



Understanding *UB-04* Billing: Key Components and Common Errors

2026 Indiana Health Coverage Programs (IHCP)
Annual Works Seminar

Agenda

- MHS Overview
- Claim Submission Process
- Claim Rejections
- MHS Claims Administrative Reviews and Appeals
- Additional Claims Assistance
- MHS Secure Provider Portal Functionality
- Facility Billing
- Provider Portal Claim and Payment Review
- Online Claim Reconsiderations on the MHS Secure Provider Portal
- Prior Authorization
- MHS Provider Engagement Team
- Questions

MHS Overview

Who Is MHS?

- Managed Health Services (MHS) is a health insurance provider that has been proudly serving Indiana residents for 30 years through Hoosier Healthwise (HHW), the Healthy Indiana Plan (HIP) and Hoosier Care Connect (HCC).
- MHS is your choice for better healthcare.

Claim Submission Process

Behavioral Health Claim Submission

- **Electronic Submission:**

- Payer ID **68068**
- MHS accepts Third Party Liability (TPL) information via Electronic Data Interchange (EDI)
- 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 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

P.O. Box 6800

Farmington, MO 63640-3818

Medical Claim Submission

- **Electronic Data Interchange (EDI) 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 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
P.O. Box 3002
Farmington, MO 63640-3802

Claim Billing with Ease

The National Provider Identifier (NPI), Tax ID, Zip +4 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:
 - Member ID (MID) 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

In-Network and Out-of-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 calendar 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 calendar days of the date of service with a copy of the primary Explanation of Payment (EOP).
- If the EOP is received after the 365 days, providers have 60 calendar days from date of primary EOP to file claim to MHS. If the third party does not respond within 90 calendar days, claims may be submitted to MHS for consideration. Claims submitted must be accompanied by proof of filing with the patient's primary.

Claim Acceptance and 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.
- NPI common rejection/denial; provider information on claim must match record at Indiana Health Coverage Programs (IHCP) enrollment – a state requirement.

Paper Claim Correction

- *UB-04* (CMS-1450) form should be submitted with the appropriate resubmission code in the 4th digit of the bill type (**4th digit = 7** for a corrected claim) in **Field 4**, along with the claim number in **Field 64** needing correction
- The **original claim** number should be provided
- If a **corrected claim** has already been filed for the **original claim**, then the latest submitted claim number should be provided on the claim form

Claim Rejections

Claim Rejections (2 of 2)

- A rejection is a claim that contains invalid or missing data elements required for acceptance of the claim in the claim process system.
- Rejected claims need corrected and submitted as a first-time new claim.
- Timely filing is not substantiated when a claim is rejected.
- Provider may need to verify that they are billing locations linked at IHCP.

Claim Rejections Resources

- EDI rejections require the provider to contact their clearinghouse and obtain a Payer Rejection Report.
- MHS website tools:
 - Provider Resources
 - Refer to Rejection Code Help Aid
 - Scroll down to Claims/Billing:
 - Top 10 Rejections Codes Help AID
 - Reject Reason Codes and Descriptions
 - Paper to electronic mapping

Reason for Claim Rejections

MEDICAL	BEHAVIORAL HEALTH
B1 Rendering and billing NPI not tied to State file 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 Clinical Laboratory Improvement Amendments (CLIA) 77 Invalid Claim Type A3 Claim Exceeded the Maximum 97 Service Line Limit	B1 Rendering and billing NPI not tied to State file 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 Claims Administrative Reviews and Appeals

Provider Claims Appeals Process

- **Level 1:** Informal Claims Dispute
- **Level 2:** Formal Claims Dispute- Administrative Appeal
- **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 Information – Medical and Behavioral Health

Medical Claims Address:

Managed Health Services
P.O. Box 3000
Attn: Appeals Department
Farmington, MO 63640-3800

Behavioral Health Claims Address:

Managed Health Services BH
Appeals
P.O. Box 6000
Attn: Appeals Department
Farmington, MO 63640-3809

Informal Claims Dispute

Level 1:

- Submit all documentation supporting your objection
 - 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)
- Must be submitted via the MHS Secure Provider Portal or in writing within **60 calendar days** of receipt of the MHS EOP by using the Medical Claim Dispute/Appeal Form
 - Requests received after day 60 will not be considered

Informal Claims Dispute - 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 appeal response to initiate a Formal Claim Appeal (Level 2).

Informal Claims Dispute – Helpful Tips

Level 1:

- 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/remittance;
 - 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 & Provider Portal Inquiries

- After the Informal Claims Appeal (Level 1) has been submitted, for assistance or questions, the provider can access the Provider Service Phone Line or Provider 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. EST
- Provider Web Portal
- Use the Messaging Tool

Provider Services Phone Requests & Provider Portal Inquiries – Helpful Tips

Disputing multiple Claim Denials:

- Provide the Provider Services Representative or Provider Portal Team Member with one claim number as an example of the specific denial. Communication is key!
- Inform the representative 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 Taxpayer Identification Number (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, 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 MHS Secure Provider Portal or in writing by using the Medical Claim Dispute/Appeal Form with an explanation including any specific details which may justify reconsideration of the disputed claim. The appeal should be clearly marked on the form as Level 2.
- In the comment box clearly state your reason for the dispute.

Formal Claims Dispute - Level 2

- If the original determination is upheld, the provider will be notified within **45 calendar days** of receipt of the appeal.
- At that time (or upon receipt of our response if sooner), you will have up to **60 calendar days** from date of appeal response to initiate a Formal Claim Appeal (Level 3).

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

429 N Pennsylvania St., Suite 109

Indianapolis, IN 46204

Additional Claim Assistance

New Online Form for Provider Issue Submissions

- Effective 06/01/2026, provider issues – claims, credentialing status, billing guideline questions and enrollment status – are submitted through a new online form instead of the regional mailboxes.
- Complete the Provider Services Team Question form; it goes directly to the MHS Provider Engagement Network Specialist team.
- Regional Provider Relations mailboxes are deactivated in waves by region – see the rollout schedule that follows.
- The form does not begin the appeals process; follow the MHS Provider Manual or Secure Portal guidelines for appeals and continue checking claim status on the Secure Portal.
- Please do not email your Provider Engagement Account Manager directly, as travel may delay a response.

How the New Submission Process Works

- **Submitting an issue:**
 - Go to the Provider Services Team Question form.
 - Complete all required fields so the team can assess the issue; attach a spreadsheet if multiple claims are involved.
 - Include claim number(s), TIN, group/facility name, practitioner name and NPI, member name and MID, product, dates of service, related prior authorization numbers, and your reason for the dispute.
- **After you submit:**
 - You receive a confirmation screen and a confirmation receipt email for your records.
 - MHS responds from **ProviderResolutions@mhsindiana.com** within 3 business days of your request, or within 3 business days of receiving any additional documentation requested.
 - The response includes a proposed solution and expected resolution date, with weekly updates until the issue is resolved.
 - Reply directly to that email with follow-up questions or additional documentation.

Regional Rollout and Mailbox Decommission Schedule

- Regional mailboxes are notified and then decommissioned on the schedule below – use the online form once your region converts.
 - South Central – notified 6/1/2026, mailbox closes 9/4/2026
 - Central – notified 6/15/2026, mailbox closes 9/18/2026
 - Southwest – notified 6/29/2026, mailbox closes 10/2/2026
 - Southeast – notified 7/13/2026, mailbox closes 10/16/2026
 - Northwest – notified 7/27/2026, mailbox closes 10/30/2026
 - Northeast – notified 8/10/2026, mailbox closes 11/13/2026
 - North Central – notified 8/24/2026, mailbox closes 11/27/2026
 - Indy Providers – notified 9/7/2026, mailbox closes 12/11/2026
- Questions: (877) 647-4848, Monday–Friday, 8 a.m.–5 p.m. ET, or mhsindiana.com.

MHS Secure Provider Portal Functionality

Secure Provider Portal Login or Registration

For Providers

[Provider Portal Login](#)

[Behavioral Health](#) ▾

[Clinical & Payment Policies](#)

[Dental Providers](#)

[Education & Trainings](#) ▾

[Email Sign Up](#)

[Enrollment and Updates](#) ▾

[News](#) ▾

[Pharmacy](#) ▾

[Prior Authorization](#) ▾

[Quality Improvement](#) ▾

[Resources](#) ▾

Provider 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](#) +

Provider Email Sign Up

[Sign Up](#)

Secure Provider Portal

This login does not include Wellcare Complete.

[Login/Register](#)

Wellcare Complete Provider Portal

Wellcare Complete requires a distinct password and login.

[Login/Register](#)

Availity



Check Eligibility, submit and check Claims and submit and confirm Auths

[Sign Up](#)

Create a login or sign into the [Online Portal](#) to get started

Homepage - MHS (Medicaid)

After logging into the portal this homepage will appear that allows providers to access information

The screenshot shows the MHS (Medicaid) homepage. At the top is a navigation bar with the MHS logo and icons for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below the navigation bar is a header section with a dropdown for 'Viewing Dashboard For: TIN' and a 'Plan Type' dropdown set to 'Medicaid'. A green 'GO' button is next to the Plan Type dropdown. Below the header, a welcome message says 'Welcome, Michelle!' followed by a link to 'Get easy access to the features you use most'. A 'Quick Actions' section follows, with a description: 'Do a quick eligibility check, find patient benefits information, create a new claim or recurring claim or an authorization.' It contains three input fields: 'Member ID or Last Name *', 'Member Date of Birth' (with a calendar icon and 'MM/DD/YYYY' format), and 'Select Action Type *' (with a dropdown menu). A blue 'SUBMIT' button is to the right. Below the Quick Actions section is an 'Authorization Overview' section with two buttons: 'Inpatient Authorizations' and 'Outpatient Authorizations', each with a 'View All' link. At the bottom is a 'Useful Links' section with three cards: 'Reports' (describing a repository of reports), 'Provider Analytics' (with an external link icon, describing data/reports/dashboard), and 'Provider Complaints' (describing submitted complaints).

mhs

Eligibility Patients Authorizations Claims Messaging Help

Viewing Dashboard For: TIN

Plan Type: Medicaid GO

Behavioral Health IN Medicaid
Wellcare - IN
Ambetter
Medicaid

Welcome, Michelle!

Get easy access to the features you use most

Quick Actions

Do a quick eligibility check, find patient benefits information, create a new claim or recurring claim or an authorization.

Member ID or Last Name * Member Date of Birth Select Action Type * SUBMIT

MM/DD/YYYY

Authorization Overview

Inpatient Authorizations View All

Outpatient Authorizations View All

Useful Links

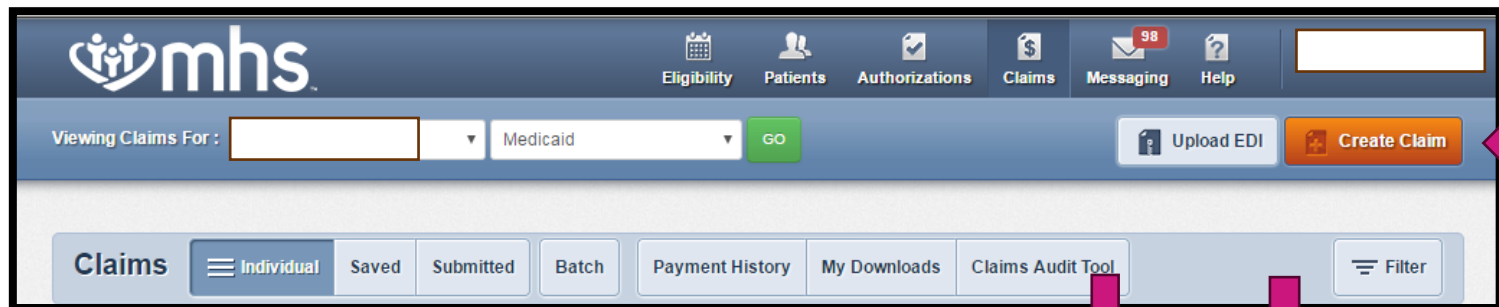
Reports
This repository contains reports that are uploaded and maintained by the health plan.

Provider Analytics [🔗](#)
Used by PCP groups to access data/reports/dashboard that assist in providing better health outcomes and lower cost.

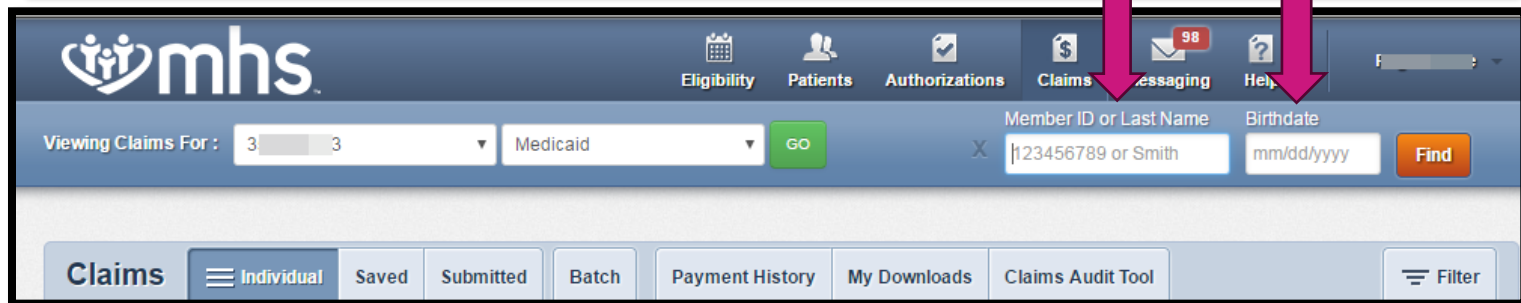
Provider Complaints
View submitted complaints to the provider.

Claims

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



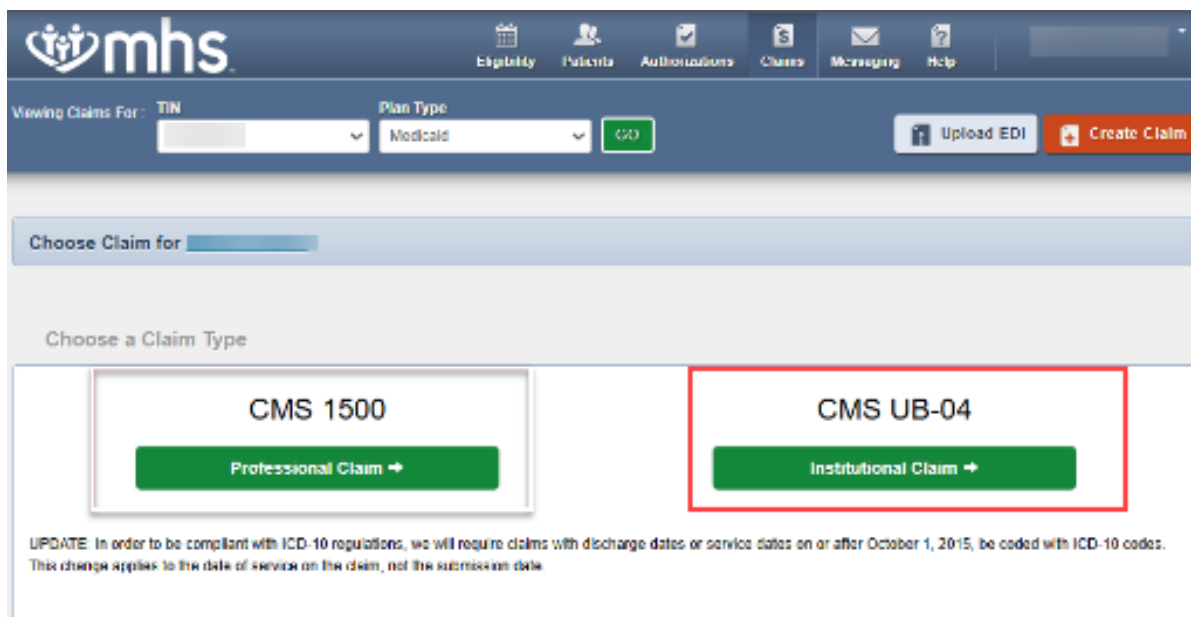
The screenshot shows the mhs web portal interface. The top navigation bar includes links for Eligibility, Patients, Authorizations, Claims, Messaging (with a 98 notification), and Help. Below the navigation bar, there is a section for 'Viewing Claims For:' with a dropdown menu set to 'Medicaid' and a 'GO' button. To the right of this section are buttons for 'Upload EDI' and 'Create Claim'. A pink arrow points to the 'Create Claim' button. Below this section is a 'Claims' tab with sub-tabs for Individual, Saved, Submitted, Batch, Payment History, My Downloads, and Claims Audit Tool. A 'Filter' button is also present.



The screenshot shows the mhs web portal interface with the 'Create Claim' form. The top navigation bar is the same as the previous screenshot. Below the navigation bar, there is a section for 'Viewing Claims For:' with a dropdown menu set to 'Medicaid' and a 'GO' button. To the right of this section are buttons for 'Upload EDI' and 'Create Claim'. A pink arrow points to the 'Create Claim' button. Below this section is a 'Claims' tab with sub-tabs for Individual, Saved, Submitted, Batch, Payment History, My Downloads, and Claims Audit Tool. A 'Filter' button is also present. The 'Create Claim' form is displayed below the tabs. It has two input fields: 'Member ID or Last Name' and 'Birthdate'. The 'Member ID or Last Name' field contains the text '123456789 or Smith'. The 'Birthdate' field contains the text 'mm/dd/yyyy'. A pink arrow points to the 'Member ID or Last Name' field, and another pink arrow points to the 'Birthdate' field. A 'Find' button is located to the right of the 'Birthdate' field.

Claims Submission

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



mhs

Eligibility Patients Authorizations Claims Messaging Help

Viewing Claims For: TIN [] Plan Type: 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

Add the provider information
Click **save** and click **next** to proceed

Click **Add New Service Line** and enter the service line's information

The screenshot shows the 'Provider Details' section of the 'Institutional Claim for [redacted]' form. A pink arrow points to the 'Billing Provider' section, which includes a redacted NPI field with a 'Search' button. Another pink arrow points to the 'Next' button at the top right of the section. Below the Billing Provider section is the 'Pay-to Provider' section, which includes fields for NPI, Taxonomy, IRS/Tax ID Number, and Pay-To Name. At the bottom is the 'Attending Provider' section with fields for NPI, Taxonomy, First Name, and Last Name.

The screenshot shows the 'Service Lines' section of the 'Institutional Claim for [redacted]' form. A pink arrow points to the 'Add New Service Line' button. The section includes a 'Total: \$0.00' summary, a 'Back' button, and a 'Next' button. The 'Add New Service Line' form includes fields for Revenue Code (with a 'Lookup' button), HCPCS / Rate / HPPS Code, NDC, Modifiers (with an 'Add' button), Service Date (MM/DD/YYYY), Service Unit, and Charge Amount. A 'Save / Update' button is also visible.

UB-04 Billing – Adding Additional Insurance

- Enter Additional Insurance (if applicable)

The screenshot displays the mhs (Medical Health Services) web interface for UB-04 Billing. The top navigation bar includes links for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below this, a header section shows 'Viewing Claims For:' with a dropdown menu set to 'Medicaid' and a 'GO' button. To the right are buttons for 'Upload EDI' and 'Create Claim'.

The main content area is titled 'Institutional Claim for' followed by a redacted patient ID. A progress bar indicates the current step in the process. Below the progress bar, the section is labeled 'THIS SECTION: 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. Below this, the 'Primary Insurance' section is highlighted with a pink arrow. A notice reads: 'Notice: If the Member has more than one primary insurance (Medicaid would be the 3rd payer), the claim cannot be submitted through the Web.'

The 'Primary Insurance' section contains several input fields:

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

Each input field has a corresponding '50' or '60' indicator on the right side, likely representing the number of lines or units for that field.

Enter Diagnosis Codes (use Add button)

The screenshot shows the 'mhs' web application interface for entering diagnosis codes. The top navigation bar includes links for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below this, there's a section for 'Viewing Claims For' with a dropdown menu 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 [redacted]' and shows a 'Your Progress' bar with several steps, the current step being 'Diagnosis Codes'. The section is labeled 'THIS SECTION: Diagnosis Codes' with the instruction 'Enter all relevant diagnosis codes.' Below this is a form with a '* Required field' label and 'Back' and 'Next' buttons. The form contains several fields: 'ICD Version Indicator*' (set to 'ICD 10'), 'Principal Diagnosis Code*' (with a pink arrow pointing to it), 'Admitting Diagnosis Code*', 'Diagnosis Codes (87A-Q)', 'Patient Reason for Visit', 'External Cause of Injury Code (ECI)', and 'Prospective Payment Code'. Each field has a placeholder text 'XXXX e.g. V87' and a 'POA Indicator' dropdown. The 'Diagnosis Codes (87A-Q)' and 'Patient Reason for Visit' fields have an 'Add' button. The 'External Cause of Injury Code (ECI)' field has a placeholder 'XXXX e.g. V87'. The 'Prospective Payment Code' field has a placeholder 'VV a = PV' and an 'Add' button. On the right side of the form, there are numbered tabs: 67, 69, 67 a-q, 70, 72, 71, and 68, 69.

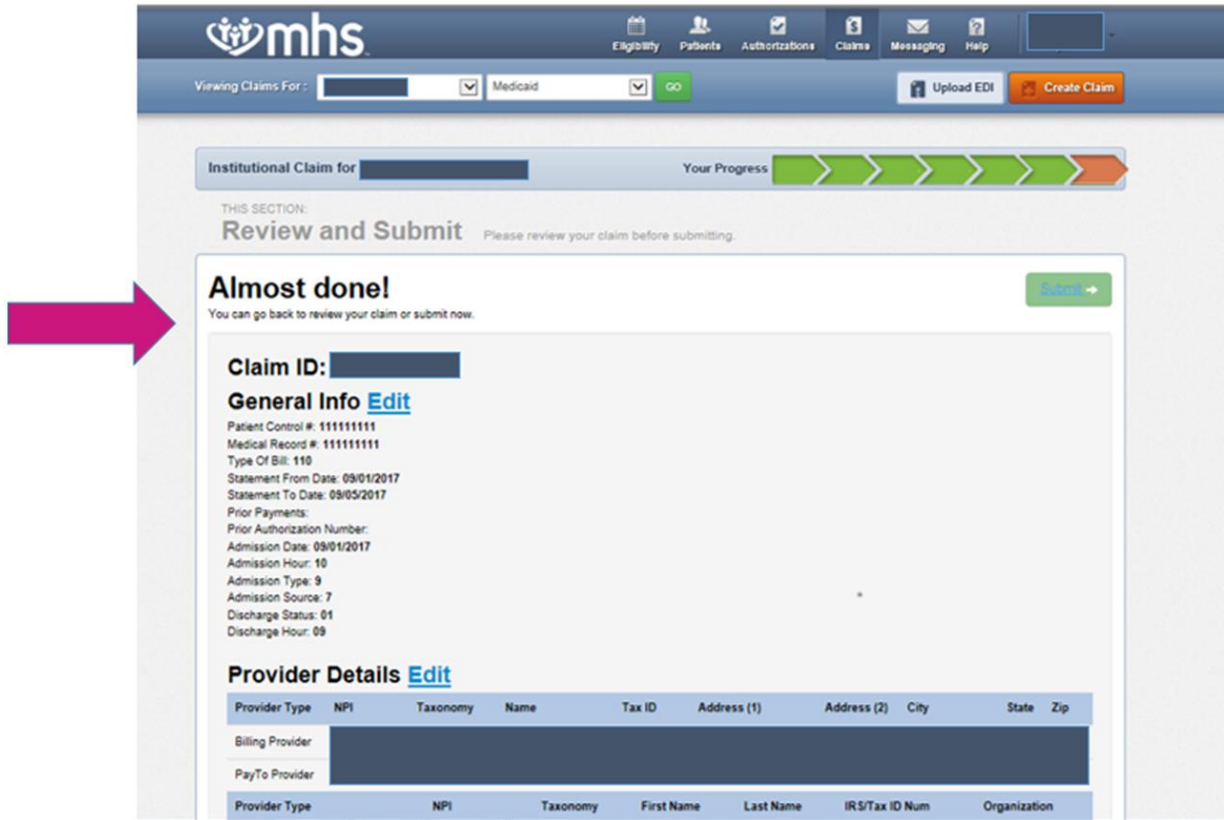
Add Attachment (if applicable)

The screenshot displays the 'mhs' web application interface for adding attachments to an institutional claim. The top navigation bar includes links for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below this, a 'Viewing Claims For' section shows a dropdown menu 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 [redacted]' and features a 'Your Progress' bar with several green arrows indicating the current step. Below this, the section is labeled 'THIS SECTION: Attachments' with the instruction 'Add attachments to the claim (5MB limit)'. A note states 'Supported types are .jpg, .tif, .pdf and .tiff'.

The 'Attachments' section contains a 'Back' button, a 'Next' button, and a message: 'If there are no attachments, click Next.' Below this, a red warning message reads: '*Do NOT send password protected files. You must click ATTACH for each file being submitted.' The 'File*' input field is highlighted with a pink arrow, and the 'Attachment Type*' dropdown menu is also visible. An 'Attach' button is located to the right of the dropdown. Below the input fields, a light blue box states 'There are no attached files.' At the bottom, another 'Back' button, 'Next' button, and the same instruction 'If there are no attachments, click Next.' are present. A pink arrow points to the 'Next' button.

Review Claim and Submit



The screenshot shows the 'mhs' web application interface for reviewing and submitting an institutional claim. The top navigation bar includes links for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below this, there's a section for 'Viewing Claims For' with a dropdown menu set to 'Medicaid' and a 'GO' button. To the right are buttons for 'Upload EDI' and 'Create Claim'.

The main content area is titled 'Institutional Claim for' followed by a redacted patient name. A progress bar shows the current step as 'Review and Submit'. Below this, the text 'THIS SECTION: Review and Submit' is displayed, along with a note: 'Please review your claim before submitting.'

A large pink arrow points to the 'Almost done!' section, which includes a 'Submit' button. Below this, the 'Claim ID' is shown as a redacted field. The 'General Info' section is highlighted with an 'Edit' link and contains the following details:

- 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

The 'Provider Details' section is also highlighted with an 'Edit' link and contains two tables:

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]						

Provider Portal Claim and Payment Review

Individual Claims

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

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

The screenshot displays the mhs Claims portal. At the top, there's a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below this, a search bar allows filtering by TIN and Plan Type (currently set to Medicaid). A green 'GO' button and buttons for 'Upload EDI' and 'Create Claim' are also present. The main section features a 'Claims' header with several tabs: 'Individual' (highlighted with a red box), 'Saved', 'Submitted', 'Batch', 'Recurring', 'Payment History', and 'Claims Audit Tool'. Under the 'Individual' tab, the section is titled 'Claims: Recent'. It includes a search bar with a date range of '01/01/2026 to 01/15/2026' and a 'Change dates' link. To the right are 'Filter' and 'Search' buttons. Below this is a table with the following data:

CLAIM NO.	CLAIM TYPE	MEMBER NAME	SERVICE DATE(S)	BILLED/PAID	CLAIM STATUS
	CMS-1500		01/01/2026 - 01/01/2026	\$191.59 / \$51.26	Paid
	CMS-1500		01/01/2026 - 01/04/2026	\$217.66 / \$94.43	Paid
	CMS-1500		01/01/2026 - 01/05/2026	\$85.80 / \$16.52	Paid
	CMS-1500		01/01/2026 - 01/06/2026	\$216.00 / \$0.00	Pending
	CMS-1500		01/01/2026 - 01/06/2026	\$368.85 / \$0.00	Denied

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 a saved Claim that is no longer necessary
5. Click **OK** to confirm the deletion

The screenshot displays the mhs Claims management interface. At the top, there is a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below this, a section for 'Viewing Claims For' includes dropdown menus for TIN and Plan Type (set to Medicaid), a 'GO' button, and buttons for 'Upload EDI' and 'Create Claim'. A 'Claims' section contains several tabs: Individual, Saved (highlighted with a red box), Submitted, Batch, Recurring, Payment History, and Claims Audit Tool. Below the tabs, a message states: 'Claims listed below have missing information or contain errors. Click 'Edit' to view a claim, then fix any errors or complete it before submitting.' There are three sub-tabs: Drafts, Professional Ready to be Submitted, and Institutional Ready to be Submitted. The 'Professional Ready to be Submitted' tab is active, showing a table of claims.

DATE CREATED ↑	CLAIM TYPE ↑	CLAIM ID ↑	MEMBER NAME ↑	MEMBER ID ↑	ORIGINAL CLAIM # ↑	TOTAL CHARGES ↑		
03/09/2026	CMS-1500					\$1,894.09	Edit	Delete
03/03/2026	Institutional					\$593.45	Edit	Delete
02/26/2026	CMS-1500				Z	\$4,844.55	Edit	Delete
01/29/2026	Institutional				Y	\$8,700.00	Edit	Delete

Submitted Claims

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

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

Claims									
Individual Saved Submitted Batch Recurring Payment History Claims Audit Tool									
SUBMITTED STATUS ↑	DATE SUBMITTED ↑	WEB #/ REF # ↑	CLAIM NUMBER ↑	CLAIM TYPE ↑	MEMBER NAME ↑	MEMBER ID ↑	ORIGINAL CLAIM # ↑	TOTAL CHARGES ↑	
👍	03/17/2026							\$232.32	RTEP 🚫
👍	03/16/2026							\$1,006.00	RTEP 🕒
👍	03/16/2026							\$5,827.04	RTEP 👍

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.
 - Electronic Funds Transfer (EFT) register with [PaySpan](#).

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

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

Transactions

All activity posted to your account between 02/19/2026 and 03/19/2026 .

Instructions: Click a Check Date link to view the payment details from your payment provider. Only available electronic files are linked. The PDF opens in a new window. You can save or print the document. If there are any discrepancies about your payment details, contact Provider Services.

CHECK DATE ↑	CHECK NUMBER ↑	CHECK CLEAR DATE ↑	MAILING ADDRESS ↑	PAYMENT AMOUNT ↑
02/19/2026 (PDF)	[]	EFT	[]	\$565.94
02/19/2026 (PDF)	0000000000	02/19/2026	[]	\$0.00
02/19/2026 (PDF)	[]	EFT	[]	\$44,387.74
02/19/2026 (PDF)	0000000000	02/19/2026	[]	\$0.00

Provider EOP

Electronic Service Requested

606 0.7648 AV 0.386

5-DIGIT 30374

████████████████████

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: ██████████	Member ID: ██████████	Claim No: ██████████
Patient Name: ██████████	PCN: ██████████	Provider ID: ██████████
Service Provider: ██████████	LNPI: ██████████	Group: ██████████
Carrier: DE		

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

EFT and ERAs

PaySpan Health

- Web-based solution for:
 - Electronic Funds
 - Transfers (EFTs) and Electronic Remittance Advices (ERAs)
- One-year retrieval of remittance advice
- Provided at no cost to providers and allows online enrollment
- Registration and more information here:
mhsindiana.com/providers/resources/electronic-transactions/payspan
- For questions call 1-877-331-7154 Monday through Friday 8a.m. to 8p.m. EST

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

Online Reconsiderations

Providers can:

- Submit informal disputes/reconsiderations on the **Secure Provider Portal**
- Submit corrected claims
- Upload/view supporting documents
- View acknowledgement letters
- Track real-time updates
- View denial code information

Benefits of Online Reconsiderations

Skip the phone call

- Providers can make their case directly on the Provider 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 when submitting online
- Providers may also view status online

Email Updates

☐ Check here to receive email status updates for this reconsideration.

Please upload files less than 25 MB each. Supported file formats are PDF, TIFF, TIF, JPEG, and JPG.

Cancel

Submit Reconsideration→

Online Reconsiderations – Helpful Tips

- 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.

Informal Claim Dispute on the Secure Provider Portal

From the Claim Details screen of a denied claim, review the status bar, member, provider, claim and payment details, then select Dispute Claim to begin a **Level 1** informal dispute.

The screenshot shows the 'Claim Details' screen. At the top, there is a 'Back to Claims' button and the title 'Claim Details'. Below this, the claim status is 'Denied' with a red 'x' icon. There are three buttons: '+ Copy Claim', 'Void/Recoup Claim', and 'Dispute Claim'. A large pink arrow points to the 'Dispute Claim' button. Below the buttons is a progress bar with three stages: 'Claim Accepted' (green checkmark), 'In Process' (green checkmark), and 'Claim Denied' (red 'x').

Below the progress bar, there are four sections: 'Member', 'Provider', 'Claim', and 'Most Recent Payment'.

Member

Member Name: _____

Member ID: _____

Member DOB: _____

Provider

Ref/Acct No.: _____

Servicing Provider: _____

Servicing NPI: _____

Claim

DOS Range: 08/04/2025 - 08/04/2025

Received Date: 08/06/2025

Billed Amount: _____

Most Recent Payment

Payment Date: 08/14/2025

Check Dated: 08/13/2025

Paid Claim Amount: \$0.00

Service Lines

Line	DOS	Proc	Dx	Modifiers	Place of Service	Charged	Paid Amount	Payment Date	Status	Payment Codes
------	-----	------	----	-----------	------------------	---------	-------------	--------------	--------	---------------

Secure Provider Portal Claim Options

SELECT

Option 2: Reconsiderations

Most providers use this option when there is a dispute in payment and/or additional documentation required.

SELECT

Option 3: Informally dispute the claim

A dispute is a informal review performed by the Claims Department.

- A response will be issued within **30 calendar day** of submission.
- You will still have the opportunity to select **Option 4: 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.

SELECT

Option 4: 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.

[Terms and Conditions](#) [\(new tab\)](#)

[Privacy Policy](#) [\(new tab\)](#)

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Claim Reconsideration

- Enter your explanation for reconsideration and check email updates.

The screenshot displays the mhs portal interface with a modal window titled "Option 2: Reconsideration Claim". The modal includes a "Claim No." field, a pink instruction box, a "Reason" dropdown menu set to "Denied for Untimely Filing", a "Notes" section with a "Brief Explanation" text area, a "500 Character Limit" warning, an "Upload Documents" section with a "Choose Files" button and a red note "Proof of Timely Filing attachment Required", an "Uploaded Files" section, and an "Email Updates" section with a checkbox and instructions. The background shows a sidebar with "SELECT" buttons and a top navigation bar with icons for Eligibility, Patients, Authorizations, Claims, Messaging, and Help.

Option 2: Reconsideration Claim

Claim No: [Field]

Please refer to the SHP Provider Manual to determine if your request is an appeal or a reconsideration

Reason
Denied for Untimely Filing

Notes
Brief Explanation
[Text Area]

500 Character Limit

Upload Documents
Choose Files
Proof of Timely Filing attachment Required

Uploaded Files

Email Updates
☐ Check here to receive email status updates for this dispute/appeal.
Please upload files less than 25 MB each. Supported file formats are PDF, TIFF, TIF, JPEG, and JPG.

Cancel Submit Reconsideration➔

Claim Appeals on the Secure Provider Portal

Claim #: [Redacted] : Denied

Copy Claim Correct Claim

✓ Your Reconsideration request # [Redacted] has been submitted successfully.

Claim Acc [Redacted] In Process Denied In Process OUTCOME TBD

RECONSIDERATION

Reconsideration Details

Created Date	Type	Current Status	Reference Number	Tools
06/11/2019	Denial Related to an Authorization	OPEN	[Redacted]	[Tools Icon]

Member Provider Claim Most Recent Payment

Member Name: [Redacted] Ball/Acct No.: [Redacted] DOS Range: [Redacted] Payment Date: [Redacted] Granted Claim Amount: [Redacted]

Member ID: [Redacted] Services Provider: [Redacted] Received Date: [Redacted] Check Number: [Redacted] Total Check Amount: [Redacted]

Member DOS: [Redacted] Billing Amount: [Redacted] Check Dated: [Redacted]

Service Lines

Line	DOS	Proc	Dx	Modifiers	Place of Service	Charged	Total Check Amount	Payment Date	Check Number	Status	Payment Codes
1	05/13/2019		Q059, N319, R02, K592		12	\$381.92	\$0.00	06/11/2019		DENY	L6,Ku

Denial Reason

Denial Code	Description
L6	DENY: BILL PRIMARY INSURER 1ST RESUBMIT WITH EOB
Ku	INFORMATIONAL-RE-ADJUDICATION PROCESS EX CODE

- The **Reconsideration Details** section is viewable to provide status and details.
- **Tools** section allows easy View of included attachments or correspondence letters and the option to add additional attachments to an open reconsideration case still in process.
- The **Most Recent Payment** will display the details of the last check or EFT that was made on the claim.

MHS Provider Engagement Team

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

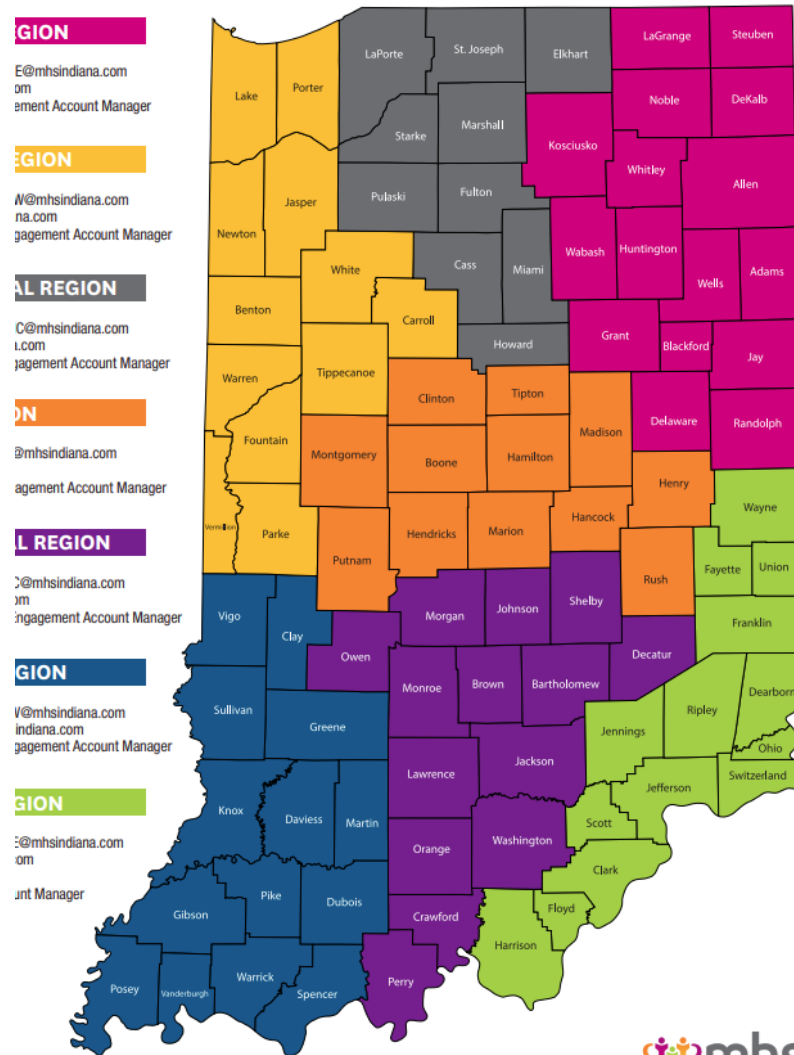
SOUTHEAST REGION

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

Note: Effective 06/01/2026, use the online Provider Services Team Question form; these mailboxes close by wave.

Provider Engagement Account Manager Map

Color Key



PEAM - Large Provider Groups

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

PEAM - Behavioral Health 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 Contacts Provider Network

JILL CLAYPOOL

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

JENNIFER GARNER

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

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

Vision and Dental Contacts

SIERRA HICKS

sierra.hicks@centene.com

Vision Provider Services: 1-844-820-6523

THOMAS “TONY” SMITH

thomas.smith3@centene.com

Dental Provider Services: 1-855-609-5157

Questions?

