PROVIDER Quick Reference Guide

Effective August 2025

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., EST, closed holidays

CASE MANAGEMENT:
8 a.m. to 5 p.m., EST, closed holidays

AFTER-HOURS EST, CLOSED HOLIDAYS:
MHS' 24/7 Nurse Advice Line for members is available to answer calls for emergent authorization needs. OR, Providers can also 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, resubmit, or appeal a decision.

Failure to do so within the specified timeframe will waive the right for reconsideration.

BH CLAIMS ADDRESS:
MHS Behavioral Health
ATTN: Claims Department
P.O. Box 6800, Farmington MO 63640-3817

MEDICAL CLAIMS REFUNDS:
To refund claims overpayment, please send check and documentation to:

MHS
Attention: Claims Recovery Team
Coordinated Care Corporation, Inc.
P.O. Box 856420, Minneapolis, MN 55485-6420

MHS FAX NUMBERS

MEDICAL APPEALS: 1-866-714-7993 **REFERRALS AND AUTHORIZATIONS: 1-866-912-4245**

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 "KRAMES 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 I and level II 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.

Availity

OTHER RESOOURCES

payspanhealth.com..... MHS is pleased to partner with PaySpan 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 payspanhealth.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.

BEHAVIORAL HEALTH

Please call for prior authorization for the following HHW/HIP/HCC and Presumptive Eligibility services: Facility services billed with revenue codes, including inpatient hospitalization, partial hospitalization and certain professional services including ECT and psych testing.

CLAIMS ADDRESS:
MHS Behavioral Health
ATTN: Claims Department
P.O. Box 6800
Farmington, MO 63640-3817

CLAIMS REFUND ADDRESS:
MHS Behavioral Health
Attn: Claims Recoupment
75 Remittance Dr., Suite 6446
Chicago, IL 60675-6446

CLAIMS APPEALS ADDRESS:
Behavioral Health Appeals
P.O. Box 3002
Farmington, MO 63640-3802

MEDICAL NECESSITY APPEALS ADDRESS:
MHS Behavioral Health
ATTN: Appeals Coordinator
P.O. Box 10378
Van Nuys, CA 91410-0378
FAX: 1-866-714-7991
appeals@mhsindiana.com

TRANSPORTATION - LCP

Ambulance claims are paid through MHS. Non-Ambulance transportation claims are paid through LCP Transportation.

PHONE: 1-877-647-4848

NON-AMBULANCE CLAIMS ADDRESS: P.O. Box 531097 • Indianapolis, IN 46253

CENTENE PHARMACY SERVICES

The pharmacy benefit is administered through Centene Pharmacy Services.

PRIOR AUTHORIZATION PHONE: 1-855-772-7121
FAX: Non-Specialty Drugs 1-866-399-0929
Specialty Drugs 1-855-678-6976
WEBSITE: www.centenepharmacy.com

CLAIMS SUBMISSION:
BIN #003858
PCN: MA
RXGROUP: 2EKA

CENTENE VISION SERVICES

Routine vision services are a self-referral service and do not require primary medical provider referral. Members receive enhanced vision services from Centene Vision network providers. Surgical vision services are coordinated by MHS directly.

PHONE: 866-599-1774

CREDENTIALING: 800-531-2818

FAX: 1-252-451-2182

WEBSITE: visionbenefits.envolvehealth.com

CLAIMS ADDRESS:
Envolve Vision
ATTN: Claims
P.O. Box 7548
Rocky Mount, NC 27804

ELECTRONIC CLAIMS:
Payor Number 56190

WEB-SUBMISSION CLAIMS:
visionbenefits.envolvehealth.com
(for participating providers)

DENTAL - ENVOLVE DENTAL

Routine dental services are a self-referral service and do not require primary medical provider referral or MHS prior authorization. Members receive comprehensive dental services from Centene Dental network providers. Outpatient/hospital services are coordinated by MHS directly.

PHONE: 1-855-609-5157

EMAIL: providerrelations@envolvehealth.com

CLAIMS ADDRESS:
Centene Dental Sevices - Claims: IN
PO Box 20847
Tampa, Fl 33622-0847

WEB-SUBMISSIONS: envolvedental.com

EDI CLAIMS:
Electronic claim submission through select clearinghouses: Payor ID 46278

CREDENTIALING HOTLINE: 1-855-609-5157
CREDENTIALING FAX: 1-844-847-9807

PRIOR AUTHORIZATIONS

A Prior Authorization (PA) is an authorization from MHS to provide services designated as requiring approval prior to treatment and/or payment. All procedures requiring authorization must be obtained by contacting MHS prior to rendering services. PA is required for certain services/procedures which are frequently over- and/or underutilized or services/procedures which are complex and may indicate a need for case management.

Check to see if a pre-authorization is necessary by using our Prior Authorization tool located on the sidebar. It's quick and easy. If an authorization is needed, you can access our Provider Portal to submit online.

HOW TO OBTAIN A PRIOR AUTHORIZATION

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

- Fax: 1-866-912-4245
- Online: Provider Portal

For DME, orthotics, prosthetics, home healthcare, and therapy (physical, occupational, speech), requests for services may be obtained via fax only: 1-866-912-4245.

Always check member eligibility for date of service as requests may be delayed if the member is with another MCE or not eligible.

MHS will accept PA requests for emergent services up to 2 business days post services for both contracted and non-contracted providers.

Previously approved PAs can be updated for changes to practitioner and/or dates of service, (unless the DOS overlaps a previous adverse determination [denial or partial approval] OR the DOS includes retro days [dates more than 1 business day prior to the initial request]), within 30 days of the original request submission. These updates must be requested prior to related claim denials.

Authorization approval is for medical necessity only. If your claim subsequently denies, please contact MHS Provider Services at 1-877-647-4848 to determine the reason for the denial.

MHS strives to return a decision on all non-emergent PA requests within 48 hours of the request. All emergent request will be responded to within 24 hours. Reasons for a delayed decision include the following:

- Lack of information
- Illegible faxes

Prior authorizations can be submitted via the MHS Secure Provider Portal or Availity for registered providers.

CONTRACTED PROVIDERS

Contracted providers requesting authorization for elective/routine services must obtain a PA at least two days prior to the date of service to ensure an authorization determination occurs prior to rendering a service. MHS does allow requests for authorization from contracted providers up to two days after the date of service, subject to the appropriate medical review.

NON-CONTRACTED PROVIDERS

Non-contracted providers must obtain authorization two days prior to the date of service. Retroactive authorizations will not be granted except in the event of an emergent situation. If a provider is unable to request a PA at least two business days in advance due to the emergent nature of the member's condition, a PA request must be initiated within two business days following the date of service/admission. MHS will make every effort to expedite the request. All emergency admissions/services require authorization within two business days of the admission/service.

Failure to obtain PA as previously described will result in claims payment denials for late notifications. Claim denials may result when a claim is denied due to a failure to obtain PA for services where PA is required.