materials that may assist in the authorization process.

Fax Request

Fax Request

All **BH Forms** can be obtain for the following treatments:

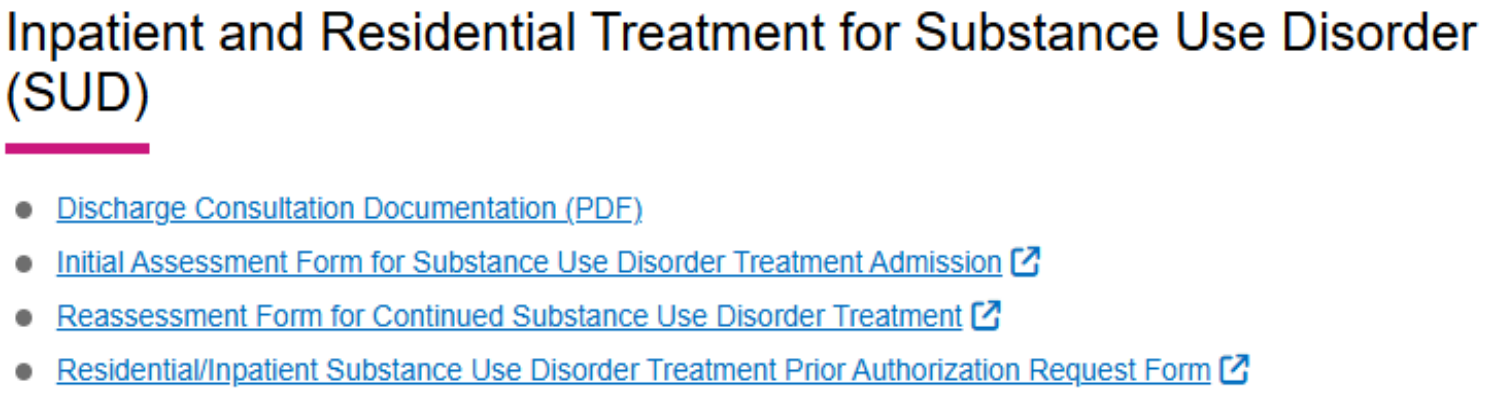
- Outpatient Treatment Request (OTR)
- Intensive Outpatient/Day Treatment Form
- Mental Health Chemical Dependency
- Applied Behavioral Analysis Treatment Psychological & Neuropsych Testing Authorization Request Form

- Fax completed forms to **1-866-694-3649.**

BH Forms

All **BH Forms** can be obtain for the following treatments:

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



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

Pertinent Information

Pertinent Information (IOT)

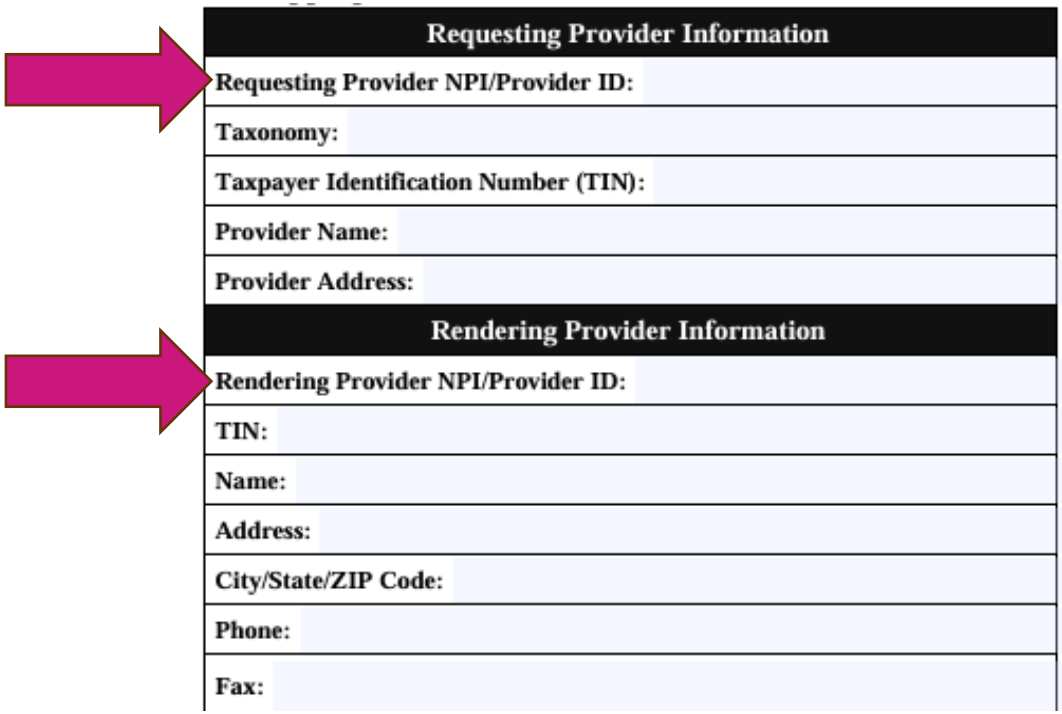
When requesting Intensive Outpatient Treatment, please follow the chart below:

(IOT) Rendered In a Facility	(IOT) Rendered In Professional Setting
Facility providers that bill institutional claims (*UB-04* claim form or the electronic equivalent) must submit PA with one of the following revenue codes based on the type of service rendered: ✓ 905 – Psychiatric-Behavioral Health Treatments/Services-Intensive Outpatient Services ✓ 906 – Chemical Dependency-Behavioral Health Treatments/Services-Intensive Outpatient Services ✓ No procedure codes to be submitted with revenue codes	Professional providers that bill claims (*CMS-1500* claim form or the electronic equivalent) must submit PA with one of the following procedure codes, based on the type of service rendered: ✓ S9480 - Psychiatric IOT ✓ H0015 - Drug & Alcohol IOT ✓ No revenue codes to be submitted with procedure codes

Pertinent Information (SUD)

When completing the “Rendering Provider Information” section of the authorization form, ensure the following:

- ✓ Enter the IHCP/MHS-enrolled **SUD facility NPI** in the Requesting and Rendering Provider NPI field.



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

Pertinent Information Previously Approved PA

- Previously approved PA's can be updated within 30 calendar days of the original request submission to accommodate changes such as:
  - Practitioner Information
  - Dates of Service (DOS)
- **Exceptions:**
  - Updates are not permitted if the new DOS overlaps with a previous adverse determination, such as a denial or partial approval.
  - Updates cannot include retroactive days (i.e., dates more than one business day prior to the initial request submission).
- **Important:**
  - All updates or corrections to PAs must be requested before any related claims are denied. Timely submissions ensure continuity of care and accurate claims processing.

Pertinent Information Limitations on Outpatient Mental Health Services

MHS adheres to the, IHCP Mental Health and Addiction Limitation Policy which imposes the following restrictions:

- A maximum of 20 BHOP units per member, per practitioner, per calendar year applies to the specified CPT codes.
- This policy reflects a change from the previous rolling 12-month period.

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

Important Guidelines:

- Do not submit authorization requests that extend beyond December 31 of the current calendar year.
- HHW Package C members are allowed up to 30 BHOP units per calendar year under this policy.

Providers are encouraged to carefully monitor utilization to ensure compliance with these limitations.

This is not a concussive list

Benefit Limitations Denials

Claims exceeding the benefit limit will deny as:

- Maximum Benefit Reached, claim denial code EX Mb:

If the member requires additional services beyond the 20-unit limitation, providers may request prior authorization for additional units.

Approval will be given based on the necessity of the services as determined by the review of medical records.

Providers will need to determine if they have provided 20 units to the member in the calendar year to determine if a prior authorization request is needed.

“Per Provider” is defined by MHS as per individual rendering practitioner NPI being billed on the *CMS-1500* claim form (Box 24J).

BH Prior Authorization Denials

Prior Authorization Denials continued

Example denial letter with denial reason:

RE: Member Name:
DOB:
Medicaid ID #:

Attn: , MD c/c Hospital Inc., Fax

Dear ,

Managed Health Services (MHS) is your partner in health through Hoosier Healthwise, the Healthy Indiana Plan (HIP) or Hoosier Care Connect. Your doctor has asked MHS to approve Inpatient Psychiatric Hospitalization (twenty-four (24) hour help in a hospital) for dates of service through discharge requested on . After we reviewed the information that your doctor sent about your need for Inpatient Psychiatric Hospitalization, we have denied that request.

We reviewed the information received against InterQual 2024, Behavioral Health, Adult and Geriatric Psychiatry, Inpatient. The request was reviewed and denied because Medical necessity criteria is not met for the requested service dates because the information given to us shows that you no longer have problems that need twenty-four (24) hour hospital care. Your mood is better. You do not have thoughts or plans to harm yourself or others. You do not hear voices telling you to harm yourself or others. You are taking your medicine. You do not need emergency medication. You are taking better care of yourself. You can get support from family, friends, or your community. You can continue treatment outside the hospital. You do not need this level of care for safe and effective treatment. The last covered day is . Dates forward are denied. Outpatient (a place to get help in the community) services with case management (help to find services) or other increased supports, might be helpful.

This decision has been made by Adam Bowman, MD, our Medical Director, who is a licensed and actively practicing Board Certified Psychiatrist.

BH Prior Authorization Appeals

Prior Authorization Appeals Contact

- Prior Authorization/BH Appeals may be submitted to MHS in the following ways:

Web: Secure Provider Portal

Email: Appeals@mhsindiana.com

Call: Medicaid: 1-877-647-4848

Fax: Medicaid: 1-866-714-7991

Mail: MHS Appeals
P.O. Box 10378
Van Nuys, CA 914-10-0378

MHS Network Team

MHS Resources

- For additional information, please contact your MHS Provider Engagement Account Manager to schedule an appointment today

- Additional resources available at on the **MHS Website**

- Register online for additional **Monthly Web Sessions**

PEAM Contact Information

NORTHEAST REGION

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

NORTHWEST REGION

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

NORTH CENTRAL REGION

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

CENTRAL REGION

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

SOUTH CENTRAL REGION

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

SOUTHWEST REGION

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

SOUTHEAST REGION

For claims issues, email:
MHS_ProviderRelations_SE@mhsindiana.com
tiffany.calloway@centene.com
Tiffany Calloway,
Provider Engagement Account Manager
1-812-697-8126

PEAM Manager Map Color Key

Large Provider Groups - Carolyn

CAROLYN VALACHOVIC MONROE

Provider Engagement Account Manager

1-317-443-8243

CMONROE@mhsindiana.com

PROVIDER GROUPS

- Eskenazi/The Health and Hospital Corp.
- Baptist Health
- Lifespring
- Wellcare
- Deaconess (including Little Company of Mary)
- Good Samaritan
- Norton (including King's Daughters, Clark & Scott Memorial)
- Indiana University Health
- Reid Hospital
- St. Elizabeth Hospital
- Community Health

Large Provider Groups – Mona

MONA GREEN

Provider Engagement Account Manager
1-812-614-1003
mona.green@mhsindiana.com

PROVIDER GROUPS

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

Behavioral Health Provider Contact

ANGEL JOHNSON

Provider Engagement Account Manager
1-317-468-5184
angel.johnson3@centene.com

PROVIDER GROUPS

Park Center
Otis Bowen
Centerstone
Valley Oaks Health
Grant-Blackford
Four County
Hamilton Center
Community Mental Health Center (Lawrenceburg)
Oaklawn
Northeastern Center
Edgewater Health
Regional Mental Health
Swanson Center
Porter-Starke Services
Southwestern Behavioral
Community Mental Health Center (Vevay/ Batesville)

Additional Contact Information

MHS Provider Network

NETWORK LEADERSHIP

JILL CLAYPOOL
Senior Vice President, Network Development & Contracting
1-877-647-4848
Jill.E.Claypool@mhsindiana.com

MARK VONDERHEIT
Senior Director, Provider Network
1-877-647-4848
MVONDERHEIT@mhsindiana.com

JENNIFER GARNER
Manager, Provider Relations
1-317-771-5537
jgarner@mhsindiana.com

NETWORK OPERATIONS

KELVIN ORR
Director, Network Operations
1-877-647-4848
Kelvin.D.Orr@mhsindiana.Com

NEW PROVIDER CONTRACTING

TIM BALKO
Director, Network Development & Contracting
1-877-647-4848
TBALKO@mhsindiana.com

MICHAEL FUNK
Manager, Network Development & Contracting
1-877-647-4848
Michael.J.Funk@mhsindiana.com

CENTENE VISION

SIERRA HICKS
sierra.hicks@centene.com
Vision Provider Services: 1-844-820-6523

CENTENE DENTAL

THOMAS "TONY" SMITH
thomas.smith3@centene.com
Dental Provider Services: 1-855-609-5157

Thank You for Attending!

By taking a few moments to complete the event and sessions evaluations, you'll help us understand your experience and shape the future of our programs.

TQRCG

mhs

Questions?

Thank you for being our partner in care.