



Navigating Member Eligibility for Providers

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Agenda

- Basics of Eligibility
- Managed Care or Fee-for-Service (FFS) Coverage
- Claims
- Members' Loss of Coverage
- Resources
- Questions?



Basics of Eligibility



Member Eligibility

Eligibility for members is determined by the Family and Social Services Administration (FSSA) and the Division of Family Resources (DFR).

Individuals can apply for Medicaid coverage in the below ways:

- Online at [FSSA Benefits Portal](#)
- In Person at their local DFR office
- By phone by calling 1-800-403-0864

Once an application has been completed, their application status can be checked online via the FSSA Benefits Portal or by calling 1-800-403-0864 between 8am – 4:30pm local time.



Member Eligibility Review

An individual's eligibility is reviewed by using various eligibility requirement such as:

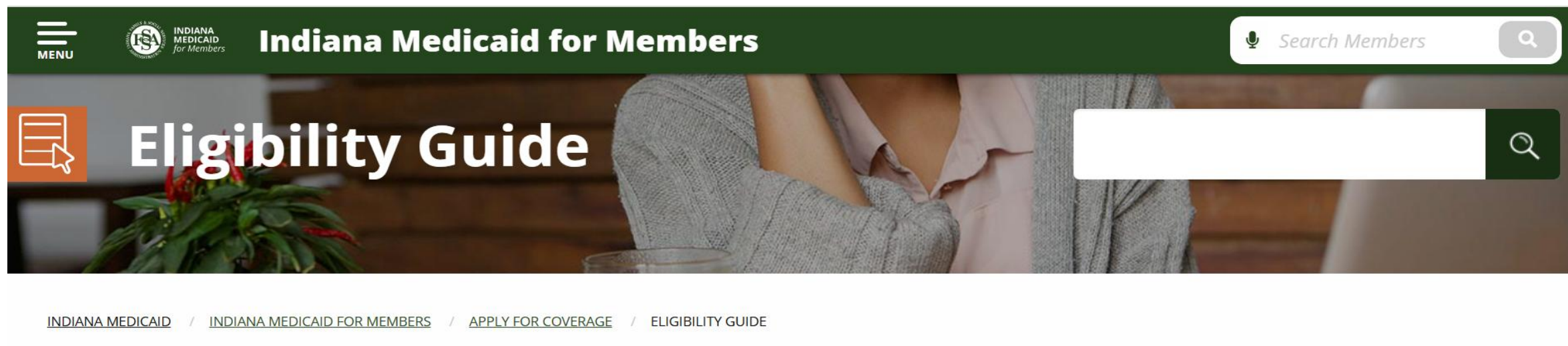
- Household income
- Family size
- Age
- Pregnancy status
- Disability
- Citizenship

Please note: Managed Care Organizations (MCOs) do not determine and are unable to assist members with their eligibility.



Eligibility Criteria

The member eligibility criteria for Medicaid coverage can be reviewed on the Indiana Medicaid for Members webpage under [Eligibility Guide](#).





Eligibility Determination

The DFR determines if a member is eligible for any of the Indiana Medicaid benefit plans by conducting an interview with the member and requesting supporting documentation.

- Members will be matched with the most appropriate benefit plan for their circumstances.

Application processing times are 45 days for standard applications and 90 days for applicants with a disability determination.



Eligibility Notifications

The applicant will receive a notice via USPS mail and the FSSA Benefits Portal regarding the approval or denial of their application.

- Once the member has received their approval notice, their coverage is active effective the date outlined in the notice.



Eligibility Notice for Health Coverage

Indiana Family and Social Services Administration
PO Box 1810
Marion, IN 46952
Phone: 1-800-403-0864
Fax: 1-888-436-9199

Payee Name :

Case Number :

AG Number :

Program :

Mailing Date :



Managed Care or Fee-for-Service (FFS) Coverage



Medicaid Benefit Plans

The Indiana Health Coverage Programs (IHCP) offers five benefit plans that individuals can qualify for based on their circumstances.

These benefit plans include:

- Traditional Medicaid, also called fee-for-service (FFS)
- Healthy Indiana Plan (HIP)
- Hoosier Healthwise (HHW)/Children's Health Insurance Plan (CHIP)
- Hoosier Care Connect (HCC)
- Indiana PathWays for Aging (PathWays)



Plan Details for Providers

A provider's source of truth for a member's coverage is the [IHCP Provider Healthcare Portal](#) (IHCP Portal).

- Provides the most accurate information
- Information comes directly from the FSSA

A screenshot of the 'INDIANA MEDICAID for Providers' web portal. The header includes the FSSA logo and navigation links for 'Contact Us', 'FAQs', and 'Login'. A green banner displays the title 'INDIANA MEDICAID for Providers'. Below this, a 'Home' button is visible. The main content area is divided into two columns. The left column contains a 'Login' section with a text input for '*User ID', a red error message 'User ID is a required field.', a 'Log In' button, and links for 'Forgot User ID?', 'Register Now', and 'Where do I enter my password?'. The right column features a 'Broadcast Messages' section with a message about system maintenance on Sunday, 8/9, and a section titled 'WHAT CAN YOU DO IN THE PROVIDER HEALTHCARE PORTAL?' which lists capabilities like submitting claims, checking claim status, inquiring on eligibility, and viewing remittance advices.



Plan Coverage

The category of coverage that the member has and if the member has an MCO or FFS will be displayed in the IHCP Provider Portal.

Managed Care Assignment Details			
Managed Care Program		Primary Medical Provider	Provider Phone
Healthy Indiana Plan Managed Care			
Effective Date	End Date	MCO / CMO Name	MCO / CMO Phone
09/25/2026	09/25/2026	MANAGED HEALTH SERVICES - HIP	1-877-647-4848



MCO Eligibility

Providers should also check member eligibility via the health plan portals.

- If the information does not match on the IHCP Provider Portal and the MCO Portal, reach out to the MCO for assistance.



Checking Eligibility

Check member's eligibility and health plan assignment on the dates of service for every service rendered.

- The OMPP recommends verifying in the IHCP Portal and then following up with the individual MCO portal for managed care members.

Eligibility Verification Request

* Indicates a required field.

Enter the member information. If Member ID is not known, enter SSN and Birth Date, or Last Name, First Name, and Birth Date.

Member ID

SSN

*Effective From

Last Name

Birth Date

Effective To

First Name

Submit

Reset

PE Application for Inmate

Coverage Details for [redacted] on 09/25/2026 to 09/25/2026

Member ID

Birth Date

Verification Response ID

[Expand All](#) | [Collapse All](#)



Claims



Checking Covered Services

All Medicaid categories do not cover the same services. Providers should check the MCO and FFS covered services to ensure payment.

Resources to check covered services:

- [IHCP Fee Schedules](#)
- [IHCP Code Sets](#)
- [Anthem](#)
- [CareSource](#)
- [Humana](#)
- [MHS](#)
- [United Healthcare](#)



Eligibility Denial Reasons

EOB Code	Description
0665	THE MEMBER IS ENROLLED IN RISK BASED MANAGED CARE. PLEASE SUBMIT TO APPROPRIATE RISK BASED MANAGED CARE PROCESSOR.
0803	MEMBER INELIGIBLE FOR ALL OR A PORTION OF THE SERVICE DATES BILLED. IF NECESSARY PLEASE RESUBMIT AND BREAK OUT SERVICES FOR WHICH THE MEMBER IS ELIGIBLE FROM SERVICES FOR WHICH THE MEMBER IS INELIGIBLE.
2003	MEMBER NOT ELIGIBLE FOR INDIANA HEALTH COVERAGE PROGRAM BENEFITS FOR DATES OF SERVICE.
2004	MEMBER NOT ELIGIBLE FOR INDIANA HEALTH COVERAGE PROGRAM BENEFITS FOR DATES OF SERVICE.
2009	MEMBER NOT ELIGIBLE FOR INDIANA HEALTH COVERAGE PROGRAM BENEFITS FOR DATES OF SERVICE.
2010	EMERGENCY SERVICE ONLY MEMBERS ARE ELIGIBLE FOR A PAYMENT ONLY FOR EMERGENCY SERVICES.
2019	MEMBER IS NOT ELIGIBLE FOR INDIANA HEALTH COVERAGE PROGRAM BENEFITS.
2029	MEMBER NOT ELIGIBLE FOR IHCP BENEFITS FOR DATES OF SERVICE.
3771	MEMBER NOT ELIGIBLE TO RECEIVE SERVICES UNDER THIS BENEFIT PLAN.



Retroactive Coverage Change

Follow the below steps if a recoupment happens due to a retroactive coverage change:

- Ensure you have the recoupment letter from the MCO or FFS that has the initial payment date and recoupment notification date.
- Identify which health plan the member is now covered under and submit a claim with the recoupment letter as an attachment and include a claim note stating this was a retroactive eligibility change involving a recoupment.
- Submit the new claim within 365 days.



Claims Issues Relating to Eligibility

If a claim is denied for no coverage **after eligibility was confirmed** take the following steps:

- Reach out to your provider relations representative with the MCO or FFS.
- File a claim dispute/administrative review.
- Complete the entire claim dispute and appeal process.
- Reach out to the OMPP Provider Relations inbox at OMPPProviderRelations@fssa.IN.gov.



MCO Claim Disputes

[405 Indiana Administrative Code \(IAC\) 1-1.6](#)

- Informal dispute within 60 calendar days from denial notice.
- Formal dispute within 60 calendar days from informal dispute decision.

These timeframes must be followed to ensure payment if it is determined your claim was denied in error.



FFS Administrative Review

Providers have 60 calendar days from the notification of claim payment or denial to submit an administrative review for FFS claims. Review the [Claim Administrative Reviews and Appeals](#) module for more information.

Creating a request for an administrative review:

- IHCP Provider Portal
- IHCP Claim Administrative Review Request Form
- In writing

Administrative reviews for FFS are handled through the IHCP fiscal agent Gainwell Technologies.



FFS Appeals

Claim appeals are completed in accordance with [Indiana Code IC 4-21.5-3-7](#) and IHCP must receive the appeal withing 15 calendar days after you receive the adverse administrative review decision.

- Submit through IHCP Portal secure correspondence message
- In writing via hand delivery, mail, email or fax:

MS07 Secretary

Indiana Family and Social Services Administration

Office of Medicaid Policy and Planning

402 W. Washington St., Room W374 Indianapolis, IN 46204-2739

Fax: 317-232-4412

Email: fssa.appeals@oalp.in.gov



Billing Members

Medicaid members can only be billed for services under certain circumstances:

- The service is not covered, and the member has signed a written consent prior to the service being completed agreeing to pay for the service.
- For more information on member billing exceptions, refer to the Provider Enrollment module.

Medicaid members cannot be balance billed or billed when payment is denied by the MCO or FFS.



Members' Loss of Coverage



Loss of Coverage Reasons

Coverage loss can be due to several reasons. Some examples are listed here:

- Failed to complete redetermination
- Over income threshold
- Failed to return required documents
- Household changes
- Enrolling in other insurance



Member Medicaid Termination

When a member has lost coverage, they should:

- Review the FSSA Benefits Portal.
- Reach out to a DFR office near them.
- Complete any missed requirements.



Additional Tips

- Don't contact the MCO to resolve eligibility issues.
- Instruct the member to contact DFR as soon as possible.
- Ensure members/authorized representatives do not ignore appeal rights.
- Advise members to update their address and phone number with the FSSA.



Resources



Resources for Members

- [Apply for Coverage](#)
- [FSSA Benefits Portal](#)
- [Find My Local DFR Office](#)
- [Eligibility Guide](#)
- [Contact Us](#)
- DFR at 1-800-403-0864



Resources for Providers

- [Member Eligibility and Benefits Coverage module](#)
- [IHCP Quick Reference Guide](#)
- [Claim Submission and Processing](#)
- [HIP Work Requirements](#)
- [IHCP Bulletins](#)



Thank You!



Please scan the QR code and complete the
session evaluation survey!



Questions?