











MHS 2019




Lunch and Learn Session



Agenda

-  MHS Overview
-  P4P Quality
-  Prior Authorization Process
-  Web Portal Functionality
-  Public Website
-  Behavioral Health Updates
-  Medical Claims processing
-  Partners and Vendors
-  Summary
-  Questions

Who is MHS?

-  Managed Health Services (MHS) is a health insurance provider that has been proudly serving Indiana residents for two decades through Hoosier Healthwise, the Healthy Indiana Plan (HIP) and Hoosier Care Connect.
-  MHS also offers a qualified health plan through the Health Insurance Marketplace called Ambetter from MHS and a Medicare Advantage product called Allwell from MHS. All of our plans include quality, comprehensive coverage, with a provider network you can trust.
-  **MHS is your choice for better healthcare.**

MHS Products






Allwell Overview: Medicare Advantage Plans

 **Allwell from MHS** provides complete continuity of care to members including:

- Integrated coordination of care
- Care management
- Co-location of behavioral health expertise
- Integration of pharmaceutical services with the PBM
- Additional services specific to the beneficiary needs

 Approach to care management facilitates the integration of:

- Community resources
- Health education
- Disease management

 Promotes access to care as beneficiaries are served through a single, locally-based multidisciplinary team including:

- RNs
- Social Workers
- Pharmacy Technicians
- Behavioral Health Case Managers

Allwell Plan Coverage



We offer HMO, PPO, and HMO DSNP plans



\$0 for Premiums*



\$0/\$5 PCP copay (HMO v. PPO)



\$0 & \$5 generics



Great Value-Add Benefits

- \$65 quarterly OTC benefit, \$85 quarterly OTC benefit for DSNP
- Hearing aid benefit
- \$150 eyeglasses benefit for HMO and PPO, \$200 benefit for DSNP
- Silver & Fit
- Preventive dental



All Part A and Part B benefits by Medicare



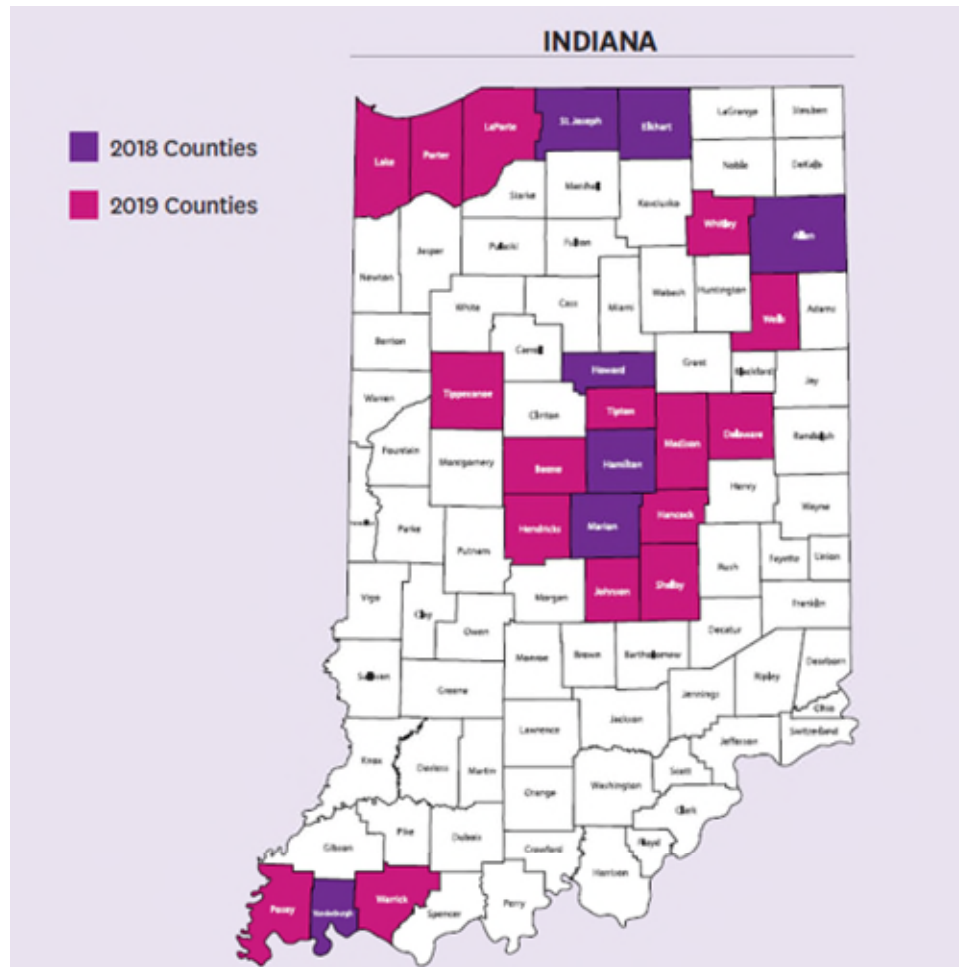
Part B drugs – such as chemotherapy drugs



Part D drugs – no deductible at network retail pharmacies or mail order, will have copay or coinsurance for some tiers

*\$0 premiums apply to all of the HMO products; and, the PPO product in Allen, Elkhart, St. Joseph, Wells, and Whitley Counties.

2019 Counties



Member ID Cards



Providers should verify eligibility before every visit by using one of the below options:

- Website: **allwell.mhsindiana.com**
- 24/7 Interactive Voice Response Line: 1-855-766-1541
- Provider Services: 1-855-766-1541
- TTY: 711

 <p>HMO CMS#: <XXXX-XX> Effective: <MM/DD/YYYY></p>		<p>FOR MEMBERS Member Services: <1-855-766-1541> (TTY: 711) 24-hr Nurse Advice: <1-855-766-1541> (TTY: 711) https://allwell.mhsindiana.com</p>	<p>FOR EMERGENCIES Dial 911 or go to the nearest Emergency Room (ER).</p>
<p>MEMBER INFORMATION Name: <First MI Last> Member ID#: <XXXXXXXX-XX> Issuer ID: <(80840)> <9151014609></p>	<p>PHARMACY INFORMATION  Rx Claims Processor: <CVS Caremark> RXBIN: <004336> RXPCN: <MEDDADV> RXGRP: <RX8910></p>	<p>FOR PROVIDERS For eligibility: <1-855-766-1541> Prior authorization or case management referrals: <1-855-766-1541> Pharmacy prior auth: <1-800-867-6564> <small>For help: (PHARMACY USE ONLY)</small> <1-888-865-6567></p>	<p>Submit Part D Drug Claims to: <Allwell> <Attn: Pharmacy Claims> <P.O. Box 419069> <Rancho Cordova, CA> <95741-9069></p>
<p>PROVIDER INFORMATION PCP Name: <> PCP Phone: <></p>	<p>MEDICAL CLAIMS EDI Payor ID: <68069> <Allwell From MHS> <Attn: Claims> <P.O. Box 3060 Farmington, MO 63640-3822></p>		

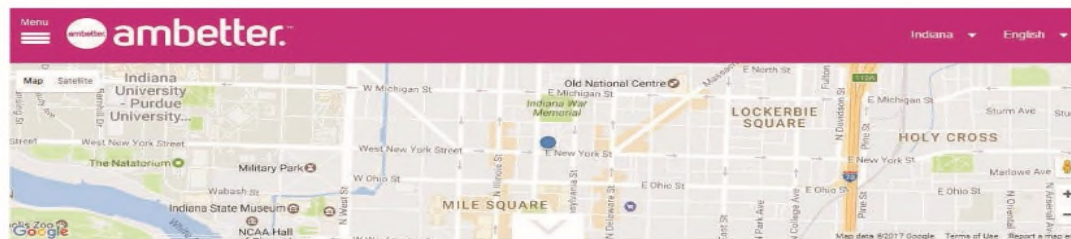
 <p>HMO SNP CMS#: <XXXX-XX> Effective: <MM/DD/YYYY></p>		<p>FOR MEMBERS Member Services: <1-833-202-4704> (TTY: 711) 24-hr Nurse Advice: <1-855-766-1541> (TTY: 711) https://allwell.mhsindiana.com</p>	<p>FOR EMERGENCIES Dial 911 or go to the nearest Emergency Room (ER).</p>
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<p>PROVIDER INFORMATION PCP Name: <> PCP Phone: <></p>	<p>MEDICAL CLAIMS EDI Payor ID: <68069> <Allwell From MHS> <Attn: Claims> <P.O. Box 3060 Farmington, MO 63640-3822></p>		

 <p>PPO CMS#: <XXXX-XX> Effective: <MM/DD/YYYY></p>		<p>FOR MEMBERS Member Services: <1-855-766-1541> (TTY: 711) 24-hr Nurse Advice: <1-855-766-1541> (TTY: 711) https://allwell.mhsindiana.com</p>	<p>FOR EMERGENCIES Dial 911 or go to the nearest Emergency Room (ER).</p>
<p>MEMBER INFORMATION Name: <First MI Last> Member ID#: <XXXXXXXX-XX> Issuer ID: <(80840)> <9151014609></p>	<p>PHARMACY INFORMATION  Rx Claims Processor: <CVS Caremark> RXBIN: <004336> RXPCN: <MEDDADV> RXGRP: <RX8911></p>	<p>FOR PROVIDERS For eligibility: <1-855-766-1541> Prior authorization or case management referrals: <1-855-766-1541> Pharmacy prior auth: <1-800-867-6564> <small>For help: (PHARMACY USE ONLY)</small> <1-888-865-6567></p>	<p>Submit Part D Drug Claims to: <Allwell> <Attn: Pharmacy Claims> <P.O. Box 419069> <Rancho Cordova, CA> <95741-9069></p>
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Ambetter from MHS is an Exclusive Provider Network Benefit Plan

- Members enrolled in Ambetter must utilize in-network participating providers and practitioners except in the case of emergency services.
- When referring a member to another provider or practitioner, please make sure that the referral is contracted with Ambetter.
- If a non-contracted provider or practitioner is utilized, except in the case of emergency services, the member will be responsible for charges that exceed the allowed amount. ***This could mean hundreds of dollars in out-of-pocket expenses for the member.***
- Contracted providers and practitioners can be identified by visiting our website at **ambetter.mhsindiana.com** and clicking on Find a Provider.



Find a HealthCare Provider



Quick Name
Search



Detailed
Search

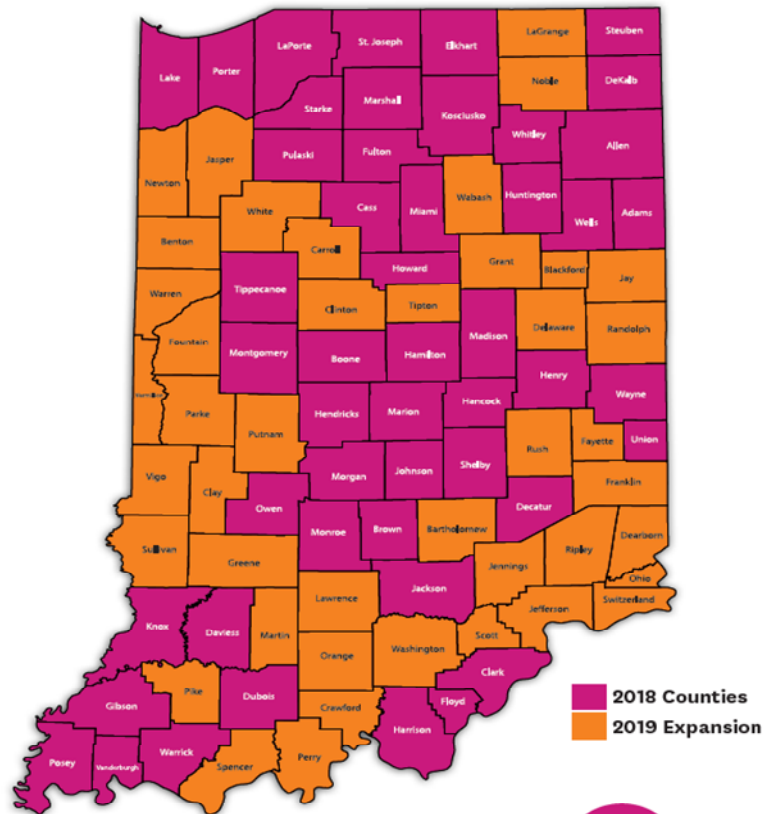


My
Favorites

**Thank you for protecting our members from
unnecessary out-of-pocket expenses!**



2019 Ambetter State-wide Coverage

2019 Coverage Map - Indiana



Verification of Eligibility, Benefits and Cost Share

Member ID Card:


FROM


Subscriber: [Jane Doe]

Member: [John Doe]

Policy #: [XXXXXXXXXX]

Member ID #: [XXXXXXXXXXXXXX]

Plan: [Ambetter Balanced Care 1]

**IN NETWORK
COVERAGE ONLY**

Effective Date of Coverage:
[XX/XX/XX]

RXBIN: 004336

RXPCN: ADV

RXGROUP: RX5453

COPAYS

PCP: \$10 coin. after ded.

Specialist: \$25 coin. after ded.

Rx (Generic/Brand): \$5/\$25 after Rx ded.

Urgent Care: 20% coin. after ded.

ER: \$250 copay after ded.

Deductible (Med/Rx):
[\$250/\$500]

Coinurance (Med/Rx):
[50%/30%]

Ambetter.mhsindiana.com

Member/Provider Services:
1-877-687-1182
TTY/TDD: 1-800-743-3333
24/7 Nurse Line: 1-877-687-1182

Medical Claims:
Managed Health Services
Attn: CLAIMS
PO Box 5010
Farmington, MO
63640-5010

Numbers below for providers:
Pharmacy Help Desk: 1-866-270-3922
EDI Payor ID: 68069
EDI Help Desk: Ambetter.mhsindiana.com

Additional information can be found in your Evidence of Coverage. If you have an Emergency, call 911 or go to the nearest Emergency Room (ER). Emergency services given by a provider not in the plan's network will be covered without prior authorization. Receiving non-emergent care through the ER or with a non-participating provider may result in a change to member responsibility. For updated coverage information, visit Ambetter.mhsindiana.com.

AMB17-IN-C-00036 ©2017 Celtic Insurance Company. All rights reserved.

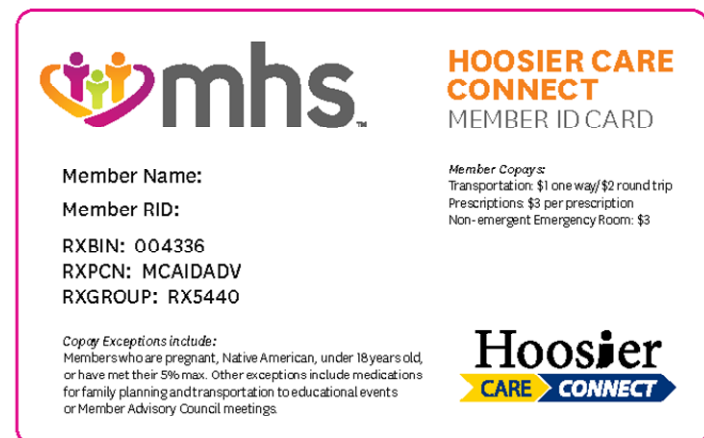
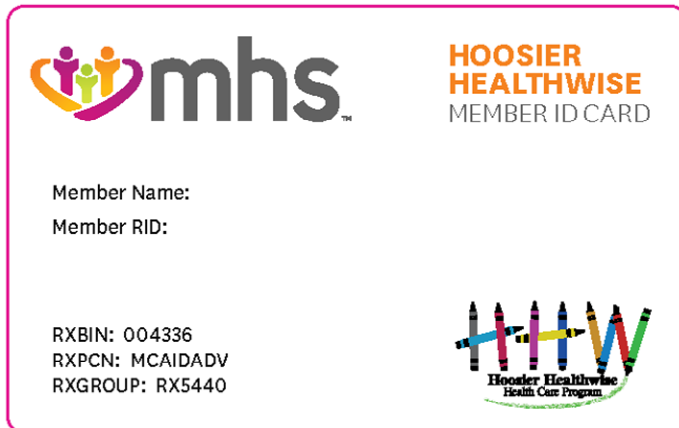
** Possession of an ID Card is not a guarantee of eligibility and benefits*



MHS Medicaid ID Cards






Used for both HIP and
HIP Maternity



Healthy Indiana Plan (HIP)

The Healthy Indiana Plan (HIP) is an affordable health insurance program from the State of Indiana for uninsured adult Hoosiers.

-  Members will select a managed care entity (MCE) responsible for coordinating care in partnership with their medical provider(s)
-  Care coordination services will be individualized based on a member's assessed level of need determined through a health screening
-  HIP provides coverage for qualified low-income Hoosiers ages 19 to 64, not receiving Medicare who are interested in participating in a low-cost, consumer-driven health care program

HIP uses a proven, consumer-driven approach that was pioneered in Indiana.

HIP Basic Plan – Copay

When members with income less than or equal to 100% FPL do not pay their HIP Plus monthly contribution, they are moved to HIP Basic. HIP Basic Members are responsible for making the below copayments for health and pharmacy services.

**Copayments may not be more than the cost of services received.*

Service	HIP Basic Co-Pay Amounts ≤100% FPL
Outpatient Services	\$4
Inpatient Services	\$75
Preferred Drugs	\$4
Non-preferred drugs	\$8
Non-emergency ER visit	\$8

POWER Up to HIP Plus

Encourage HIP members to join HIP Plus

Enhanced benefit package

- No copays! Only pay a monthly contribution
- Dental coverage
- Vision coverage
- Additional therapy services
- Rx mail order option
- Chiropractic care

When can members POWER Up?

- Open enrollment
- Redetermination/Potential Plus Loop

Contact MHS Customer Service to POWER Up to HIP Plus

- 1-877-647-4848



Hoosier Healthwise

Hoosier Healthwise covers the following members:

 Children up to age 19




 Pregnant women

 The Children's Health Insurance Plan (CHIP)

- This option is available for individuals up to age 19 who may earn too much money to qualify for the standard Hoosier Healthwise coverage

Hoosier Care Connect

Hoosier Care Connect is a coordinated care program for Indiana Health Coverage Programs (IHCP) members age 65 and over, or with blindness or a disability who are residing in the community and are not eligible for Medicare

-  Members will select a managed care entity (MCE) responsible for coordinating care in partnership with their medical provider(s)
-  Hoosier Care Connect members will receive all Medicaid-covered benefits in addition to care coordination services
-  Care coordination services will be individualized based on a member's assessed level of need determined through a health screening

HEDIS/Pay for Performance (P4P)





Why Should Providers Care About HEDIS?



HEDIS rates are used to:

- Guide Pay For Performance Measures
- Levy bonuses
- Support increased quality outcomes for Members
- Encourage preventive care services

2019 P4P

-  Bonus Pay for Performance (P4P) fund written into Primary Medical Provider contracts
-  Measures are different for each product line
-  Measures aligned with HEDIS[®] and NCQA
-  Annual payout



2019 HHW P4P

P4P SCHEDULE A-2A-1 Hoosier Healthwise

Please send information to Managed Health Services (MHS), Attn: P4P Program, 550 N. Meridian Street, Suite 101, Indianapolis, IN 46204.

Pay-For-Performance Measures	Goal Rate	Minimum Number of Covered Persons	Points	
Children's Care (Quality)				
Childhood Immunization Status (CIS) COMBO 10	% of 2 year old Covered Persons who had the following immunizations by their second birthday: 4 DTaP, 3 IPV, 1 MMR, 3 Hib, 3 Hep B, 1 VZV, 4 PCV, 1 Hep A, 2 or 3 RV (depending on dose schedule), 2 Flu	HEDIS 75 th percentile	10	5 points
Lead Screening in Children	% of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday. HEDIS measure (HEDIS LSC) using hybrid data.	HEDIS 75 th percentile	10	10 points
Follow-Up Care for Children Prescribed ADHD Medication – Initiation Phase	% of members 6–12 years of age as of the IPSP with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase	HEDIS 75 th percentile	5	5 points
Follow-Up Care for Children Prescribed ADHD Medication – continuation phase	% of members 6–12 years of age as of the IPSP with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended	HEDIS 75 th percentile	5	5 points
Well-Child Visits in the First 15 Months of Life (W15)	% of Covered Persons turning 15 mos within the current year who had 6 or more visits with PMP before turning 15 mos old.	HEDIS 75 th percentile	10	10 points
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	% of Covered Persons who turned 3-6 years old within the year who had 1 or more well child visits within the current year	HEDIS 75 th percentile	10	10 points
Adolescent Well-Care Visits (AWC)	% of Covered Persons 12-21 years old who had at least 1 comprehensive well care visit with PMP or OB within the current year	HEDIS 75 th percentile	10	10 points

P4P SCHEDULE A-2A-1 Hoosier Healthwise

Maternal Care (Quality)				
Prenatal and Postpartum Care (PPC)	Postpartum Care - % of deliveries that had a postpartum visit on or between 21 and 56 days after delivery	HEDIS 75 th percentile	5	6 points
Timeliness of Ongoing Prenatal Care (PPC)	% of deliveries that received a prenatal care visit as a member of the organization in the first trimester, on the enrollment start date or within 42 days of enrollment in the organization. HEDIS measure (HEDIS PPC) using hybrid data.	HEDIS 75 th percentile	5	9 points
Ambulatory Measures				
Ambulatory Care (AMB) – ER utilization	Utilization of ambulatory care in the ED - # visits per 1,000 member months	HEDIS 10 th percentile	10	10 points
Respiratory Care				
MED Management for People With Asthma (Med 75% rate)	% of members 5–64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications and remained on an asthma controller medication for at least 75% of their treatment period	HEDIS 75 th percentile	5	10 points
Provider Outreach (Administrative) Credit Given to Providers in Good Standing:				10 points
<p>A Provider is determined to be in "Good Standing" if they comply and complete the following:</p> <ol style="list-style-type: none"> Host, or participate in, a Preventive Health Outreach program or activity, Do not have a closed Provider Panel, and are able to accept new members, Attendance in one MHS training/orientation sessions during the calendar year. <p>OR</p> <ol style="list-style-type: none"> Enrolls in My Health Direct before the end of the 1st quarter of the new calendar year and remains enrolled through the end of the calendar year. 				



2019 HIP P4P

P4P SCHEDULE A-2B-1 Healthy Indiana Plan (HIP)

Please send information to Managed Health Services (MHS), Attn: P4P Program, 550 N. Meridian Street, Suite 101, Indianapolis, IN 46204.

Pay-For-Performance Measures		Goal Rate	Minimum Number of Covered Persons	Points
Women's Care (Quality)				
Chlamydia Screening in Women (CHL)	% of female Covered Persons age 16-24 years identified as sexually active who had at least one Chlamydia test in the current year	HEDIS 75th percentile	5	5 points
Cervical Cancer Screening (CCS)	% of female Covered Persons age 24-64 years who received 1 or more Pap tests to screen for cervical cancer in the current year	HEDIS 75th percentile	5	5 points
Breast Cancer Screening (BCS)	% of women 50-74 years of age who had a mammogram to screen for breast cancer	HEDIS 75th percentile	5	5 points
Maternal Care (Quality)				
Prenatal and Postpartum Care (PPC)	Postpartum Care - % of deliveries that had a postpartum visit on or between 21 and 56 days after delivery	HEDIS 75th percentile	5	10 points
Timeliness of Ongoing Prenatal Care (PPC)	% of deliveries that received a prenatal care visit as a member of the organization in the first trimester, on the enrollment start date or within 42 days of enrollment in the organization. HEDIS measure (HEDIS PPC) using hybrid data.	HEDIS 75th percentile	5	10 points
Respiratory Care				
MED Management for People With Asthma (Med 75% rate)	% of members 5-64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications and remained on an asthma controller medication for at least 75% of their treatment period	HEDIS 75th percentile	5	5 points
Ambulatory Measures				

P4P SCHEDULE A-2B-1 Healthy Indiana Plan (HIP)

Behavior Health Care				
Antidepressant Medication Management (AMM) – Acute Phase	% of members who remained on an antidepressant medication for at least 84 days (12 weeks)	HEDIS 75th percentile	5	6 points
Diabetes Care				
Diabetes Care - Eye exam (retinal) performed	% of members 18-75 years of age with diabetes (type 1 and type 2) who had an eye exam (retinal) performed	HEDIS 75th percentile	5	6 points
Diabetes Care - Medical attention for nephropathy	% of members 18-75 years of age with diabetes (type 1 and type 2) who had medical attention for nephropathy	HEDIS 75th percentile	5	6 points
Adult Care				
Adult Preventive Care	% of members 19 years or older who had a preventive care visit.	HEDIS 75th percentile	10	20 points
Provider Outreach (Administrative) Credit Given to Providers in Good Standing:				10 points
A Provider is determined to be in "Good Standing" if they comply and complete the following: <ol style="list-style-type: none"> 1. Host, or participate in, a Preventive Health Outreach program or activity, 2. Do not have a closed Provider Panel, and are able to accept new members, 3. Attendance in one MHS training/orientation sessions during the calendar year. OR <ol style="list-style-type: none"> 1. Enrolls in My Health Direct before the end of the 1st quarter of the new calendar year and remains enrolled through the end of the calendar year. 				

2019 HCC P4P

P4P SCHEDULE 2C-1A Hoosier Care Connect

Please send information to Managed Health Services (MHS), Attn: P4P Program, 550 N. Meridian Street, Suite 101, Indianapolis, IN 46204.




Pay-For-Performance Measures		Goal Rate	Minimum Number of Covered Persons	Points
Children's Care (Quality)				
Childhood Immunization Status (CIS) COMBO 10	% of 2 year old Covered Persons who had the following immunizations by their second birthday: 4 DTaP, 3 IPV, 1 MMR, 3 Hib, 3 Hep B, 1 VZV, 4 PCV, 1 Hep A, 2 or 3 RV (depending on dose schedule), 2 Flu	HEDIS 75 th percentile	10	5 points
Well-Child Visits in the First 15 Months of Life (W15)	% of Covered Persons turning 15 months within the current year who had 6 or more visits with PMP before turning 15 months old	HEDIS 75 th percentile	10	10 points
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	% of Covered Persons who turned 3-6 years old within the year who had 1 or more well child visits within the current year	HEDIS 75 th percentile	10	10 points
Adolescent Well-Care Visits (AWC)	% of Covered Persons 12-21 years old who had at least 1 comprehensive well care visit with PMP or OB within the current year	HEDIS 75 th percentile	10	10 points
Respiratory Care				
MED Management for People With Asthma (Med 75% rate)	% of members 5–64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications and remained on an asthma controller medication for at least 75% of their treatment period	HEDIS 75 th percentile	5	5 points
Pharmacotherapy Management of COPD Exacerbation (PCE) - systemic corticosteroid	% of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED visit on or between January 1– November 30 of the measurement year and who were dispensed a systemic corticosteroid (or there was evidence of an active prescription) within 14 days of the event	HEDIS 75 th percentile	5	5 points

P4P SCHEDULE 3A-1 Hoosier Care Connect


Diabetes Care					
Diabetes Care - Eye exam (retinal) performed	% of members 18-75 years of age with diabetes (type 1 and type 2) who had an eye exam (retinal) performed	HEDIS 75 th percentile	5	6 points	
Diabetes Care - Medical attention for nephropathy	% of members 18-75 years of age with diabetes (type 1 and type 2) who had medical attention for nephropathy	HEDIS 75 th percentile	5	6 points	
Behavioral Health Care					
Antidepressant Medication Management (AMM) - Acute Phase	% of members who remained on an antidepressant medication for at least 84 days (12 weeks)	HEDIS 75 th percentile	5	6 points	
Adult Care					
Adult Preventive Care	% of members 19 years or older who had a preventive care visit.	HEDIS 75 th percentile	10	15 points	
Ambulatory Measures					
Ambulatory Care (AMB) - ER utilization	Utilization of ambulatory care in the ED - # visits per 1,000 member months	HEDIS 10 th percentile	10	12 points	
Provider Outreach (Administrative) Credit Given to Providers in Good Standing: 10 points					
A Provider is determined to be in "Good Standing" if they comply and complete the following: <ol style="list-style-type: none"> 1. Host, or participate in, a Preventive Health Outreach program or activity, 2. Do not have a closed Provider Panel, and are able to accept new members, 3. Attendance in one MHS training/orientation sessions during the calendar year. OR <ol style="list-style-type: none"> 1. Enrolls in My Health Direct before the end of the 1st quarter of the new calendar year and remains enrolled through the end of the calendar year. 					

Administrative Measures

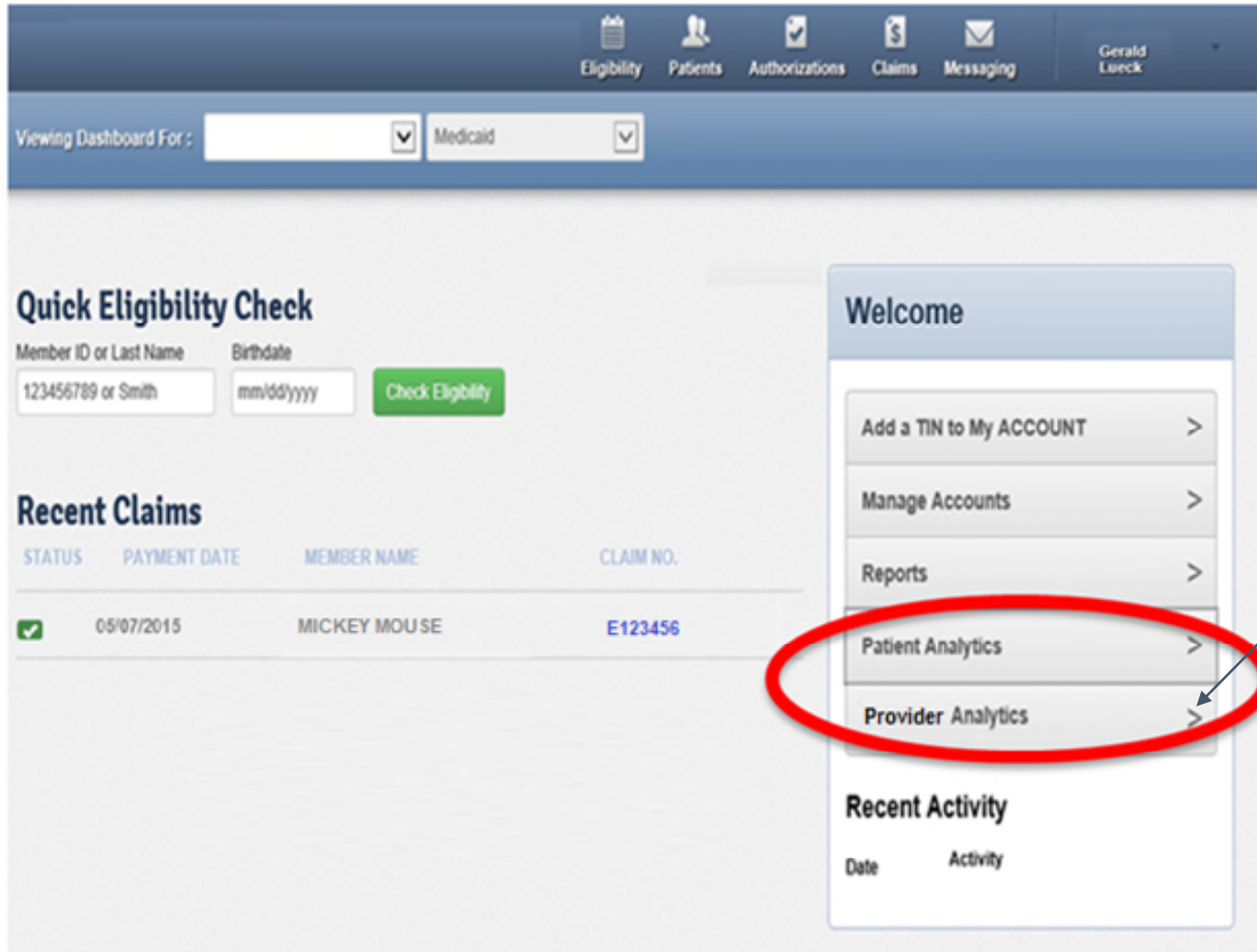
A provider is determined in “Good Standing” if they comply and complete the following:

-  Host or participate in a Preventative Health Outreach or activity.
-  Do not have a closed Provider Panel, and are able to accept new members.
-  Attendance of one MHS training/orientation sessions during the calendar year.

OR

-  Enroll in My Health Direct before the end of the 1st quarter of the new calendar year and remains enrolled through the end of the year.

Provider analytics



Eligibility Patients Authorizations Claims Messaging Gerald Lueck

Viewing Dashboard For : Medicaid

Quick Eligibility Check

Member ID or Last Name Birthdate

123456789 or Smith mm/dd/yyyy [Check Eligibility](#)

Recent Claims

STATUS	PAYMENT DATE	MEMBER NAME	CLAIM NO.
✓	05/07/2015	MICKEY MOUSE	E123456

Welcome

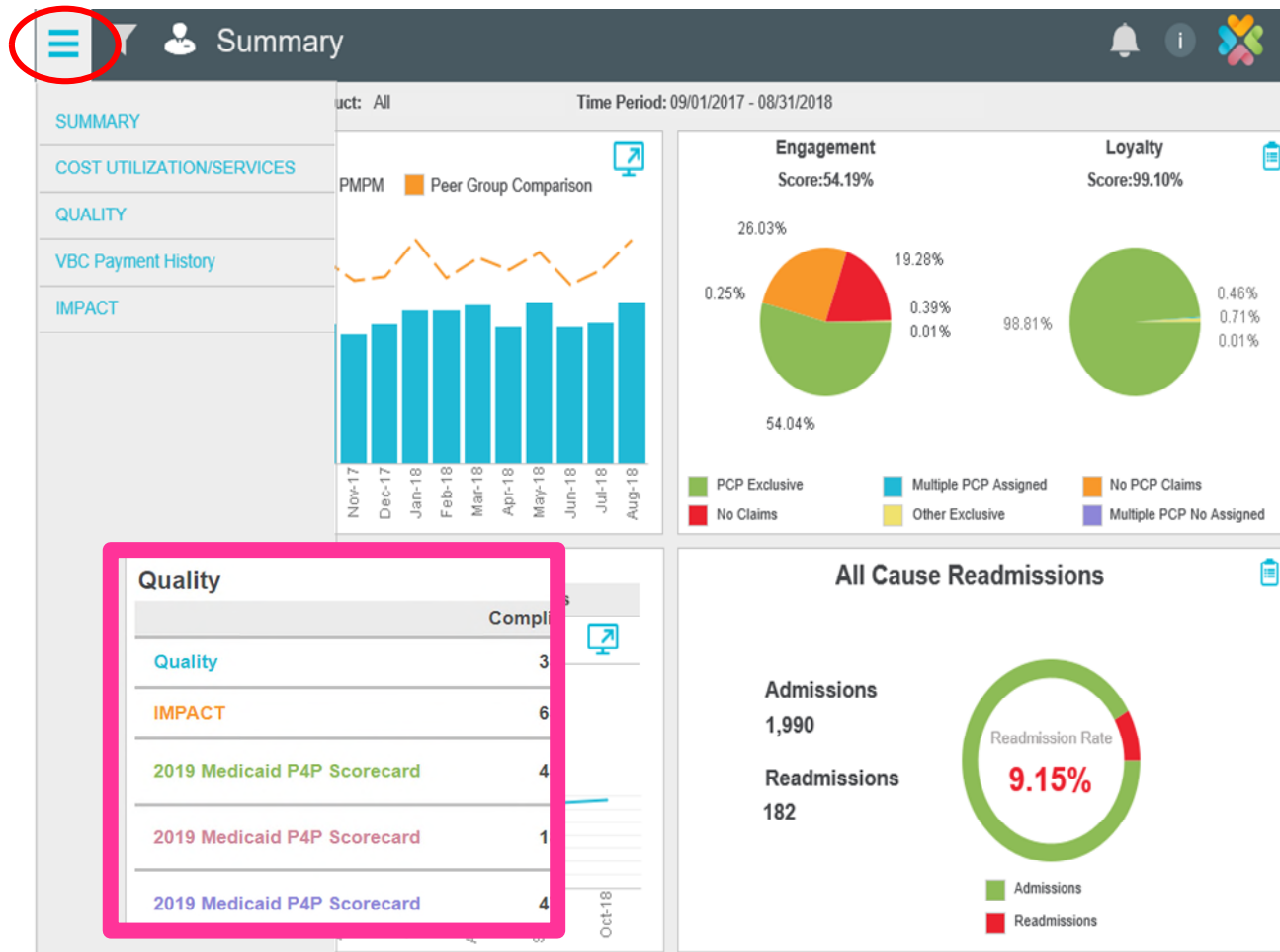
- Add a TIN to My ACCOUNT >
- Manage Accounts >
- Reports >
- Patient Analytics >
- Provider Analytics >

Recent Activity

Date	Activity
------	----------

Provider Analytics link is located on the landing page of the Provider Portal.

Navigation of provider analytics dashboard








On the Summary dashboard, providers will click on the Navigation Bars located in the upper left hand corner to make their selection.

Prior Authorization

Prior Authorization

Prior Authorization (Medical Services)

Prior Authorization is an approval from MHS to provide services designated as needing authorization before treatment and/or payment

-  Inpatient authorizations = IP + 10 digits
-  Outpatient authorizations = OP + 10 digits
-  Emergent ER Symptoms suggesting imminent, life-threatening condition no PA required, but notification requested within **two business days**
-  Urgent concurrent = Emergent inpatient admission. Determination timeline within **24 hours** of receipt of request.
-  Pre-service non urgent = Elective scheduled procedures. Determination within **15 calendar days**. Benefit limitations apply (dependent on product).

Prior Authorization

Is Prior Authorization Needed?

- MHS website: mhsindiana.com
- Quick reference guide
- Non-contracted provider services now align with PA requirements for contracted providers





effective June 1, 2015

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

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

mhsindiana.com

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

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

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

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

MANAGED HEALTH SERVICES (MHS)

ELECTRONIC PAYER ID:
68069

BEHAVIORAL HEALTH PAYER ID:
68068

MEDICAL CLAIMS ADDRESS:
Managed Health Services
P.O. Box 3002
Farmington, MD 21640-3802

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

MEDICAL NECESSITY APPEALS ONLY ADDRESS:
ATTN: APPEALS
P.O. Box 44367
Indianapolis, IN 46244

MEDICAL CLAIMS APPEALS ADDRESS:
Managed Health Services
P.O. Box 3000
Farmington, MD 21640-3800

Providers have 67 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.

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

MHS FAX NUMBERS

NETWORK MANAGEMENT: 1-866-012-4344
Ex. Provider enrollment, office or billing address change

MEDICAL APPEALS: 1-866-714-7993

CASE MANAGEMENT: 1-866-804-3653
Ex. Member Referrals to CM/DM

REFERRALS AND AUTHORIZATIONS: 1-866-012-4245

MHS WEBSITE: MHSINDIANA.COM

mhsindiana.com/providers Latest MHS provider updates and news, as well as forms, manuals, guides, online PA tool and tutorials. (Please visit mhsindiana.com/forms to get the latest forms for submission to MHS.)

mhsindiana.com/health MHS' Health Library. Click on "KRA-MES 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, claims, claim adjustments, and view your panel's medical records and care gaps.

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


OTHER RESOURCES

payspanhealth.com MHS is pleased to partner with PaySpan to provide an innovative web-based solution for Electronic Funds Transfers (EFTs) and Electronic Remittance Advice (ERA). 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.

05/15/2015 11/15

Prior Authorization



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

Contrast
☐ On
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a a a
language

FOR MEMBERS
FOR PROVIDERS
GET INSURED

FOR PROVIDERS
Login
Enrollment and Updates
Prior Authorization
Medicaid Pre-Auth
Ambetter Pre-Auth
Medicare Pre-Auth
Dental Providers
Pharmacy
Opioid Resources
Behavioral Health
Provider Resources
QI Program
Provider News
Email Sign Up

Medicaid Pre-Auth

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

Vision services need to be verified by [Envolve Vision](#).
Dental services need to be verified by [Envolve Dental](#).
Ambulance and Transportation services need to be verified by [LCP Transportation](#).
Musculoskeletal services need to be verified by [TurningPoint](#).

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

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

☐ Yes ☐ No

Types of Services	YES	NO
Is the member being admitted to an inpatient facility?	<input type="radio"/>	<input type="radio"/>
Are services, other than DME, orthotics, prosthetics, and supplies, being rendered in the home?	<input type="radio"/>	<input type="radio"/>
Are anesthesia services being rendered for pain management?	<input type="radio"/>	<input type="radio"/>
Are services for infertility?	<input type="radio"/>	<input type="radio"/>

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

Prior Authorization

Prior Authorization

Medicaid Pre-Auth

Ambetter Pre-Auth

Medicare Pre-Auth

Dental Providers

Pharmacy

Opioid Resources

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Provider Resources

QI Program

Provider News

Email Sign Up

Correct coding and billing practices. For specific details, please refer to the provider manual. If you are uncertain that prior authorization is needed, please submit a request for an accurate response.

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Types of Services	YES	NO
Is the member being admitted to an inpatient facility?	<input type="radio"/>	<input checked="" type="radio"/>
Are services, other than DME, orthotics, prosthetics, and supplies, being rendered in the home?	<input type="radio"/>	<input checked="" type="radio"/>
Are anesthesia services being rendered for pain management?	<input type="radio"/>	<input checked="" type="radio"/>
Are services for infertility?	<input type="radio"/>	<input checked="" type="radio"/>

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





99394

N
No





99394 - PREV VISIT EST AGE 12-17
No Pre-authorization required for all providers.

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

Web Authorization

-  Providers can submit Prior Authorizations online via the MHS Secure Provider Portal at mhsindiana.com/login
 - When using the portal, providers can upload supporting documentation directly
-  **Exceptions**: Must submit hospice, home health and biopharmacy PA requests via **fax**
-  Providers also can check authorization status on the portal
-  Failure to obtain PA will result in claims payment denials for late notifications.

Telephone Authorization

-  Providers can initiate Prior Authorization through the MHS referral line by calling 1-877-647-4848
 - Monday - Friday 8 a.m. to 5 p.m. (Closed for lunch from noon to 1 p.m.)
 - After hours, MHS 24 hour nurse line available to take emergent requests.
-  The PA process begins at MHS by speaking with the MHS non-clinical referral staff
-  For procedures requiring additional review, we will transfer providers to a “live” nurse line to facilitate the PA process
-  Please have all clinical information ready at time of call

Fax Authorization

1-866-912-4245: MHS Medical Management Department

Patient Information					
Medicaid ID/RID#:					
DOB:					
Patient Name:					
Address:					
City/State/Zip:					
Patient/Guardian Phone:					
PMP Name:					
PMP NPI:					
PMP Phone:					
Medical Diagnosis (Use of ICD-9 Diagnostic Code is Required)					
Dx1		Dx2		Dx3	

*Member RID, name, and
DOB **required***




*Diagnosis code(s)
required*

Please check the requested assignment category below:

- | | | |
|--------------------------------------|-----------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> DME | <input type="checkbox"/> Inpatient | <input type="checkbox"/> Physical Therapy |
| <input type="checkbox"/> Purchased | <input type="checkbox"/> Observation | <input type="checkbox"/> Speech Therapy |
| <input type="checkbox"/> Rented | <input type="checkbox"/> Office Visit | <input type="checkbox"/> Transportation |
| <input type="checkbox"/> Home Health | <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> Other |
| <input type="checkbox"/> Hospice | <input type="checkbox"/> Outpatient | |

Check service category



Prior Authorization (PA) Request

-  Providers **must** update previously approved PAs within 30 days* of the original date of service prior to claim denial for changes in:
 - Dates of service
 - CPT/HCPCS codes
 - Physician
-  Providers must initiate appeals within 60 days of the receipt of the denial letter for MHS to consider.
-  Additional Information found in the [MHS Provider Manual](#)

**Providers may make corrections within 30 days to the existing PA as long as the claim has not been submitted*


Prior Authorization


MHS Medical Management will review state guidelines and all available clinical documentation and seek Medical Director input as needed

-  PA for observation level of care (**up to 72 hours for Medicaid or 48 hours for Ambetter and Allwell**), diagnostic services do not require an authorization for contracted facilities. Non-contracted facilities do not require prior authorization.
-  If the provider requests an inpatient level of care for a covered/eligible condition, or procedure and documentation supports an outpatient/observation level of care, MHS will send the case for Medical Director review


Prior Authorization

Outpatient Services

 All elective procedures that require prior authorization must send request to MHS at least **two business days** prior to the date of service

 All urgent and emergent services do not require prior authorization, but admissions must be called in to MHS within **two business days** following the admit

 Prior Authorizations are **not** a guarantee of payment




 Failure to obtain PA 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.

 Members **must** be Medicaid Eligible on the date of service

Failure to obtain prior authorization for non urgent and emergent services will result in a denial for related claims


Prior Authorization

Transfers

-  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 Transfers include, but are not limited to:
 - Facility to facility
 - Higher level of care changes require PA and it is the responsibility of the transferring facility to obtain
-  **Failure to obtain PA will result in claims payment denials for late notification**

Self-Referral Services




Exceptions to prior authorization requirements

 Members can see these specialists and get these services without a direct referral from their PMP:


- Podiatrist
- Chiropractor
- Family planning
- Immunizations
- Routine vision care
- Routine dental care
- Behavioral health by type and specialty
- HIV/AIDS case management
- Diabetes self management

****Benefit limitations apply***

Therapy Services - (Speech, Occupational, Physical Therapy)

-  Effective July 1, 2019, physical, occupational and speech therapy (PT, OT, and ST) services will no longer be managed through a post-service review process for MHS.
-  Prior authorization for PT, OT, and ST services will be required to determine whether services are medically necessary and appropriate.
-  The utilization management of these services will continue to be managed by NIA.

TurningPoint Healthcare Solutions

 Effective 6/1/2019 Turning Point manages all prior authorizations for medical necessity and appropriate length of stay (when applicable) for musculoskeletal surgical procedures:

MUSCULOSKELETAL

Orthopedic Surgical Procedures

Including all associated partial, total, and revision surgeries






- ✓ Knee Arthroplasty
- ✓ Unicompartmental/Bicompartmental Knee Replacement
- ✓ Hip Arthroplasty
- ✓ Shoulder Arthroplasty
- ✓ Elbow Arthroplasty
- ✓ Ankle Arthroplasty
- ✓ Wrist Arthroplasty
- ✓ Acromioplasty and Rotator Cuff Repair
- ✓ Anterior Cruciate Ligament Repair
- ✓ Knee Arthroscopy
- ✓ Hip Resurfacing
- ✓ Meniscal Repair
- ✓ Hip Arthroscopy
- ✓ Femoroacetabular Arthroscopy
- ✓ Ankle Fusion
- ✓ Shoulder Fusion
- ✓ Wrist Fusion
- ✓ Osteochondral Defect Repair

Spinal Surgical Procedures

Including all associated partial, total, and revision surgeries

- ✓ Spinal Fusion Surgeries
 - ✓ Cervical
 - ✓ Lumbar
 - ✓ Thoracic
 - ✓ Sacral
 - ✓ Scoliosis
- ✓ Disc Replacement
- ✓ Laminectomy/Discectomy
- ✓ Kyphoplasty/Vertebroplasty
- ✓ Sacroiliac Joint Fusion
- ✓ Implantable Pain Pumps
- ✓ Spinal Cord Neurostimulator
- ✓ Spinal Decompression

Turning Point

-  Emergency Related Procedures do not require authorization
-  It is the responsibility of the ordering physician to obtain authorization
-  Providers rendering musculoskeletal services, must verify that the necessary authorization has been obtained; failure to do so may result in non-payment of your claims
-  Clinical Policies are available by contacting TurningPoint at 1-574-784-1005 for access to digital copies
-  **TRAINING:**
 - Informational webinars are available! Please register at:
<https://register.gotowebinar.com/rt/7079530369468972290>

Turning Point's Utilization Management



Web Portal Intake:

- myturningpoint-healthcare.com










Telephonic Intake:

- 574-784-1005 | 855-415-7482








Facsimile Intake: 463-207-5864

Durable & Home Medical Equipment

-  Members and referring providers do not need to search for a DME provider or provider of medical supplies to service their needs
-  Order is submitted directly to MHS, through the Medline portal, unless PA is required, and delivered to the member
-  **Web Portal:** Simply go to mhsindiana.com, log into the provider portal, and click on “Create Authorization.” Choose DME and you will be directed to the **Medline** portal for order entry.
-  Availability via Medline’s web portal to submit orders and track delivery
-  Prior authorization required by the **ordering physician** for all non-participating DME providers.
-  Does not apply to items provided by and billed by physician office
-  Exclusions applicable to specific hospital based DME/HME vendors

IMAGING PRIOR AUTHORIZATION REQUESTS- NIA

-  National Imaging Associates (NIA) manages non-emergent, advanced, outpatient imaging services to include prior authorization for MHS members
-  The ordering physician is responsible for obtaining authorization
-  To obtain authorization, go to the NIA website **RadMD.com** or through the NIA dedicated toll-free phone number, **1-866-904-5096**
-  Failure to obtain PA may result in nonpayment of claim
-  Emergency room, observation and inpatient imaging procedures do not require authorization

PA Denial and Appeal Process



If MHS denies the requested service:

- And the member is still receiving services, the provider has the right to an expedited appeal. The attending physician must request this.
- And the member already has been discharged, the attending physician must submit an appeal in writing within **60 days** of the denial








The attending physician has the right to a peer-to-peer discussion with an MHS physician

- Providers initiate peer-to-peer discussions and expedited appeals by calling an MHS appeals coordinator at 1-877-647-4848
- They must request peer-to-peer within **10 days** of the adverse determination









Prior authorization appeals are also known as medical necessity appeals


PA Denial and Appeal Process

-  Send Prior Authorization/Medical Necessity Appeals to:
Managed Health Services
Attn: Appeals Coordinator
550 North Meridian Street, Suite 101
Indianapolis, IN 46204
-  Providers must initiate appeals within **60 days** of the receipt of the denial letter for MHS to consider
-  We will communicate determination to the provider within **20 business days** of receipt
-  ***A prior authorization appeal is different than a claim appeal request***
-  Applicable to members and non-contracted providers

Prior Authorization (PA) Request

-  MHS strives to return a decision on **all** PA requests within **two business days** of request
-  Reasons for a delayed decision may include:
 - Lack of information or incomplete request
 - Illegible faxed copies of PA forms – e.g. handwriting is illegible or fax is otherwise not readable
 - Request requiring Medical Director review
-  MHS has up to **seven days** to render PA decisions
-  PA approval requires the need for medical necessity
-  If your claim is denied, please contact Provider Services at 1-877-647-4848 to determine the cause of the denial
-  Medical Management **does not** verify eligibility or benefit limitations
 - Provider is responsible for eligibility and benefit verification

Continuity of Care PA Request









 MHS will honor pre-existing authorizations from any other Medicaid program during the first 30 days of enrollment or up to the expiration date of the previous authorization, whichever occurs first, and upon notification to MHS. Include the approval from the prior MCE with the request

Reference: MHS Provider Manual Chapter 6

MHS Portal

MHS Portal

Providers may register at mhsindiana.com to access MHS' Secure portal to:

-  Check member eligibility
-  Manage multiple practices and line of business under one account
-  View panels and membership information
-  View member's RX and medical history
-  Submit/check claims and authorizations
-  Access explanation of payments
-  Access quality reports
-  Access gaps in care

Secure Web Portal Login or Registration

 Login/Register is the same for **MHS**, **Ambetter from MHS**, **Allwell from MHS** and **Behavioral Health Providers**



Home Find a Provider **Portal Login** Events Contact Us

Contrast ☐ On ☒ Off a a a language ▾

FOR MEMBERS

FOR PROVIDERS

GET INSURED

FOR PROVIDERS


Login

Become a Provider


Prior Authorization 

Dental Providers

Pharmacy 

Behavioral Health 

Provider Resources 

QI Program 

Provider News

Portal Login

 Login/Register

[Click here for additional information and step by step guides.](#)

Behavioral Health Secure Portal

[Click here for the Cenpatco behavioral health portal.](#)

Registration Help





If you are having trouble with your registration, you may need to submit a non-par set-up form. Visit our [Become a Provider](#) page to get started. For further assistance, you can call our Secure Provider Portal Help Line at 1-866-912-0327.

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

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

Web Portal Training Documents



Home Find a Provider Portal Login Events Contact Us

Contrast ☐ On ☐ Off ☐ a ☐ language -

FOR MEMBERS

FOR PROVIDERS

GET INSURED

FOR PROVIDERS

- Login
- Become a Provider
- Prior Authorization +
- Dental Providers
- Pharmacy +
- Behavioral Health +
- Provider Resources +
- QI Program +
- Provider News

Web Portal

We encourage our providers to take advantage of our easy-to-use secure Provider Portal instead of making a phone call. On our secure portal, you can:

- Manage multiple practices under one account
- Check member eligibility
- View medical history and gaps in care
- Submit and manage claims
- Submit prior authorizations
- Securely contact a plan representative

We also have the following enhanced features below:

- Update demographic information
- Assist your patients in completing their Health Risk Assessment forms
- See patient Care Gaps (indicates if your patient is due for a preventive exam or service)
- Check the status of Prior Authorization requests
- Utilize the Member Management Forms

Follow the [registration guide \(PDF\)](#) or if you have any questions, please call the Web Portal helpdesk line at 1-866-912-0327.

There's no waiting, no on-hold music, no time limits. Registration is free and easy.

MHS Secure Provider Portal Training Documents

Guides:

- [Provider Secure Portal Guide \(PDF\)](#)
- [Provider Secure Portal Flyer \(PDF\)](#)
- [Account Details ORG \(PDF\)](#)
- [Account Manager User Guide \(PDF\)](#)
- [Member Management Forms Guide \(PDF\)](#)

How To:

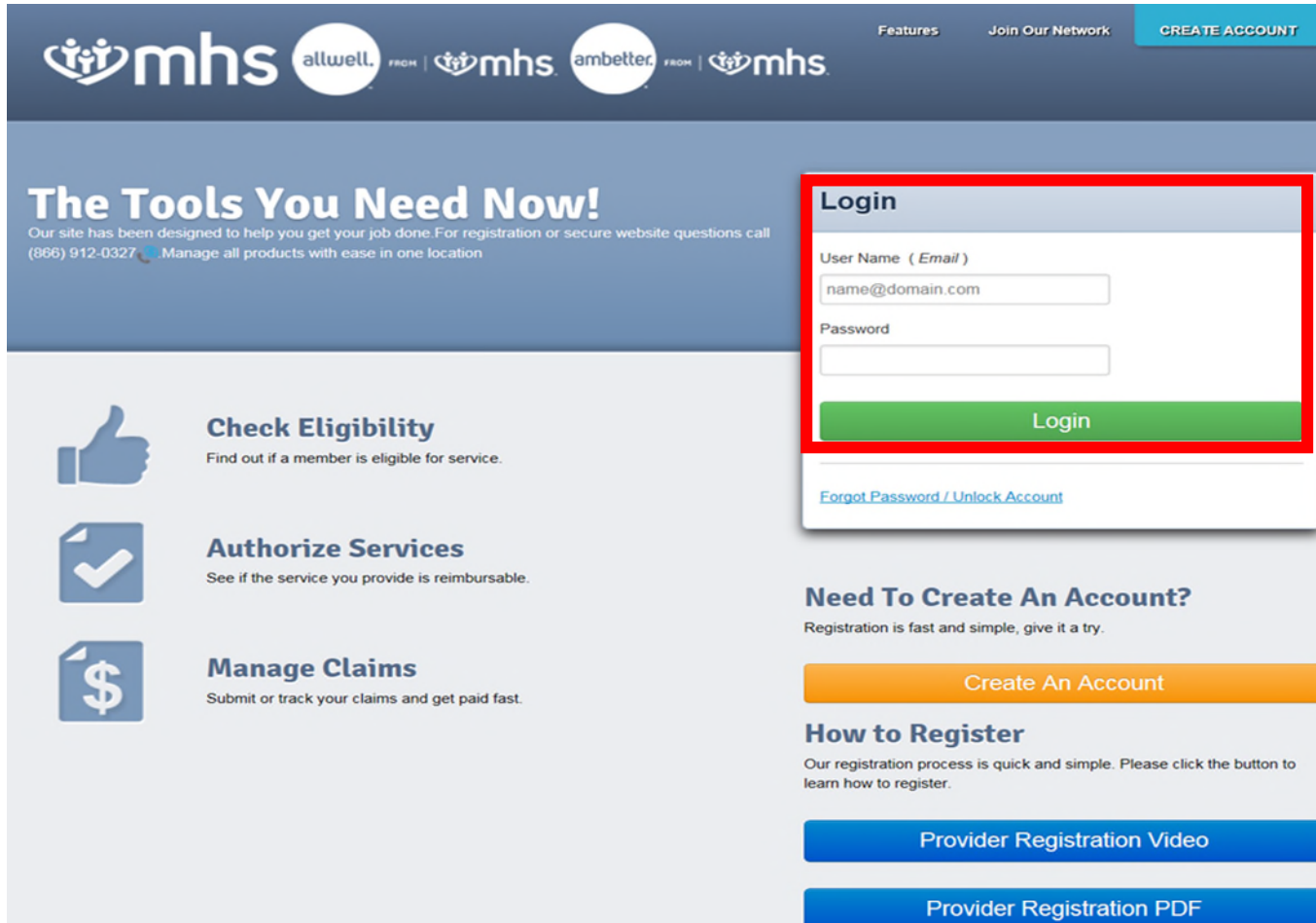
- [Submit a Claim CMS 1500 \(PDF\)](#)
- [Submit a Claim CMS UB-04 \(PDF\)](#)
- [Submit a Corrected Claim \(PDF\)](#)
- [View Claim Status \(PDF\)](#)
- [View Payment History \(PDF\)](#)



Documents Include:

- Registration Guide
- MHS Web Portal Functionality Guides
- How To Complete Specific Tasks on the MHS Web Portal

Complete Registration or Login



The screenshot displays the MHS website interface. At the top, the navigation bar includes the MHS logo, 'allwell FROM mhs', and 'ambetter FROM mhs'. Links for 'Features', 'Join Our Network', and a 'CREATE ACCOUNT' button are present. The main heading 'The Tools You Need Now!' is followed by a subtext: 'Our site has been designed to help you get your job done. For registration or secure website questions call (866) 912-0327. Manage all products with ease in one location.' Below this, three service tiles are shown: 'Check Eligibility' (thumbs up icon), 'Authorize Services' (checkmark icon), and 'Manage Claims' (dollar sign icon). On the right, a 'Login' form is highlighted with a red border. It contains fields for 'User Name (Email)' (with 'name@domain.com' entered) and 'Password', and a green 'Login' button. Below the login form is a link for 'Forgot Password / Unlock Account'. Further down, a section titled 'Need To Create An Account?' includes a registration description and a yellow 'Create An Account' button. At the bottom, two blue buttons offer 'Provider Registration Video' and 'Provider Registration PDF'.

Login

User Name (Email)

Password

Login

[Forgot Password / Unlock Account](#)

Check Eligibility
 Find out if a member is eligible for service.

Authorize Services
 See if the service you provide is reimbursable.

Manage Claims
 Submit or track your claims and get paid fast.

Need To Create An Account?
 Registration is fast and simple, give it a try.

Create An Account

How to Register
 Our registration process is quick and simple. Please click the button to learn how to register.

Provider Registration Video

Provider Registration PDF

MHS Welcome and Quick Links

Welcome

Add a TIN to My ACCOUNT >

Manage Accounts >

Reports >

Patient Analytics >

Provider Analytics--Coming Soon >

Recent Activity

Date

Activity

Quick Links

[Provider Resources](#)

[Member Management Forms](#)

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

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

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

Please note: Claims information is updated every 24 hours.

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

Go Paperless

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

PlaySpan Site

Welcome

- **Multiple TINs** can be managed from a single account.
- **Account Managers** can oversee the secure portal accounts of their staff/office. User can be added, disabled, and have their permissions changed.
- **Reports** are available here
- **Patient and Provider Analytics**

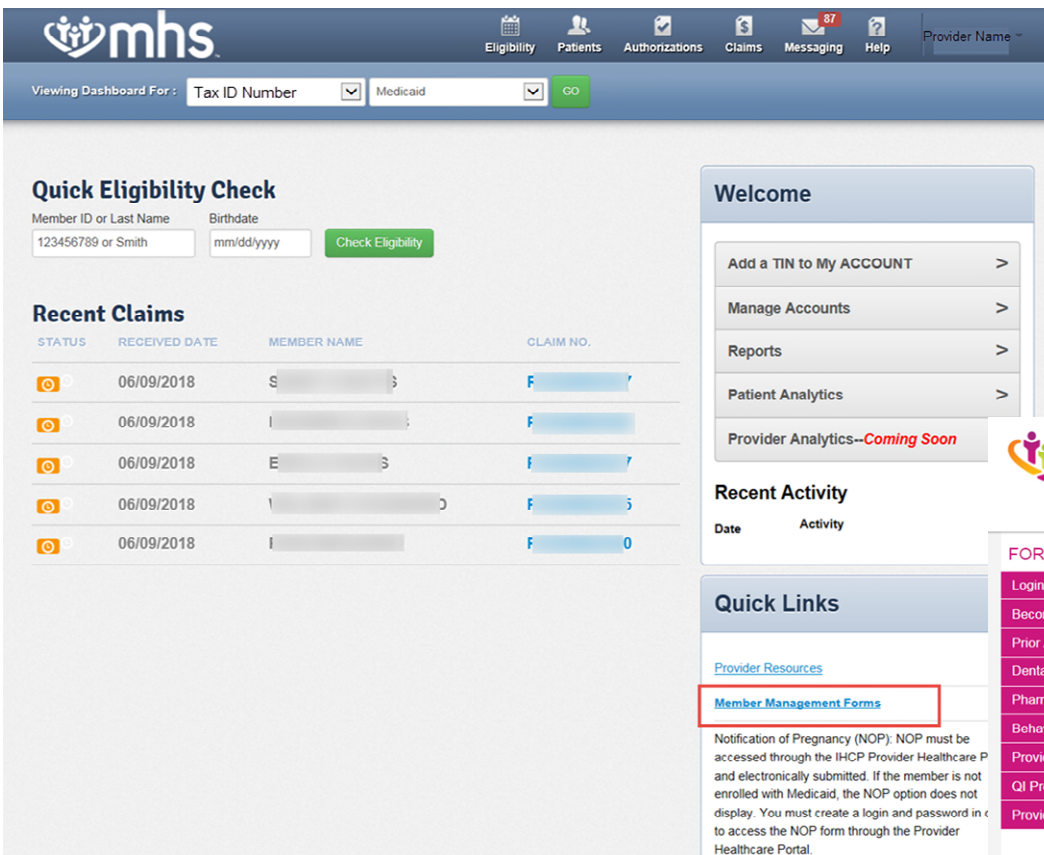
Quick Links

- Public link to **Provider Resources**
 - ☐ Demographic Update Tool
 - ☐ Preferred Drug Lists
 - ☐ Provider Education
- **Member Management Forms**
- **IHCP Provider Healthcare Portal link**
- **Pharmacy Information**

Go Paperless


MHS Member Management Forms

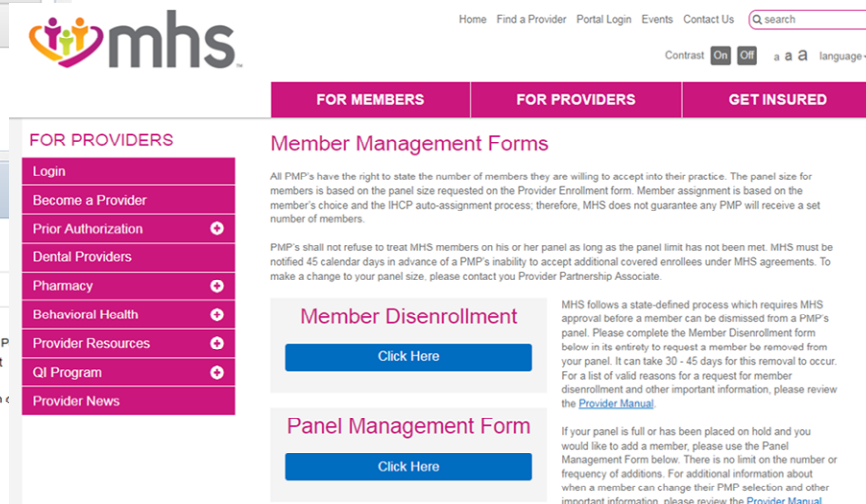
 Click on **Member Management Forms** under **Quick Links**



The screenshot shows the MHS Member Management dashboard. At the top, there's a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below this is a search bar for 'Tax ID Number' and 'Medicaid'. The main content area is divided into several sections:

- Quick Eligibility Check:** A form with fields for 'Member ID or Last Name' (123456789 or Smith) and 'Birthdate' (mm/dd/yyyy), with a 'Check Eligibility' button.
- Recent Claims:** A table with columns for STATUS, RECEIVED DATE, MEMBER NAME, and CLAIM NO. It lists several claims from 06/09/2018.
- Welcome:** A sidebar with links: 'Add a TIN to My ACCOUNT', 'Manage Accounts', 'Reports', 'Patient Analytics', and 'Provider Analytics--Coming Soon'.
- Recent Activity:** A table with columns for Date and Activity.
- Quick Links:** A section with a link to 'Member Management Forms' highlighted in a red box. Below it is a notification about the Notification of Pregnancy (NOP) form.

-  **Choose between:**
- Member Disenrollment Form
 - Panel Management Form



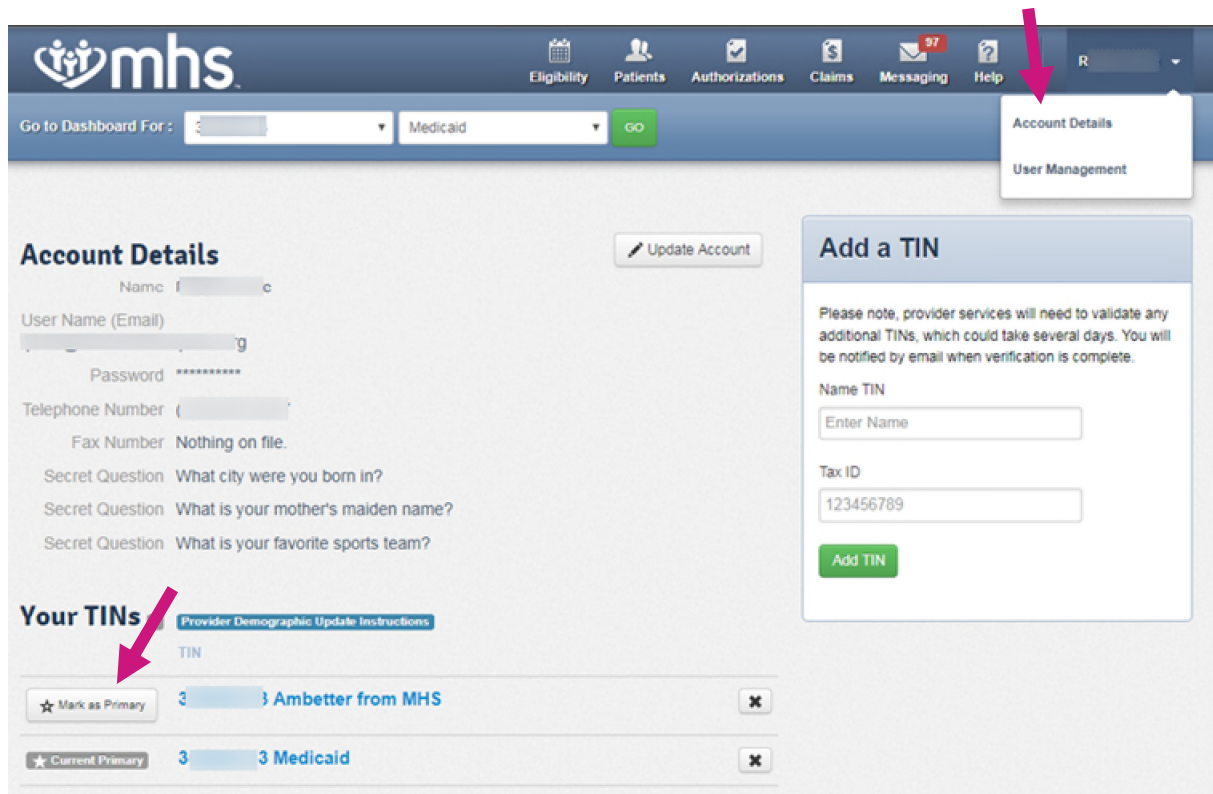
The screenshot shows the 'Member Management Forms' page. It has a navigation bar with links for Home, Find a Provider, Portal Login, Events, Contact Us, and a search bar. Below the navigation bar are three tabs: 'FOR MEMBERS', 'FOR PROVIDERS', and 'GET INSURED'. The 'FOR PROVIDERS' tab is selected, showing a list of links: Login, Become a Provider, Prior Authorization, Dental Providers, Pharmacy, Behavioral Health, Provider Resources, QI Program, and Provider News. The 'Member Disenrollment' section is highlighted, with a 'Click Here' button. Below it is the 'Panel Management Form' section, also with a 'Click Here' button. The page includes detailed text about the disenrollment process and the panel management form.

Account Details

To view your Account Details:

1. Select the **drop-down arrow** next to user name in the upper right corner on the dashboard
2. Click **Account Details**

Note: Under Your TINs you see the Current **Primary** Default TIN for the account, and can select another TIN to **Mark As Default** or **Remove** a TIN.



mhs Eligibility Patients Authorizations Claims Messaging 97 Help R

Go to Dashboard For : Medicaid

Account Details

Name

User Name (Email)

Password

Telephone Number

Fax Number Nothing on file.

Secret Question What city were you born in?

Secret Question What is your mother's maiden name?

Secret Question What is your favorite sports team?

Your TINs

TIN

3 Ambetter from MHS

3 Medicaid

Add a TIN

Please note, provider services will need to validate any additional TINs, which could take several days. You will be notified by email when verification is complete.

Name TIN

Tax ID

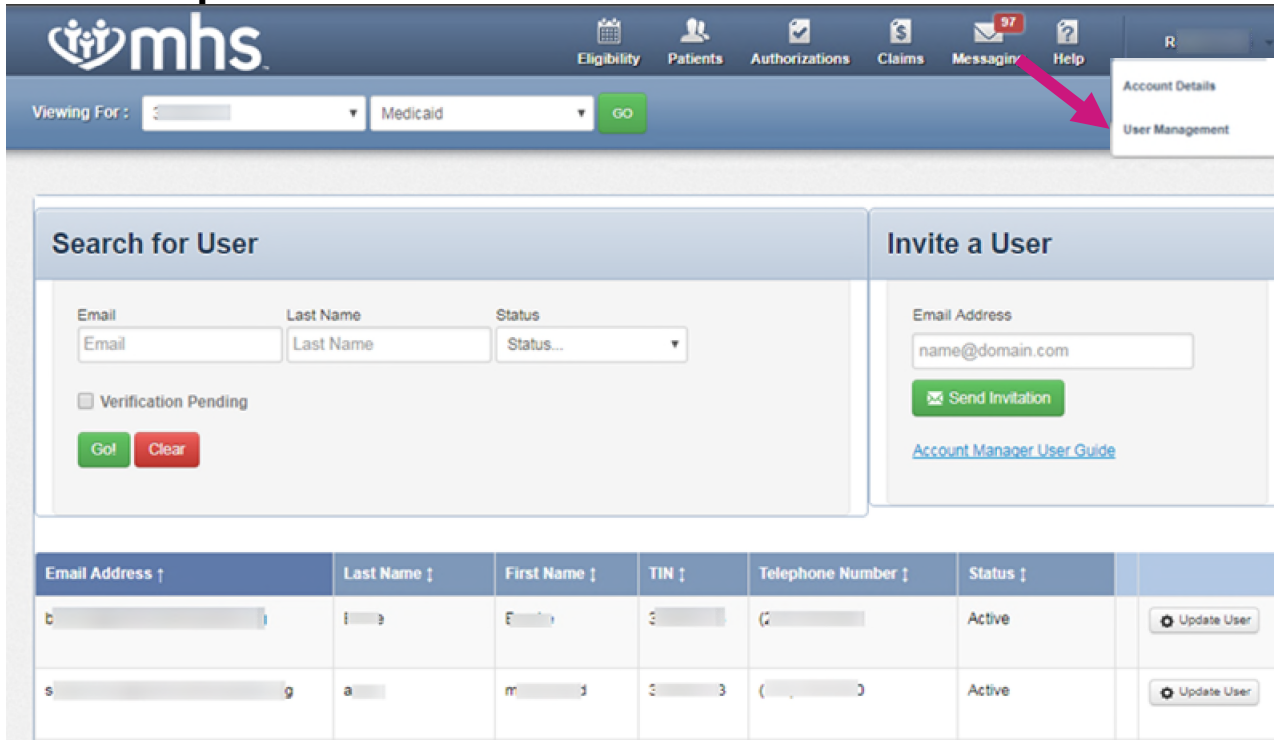
Account Manager

User Management



For **Account Managers** to manage their office staff/users associated to their practice:

When using this feature you can disable/enable users, and manage permissions for your account.

1. Select the drop-down arrow next to your name in the upper right corner.
2. Select **User Management**.
3. Click **Update User** next to the user name.
















The screenshot shows the MHS Account Manager interface. At the top, there's a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, Messaging (with a red badge showing 97), and Help. A red arrow points to the 'User Management' option in the dropdown menu next to the user's name 'R'. Below the navigation bar, there's a 'Viewing For' section with a dropdown menu set to 'Medicaid' and a 'GO' button. The main content area is divided into two panels: 'Search for User' and 'Invite a User'. The 'Search for User' panel has input fields for Email, Last Name, and Status, a 'Verification Pending' checkbox, and 'Go' and 'Clear' buttons. The 'Invite a User' panel has an 'Email Address' input field, a 'Send Invitation' button, and a link to the 'Account Manager User Guide'. Below these panels is a table with columns: Email Address, Last Name, First Name, TIN, Telephone Number, Status, and an 'Update User' button. The table contains two rows of user data.

Email Address ↑	Last Name ↑	First Name ↑	TIN ↑	Telephone Number ↑	Status ↑	
b				(Active	 Update User
s	a	m	3	(Active	 Update User

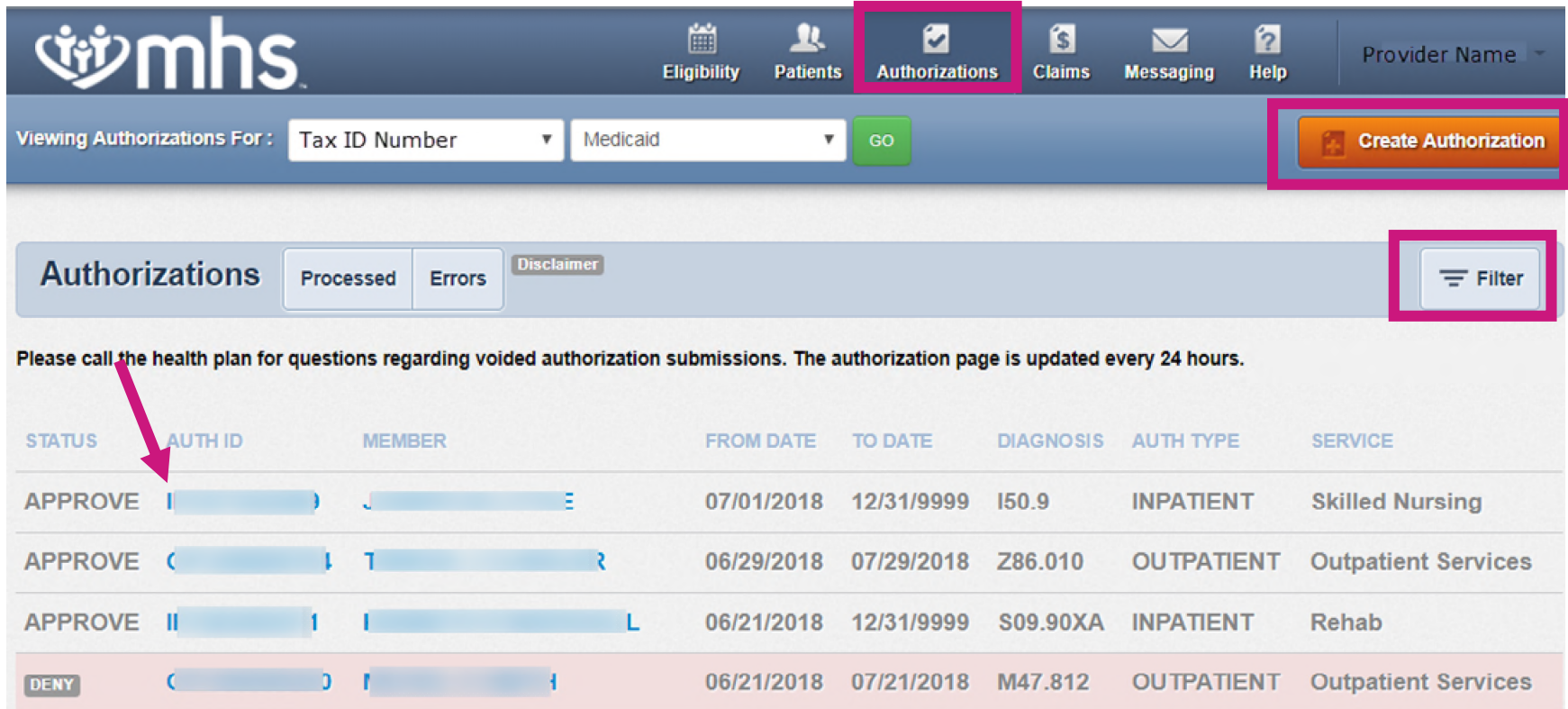
Member Record

Member Record Details

-  Member Overview
-  Cost Sharing
-  Assessments
-  Health Record
-  Visits, Medications, Immunizations, Labs, and Allergies
-  Care Plan
-  Authorizations
-  Referrals
-  Coordination of Benefits
-  Claims
-  Power Account Service Estimate *only HIP Members
-  Document Resource Center
-  Notes

Authorizations

- View, create and filter group Authorizations
- Click on the **AUTH ID** to see additional information
- Filter Authorizations by **Date Range**, **Member**, **Authorization#**, **Confirmation#**, **Status** or **Auth Type**



Viewing Authorizations For : Tax ID Number Medicaid GO

Create Authorization

Authorizations Processed Errors Disclaimer

Please call the health plan for questions regarding voided authorization submissions. The authorization page is updated every 24 hours.

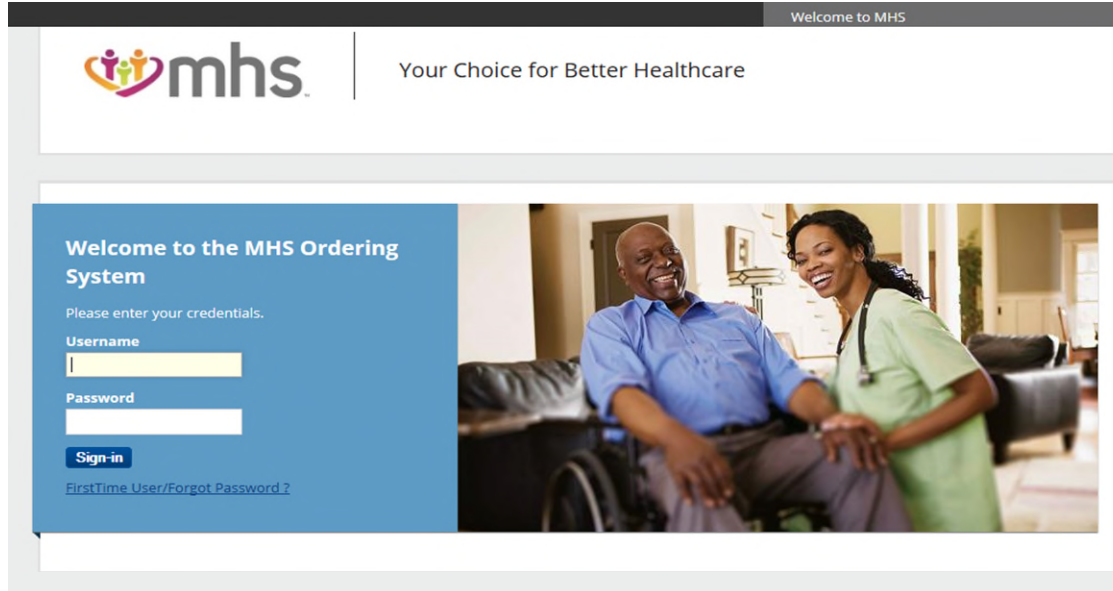
STATUS	AUTH ID	MEMBER	FROM DATE	TO DATE	DIAGNOSIS	AUTH TYPE	SERVICE
APPROVE			07/01/2018	12/31/9999	I50.9	INPATIENT	Skilled Nursing
APPROVE			06/29/2018	07/29/2018	Z86.010	OUTPATIENT	Outpatient Services
APPROVE			06/21/2018	12/31/9999	S09.90XA	INPATIENT	Rehab
DENY			06/21/2018	07/21/2018	M47.812	OUTPATIENT	Outpatient Services

Authorization for Durable & Home Medical Equipment



Requests should be initiated via **MHS Secure portal**





1. Select **Authorizations** tab and click on **Create Authorization**.
2. Enter **Member ID** or **Last Name** and **Date of Birth**
3. Choose **DME** and you will be directed to the Medline portal for order entry.

A screenshot of the MHS Ordering System login page. The page has a white header with the MHS logo and the tagline "Your Choice for Better Healthcare". Below the header, there is a blue sidebar on the left with the text "Welcome to the MHS Ordering System" and "Please enter your credentials." followed by input fields for "Username" and "Password", a "Sign-in" button, and a link for "FirstTime User/Forgot Password?". To the right of the sidebar is a large image of a smiling healthcare professional in green scrubs assisting an elderly man in a wheelchair.

Claims

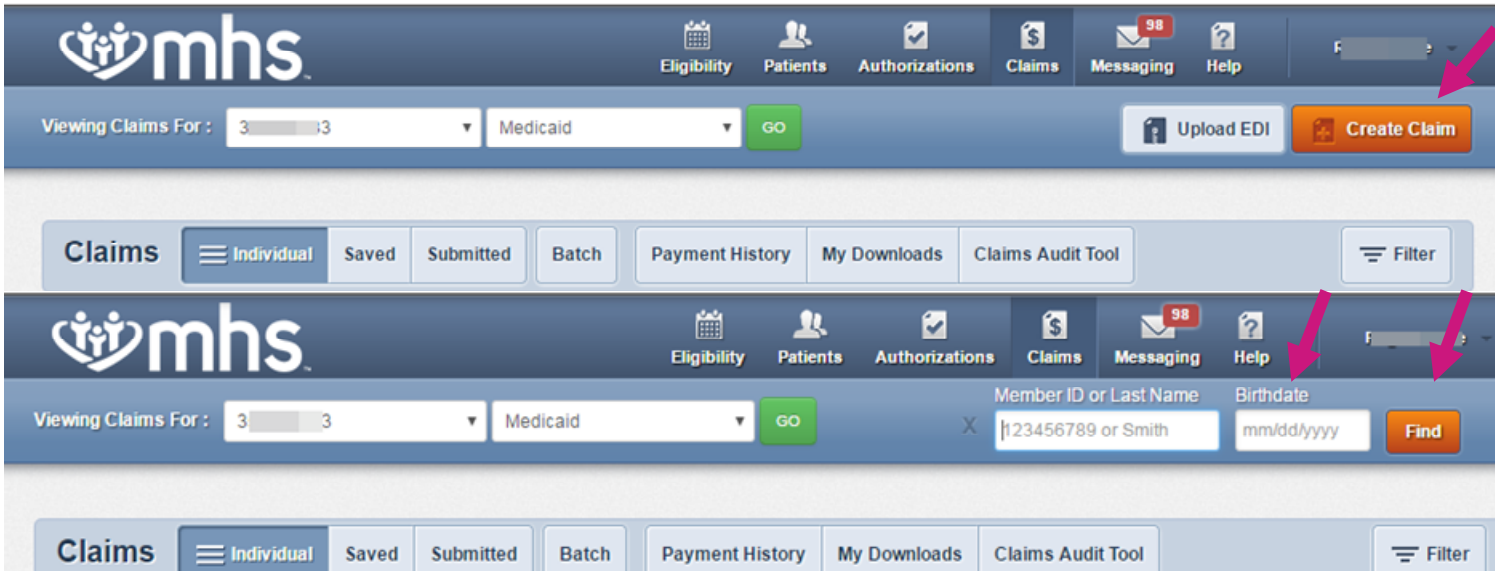
Claims

Web Portal Claims Functionalities

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

Submit a New Claim

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

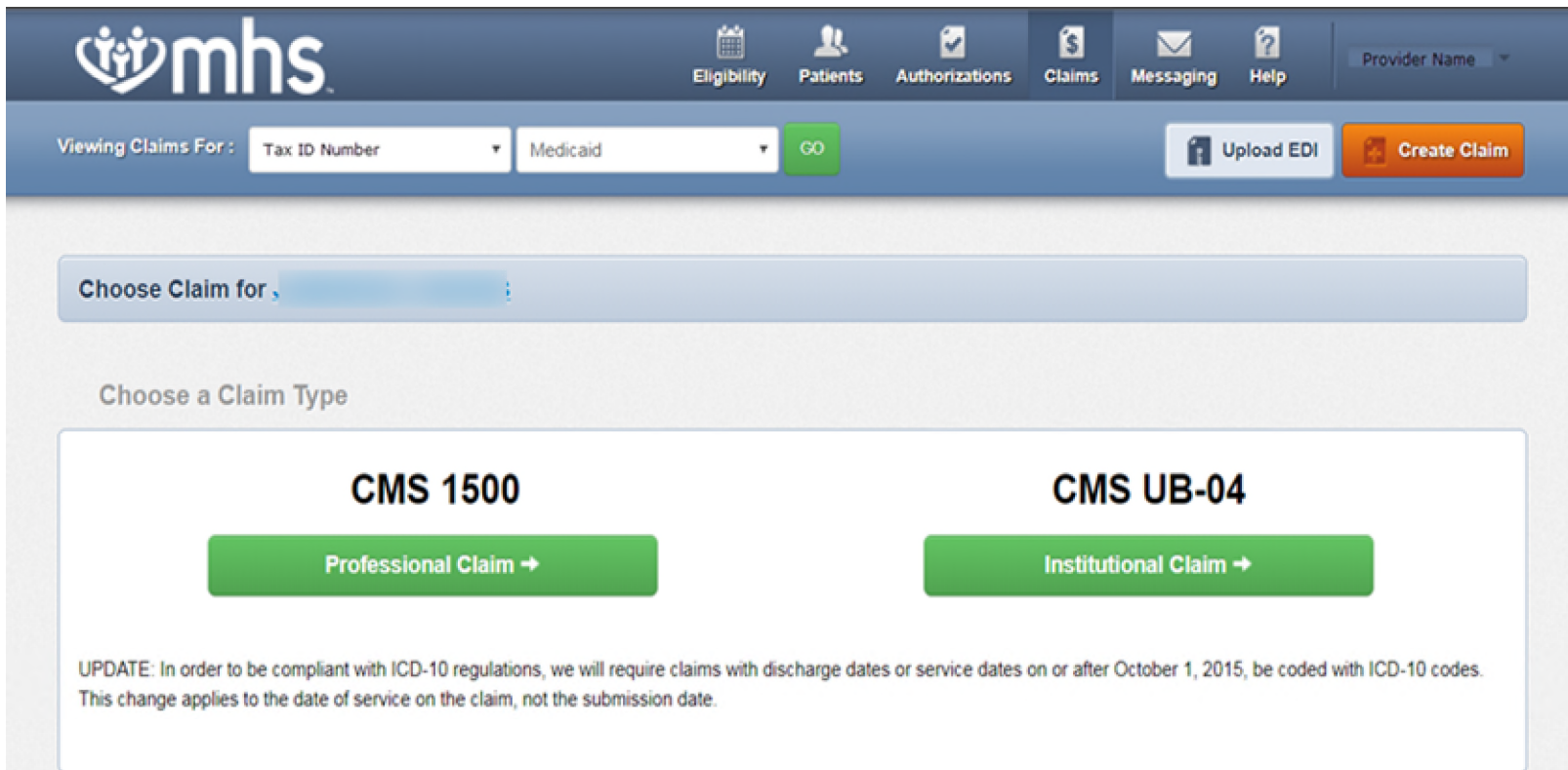


The screenshot displays the MHS Web Portal interface. At the top, there is a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, Messaging (with a 98 notification), and Help. Below this is a section for 'Viewing Claims For' with a dropdown menu set to '3' and a 'Medicaid' filter, followed by a 'GO' button. To the right of this section is an 'Upload EDI' button and a prominent orange 'Create Claim' button, which is highlighted with a red arrow. Below the 'Viewing Claims For' section is a 'Claims' tab with sub-tabs for Individual, Saved, Submitted, Batch, Payment History, My Downloads, and Claims Audit Tool, along with a 'Filter' button. The bottom section of the screenshot shows a search area with fields for 'Member ID or Last Name' (containing '123456789 or Smith') and 'Birthdate' (with a format hint 'mm/dd/yyyy'), and a 'Find' button. Red arrows point to the 'Claims' tab, the 'Member ID or Last Name' field, and the 'Birthdate' field.

Claim Submission

Choose the Claim Type

- **Professional** or **Institutional** claim submission




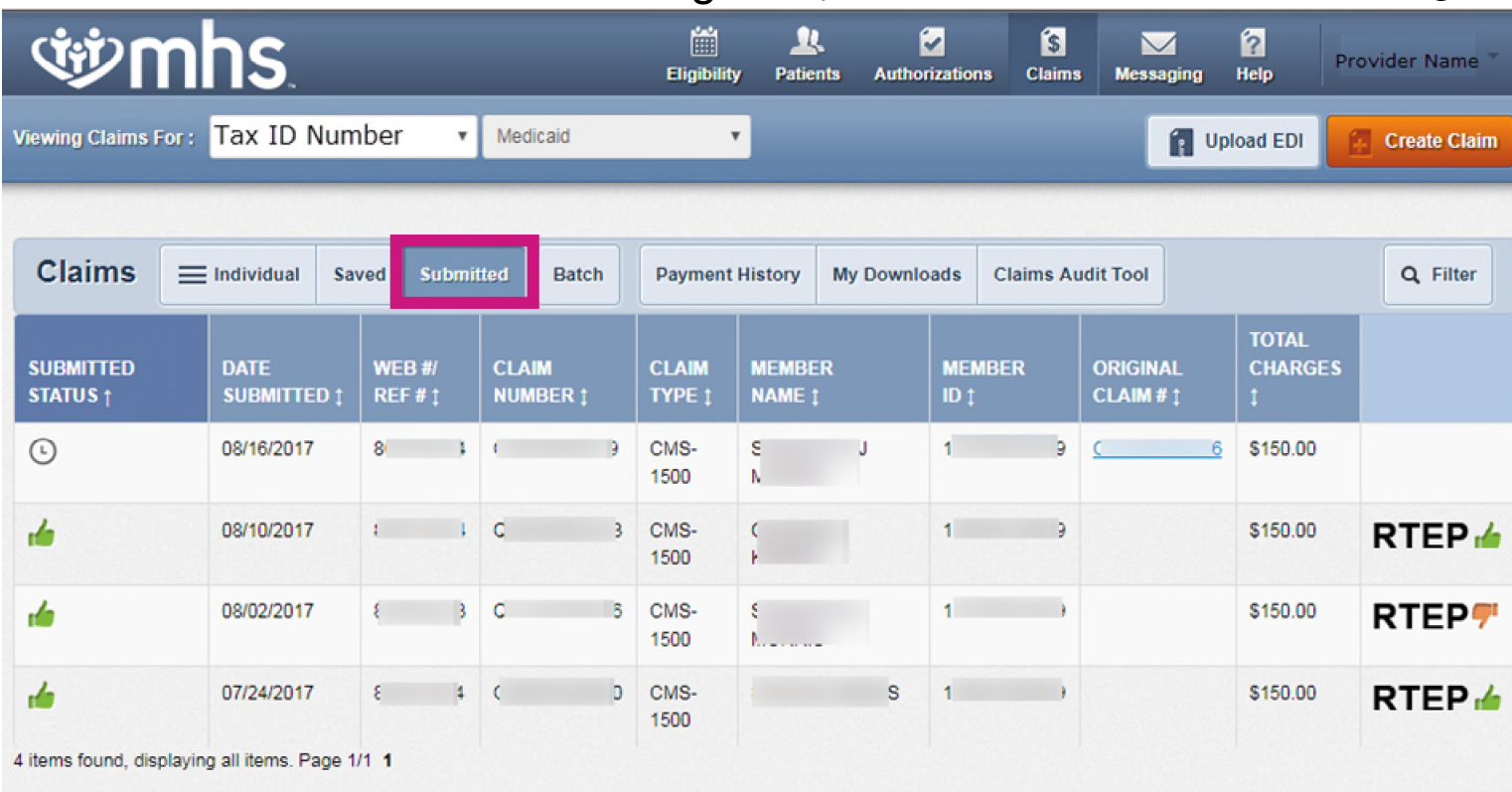
The screenshot shows the MHS Claim Submission web application. At the top is a navigation bar with the MHS logo and icons for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. A dropdown menu for 'Provider Name' is on the right. Below the navigation bar is a section for 'Viewing Claims For:' with two dropdown menus: 'Tax ID Number' and 'Medicaid', followed by a green 'GO' button. To the right are two buttons: 'Upload EDI' and 'Create Claim'. Below this is a light blue box with the text 'Choose Claim for ,'. Underneath is a section titled 'Choose a Claim Type'. It contains two columns. The left column is for 'CMS 1500' and has a green button labeled 'Professional Claim →'. The right column is for 'CMS UB-04' and has a green button labeled 'Institutional Claim →'. At the bottom of the form is an 'UPDATE' notice: '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.'








Submitted Claims

 The **Submitted** tab will show only claims created via the MHS portal.

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

 **RTEP** claims also show if eligible. (i.e. line 2 was submitted. But was not eligible for RTEP.)



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

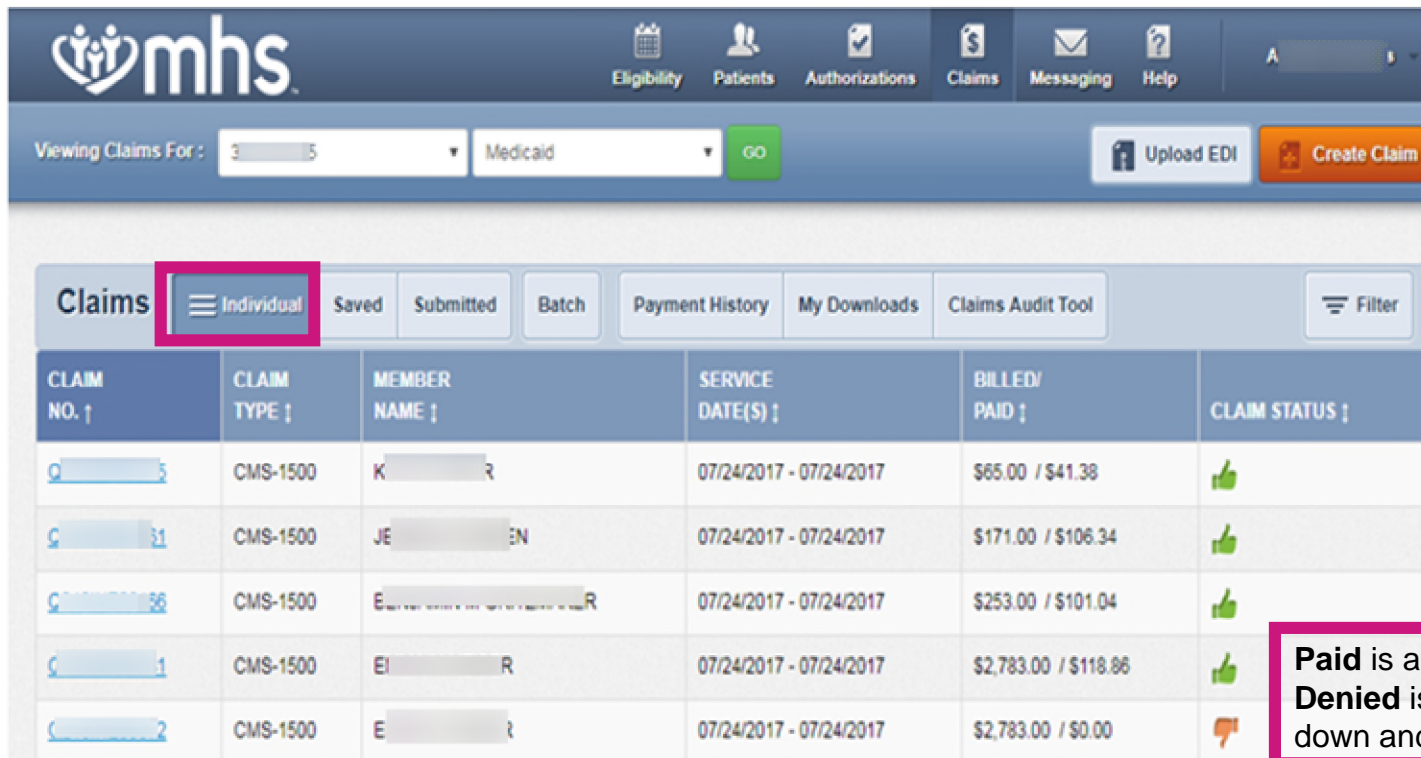
4 items found, displaying all items. Page 1/1 1

Individual Claims



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

- View the Claim Number, Claim Type, Member Name, Service Dates, Billed/Paid, and Claim Status



The screenshot shows the MHS web application interface for viewing individual claims. The top navigation bar includes links for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below this, there are filters for 'Viewing Claims For' (set to 3) and 'Medicaid'. A 'GO' button and 'Upload EDI'/'Create Claim' buttons are also present. The main content area shows a table of claims with columns for Claim No., Claim Type, Member Name, Service Date(s), Billed/Paid, and Claim Status. The 'Individual' tab is selected and highlighted with a red box. A red box also highlights the 'Paid' status icon (green thumbs up) in the first row of the table.

CLAIM NO. ↑	CLAIM TYPE ↑	MEMBER NAME ↑	SERVICE DATE(S) ↑	BILLED/ PAID ↑	CLAIM STATUS ↑
Q 15	CMS-1500	K R	07/24/2017 - 07/24/2017	\$65.00 / \$41.38	👍
C 31	CMS-1500	JE EN	07/24/2017 - 07/24/2017	\$171.00 / \$106.34	👍
C 56	CMS-1500	E R	07/24/2017 - 07/24/2017	\$253.00 / \$101.04	👍
C 1	CMS-1500	EI R	07/24/2017 - 07/24/2017	\$2,783.00 / \$118.86	👍
C 2	CMS-1500	E R	07/24/2017 - 07/24/2017	\$2,783.00 / \$0.00	👎

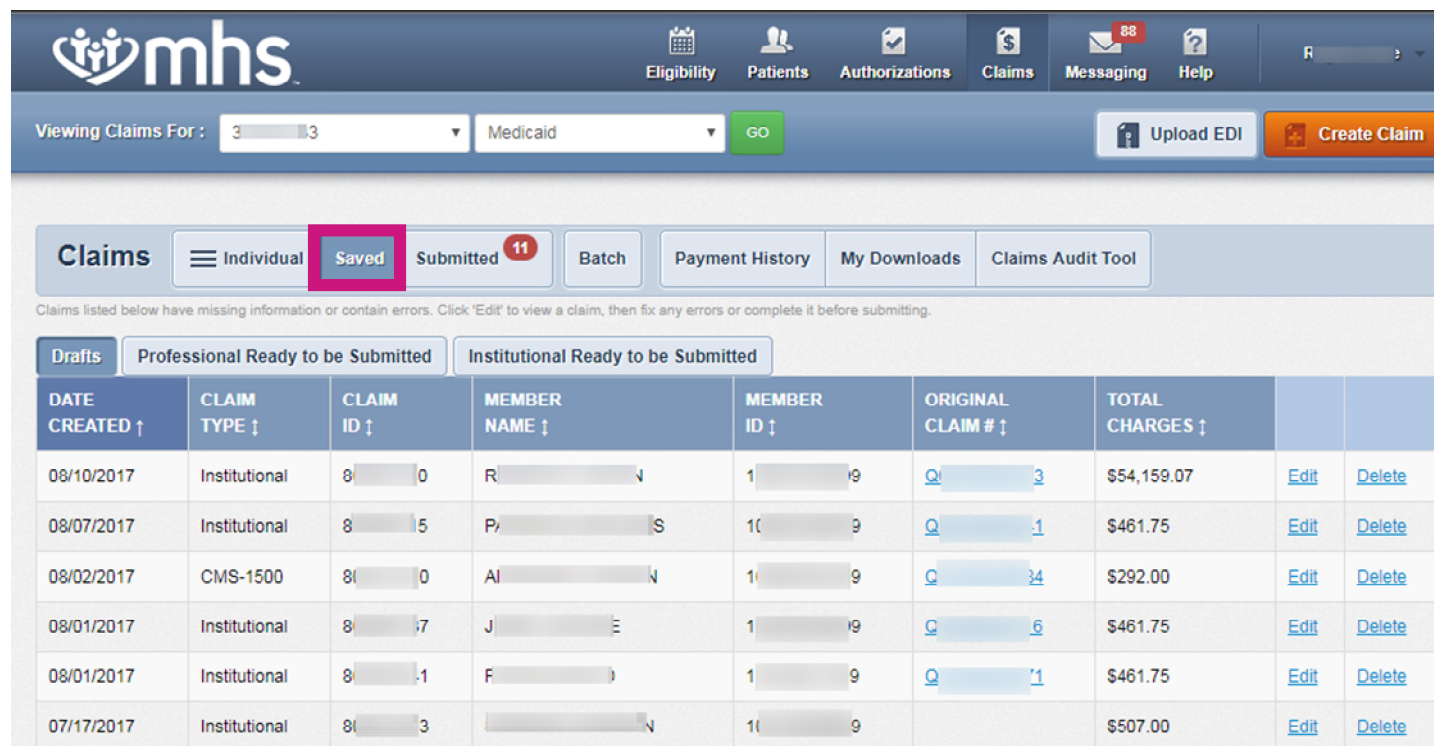
Paid is a green thumbs up,
Denied is a orange thumbs down and a clock is **Pending**

Saved Claims



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

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



The screenshot shows the MHS Claims Management interface. At the top, there's a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, Messaging (with 88 notifications), and Help. Below this is a search bar with 'Viewing Claims For:' and filters for '3' and 'Medicaid'. A 'GO' button and 'Upload EDI'/'Create Claim' buttons are also present.

The main section has a 'Claims' tab with sub-tabs: Individual, **Saved** (highlighted), Submitted (with 11 notifications), Batch, Payment History, My Downloads, 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 filter tabs: Drafts, Professional Ready to be Submitted, and Institutional Ready to be Submitted. The 'Institutional Ready to be Submitted' tab is active.

DATE CREATED ↑	CLAIM TYPE ↑	CLAIM ID ↑	MEMBER NAME ↑	MEMBER ID ↑	ORIGINAL CLAIM # ↑	TOTAL CHARGES ↑		
08/10/2017	Institutional	8100	R...	109	Q...3	\$54,159.07	Edit	Delete
08/07/2017	Institutional	8105	P...	109	Q...1	\$461.75	Edit	Delete
08/02/2017	CMS-1500	8100	A...	109	Q...4	\$292.00	Edit	Delete
08/01/2017	Institutional	8107	J...	109	Q...6	\$461.75	Edit	Delete
08/01/2017	Institutional	8101	F...	109	Q...1	\$461.75	Edit	Delete
07/17/2017	Institutional	8103	...	109		\$507.00	Edit	Delete

Correcting Claims

 After clicking on a **Claim #** link


1. Click **Correct Claim**
2. Proceed through the claims screens correcting the information that you may have omitted when the claim was originally submitted.
3. Continue clicking **Next** to move through the screens required to resubmit.
4. Review the claim information
5. Click **Submit**.

[Back to Claims](#)
[Correct Claim](#)
[Copy Claim](#)
Claim No.: Q180INE01235

Ref/Acct No.: P10007521700
 Member ID: 1() 9
 Member Name: () Y
 Member DOB: 1() ?
 Servicing Provider: SHAH, VINEET
 Servicing NPI: 1699868455
 DOS Range: 05/25/2017 - 05/25/2017

Received Date: 06/29/2017
 Billed Amount: \$99.00
 Payment Amount: \$0.00
 Payment Date: 07/10/2017
 Status: DENIED

LINE	DOS	PROC	DX	MODIFIERS	PLACE OF SERVICE	CHARGED	PAYMENT AMOUNT	PAYMENT DATE	CHECK NO.	STATUS	STATUS DESCRIPTION
1	05/25/2017	73110	S62101 A	TC, RT	11	\$99.00	\$0.00	07/10/2017	09004 13973	DENY	DUPLICATE CLAIMS OR MULTIPLE PROVIDERS BILLING SAME/SIMILAR CODE(S)

 Only claims with a status of **PAID** or **DENIED** can be corrected online.

Payment History

View Service Line Details

- The explanation of payment details displays the date and check number
- This view shows each patient payment by service line detail made on the check

Explanation of Payment Details

[Back to Payments List](#)
[Download \(Excel Format\)](#)
[Print](#)

Your request has been received
X
Go to Claims>My Downloads to retrieve your file or check the status of your download request.

Check/Trace Number:0900428203 Check Date:08/17/2017

Insured Name: E
Patient Name: A
Control Number: 7
Service Provider: IWUAGWU, ANTHONY

Group: T
ID: 1
Account: F
NPI: 1699844886

View Service Line Details

Insured Name: E
Patient Name: A
Control Number: 7
Service Provider: IWUAGWU, ANTHONY






Group: T
ID: 1
Account: F
NPI: 1699844886

View Service Line Details

Serv	Date	Proc#/ Proc2	Mod	Days/ Cnt Qty	Charged	Allowed	Deduct/ Copay	Coinsur	Discount/ Interest	Med Allow/ Med Paid	TPP	Denied	Remit Codes	Payment
10	06/03/2017	99235		0/1	305.00	160.37	0.00/0.00	0.00	0.00/0.00	0.00/0.00	0.00	0.00	on	160.37
Sub Total:					\$305.00	\$160.37	\$0.00/\$0.00	\$0.00	\$0.00/\$0.00	\$0.00/\$0.00	\$0.00	\$0.00		\$160.37

Remit Code Descriptions
on
REDUCED PAYMENT FOR OUT OF NETWORK PROVIDER

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, only a **1 month** span 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.
-  When filtering **Payment History** the span is limited to 1 month.

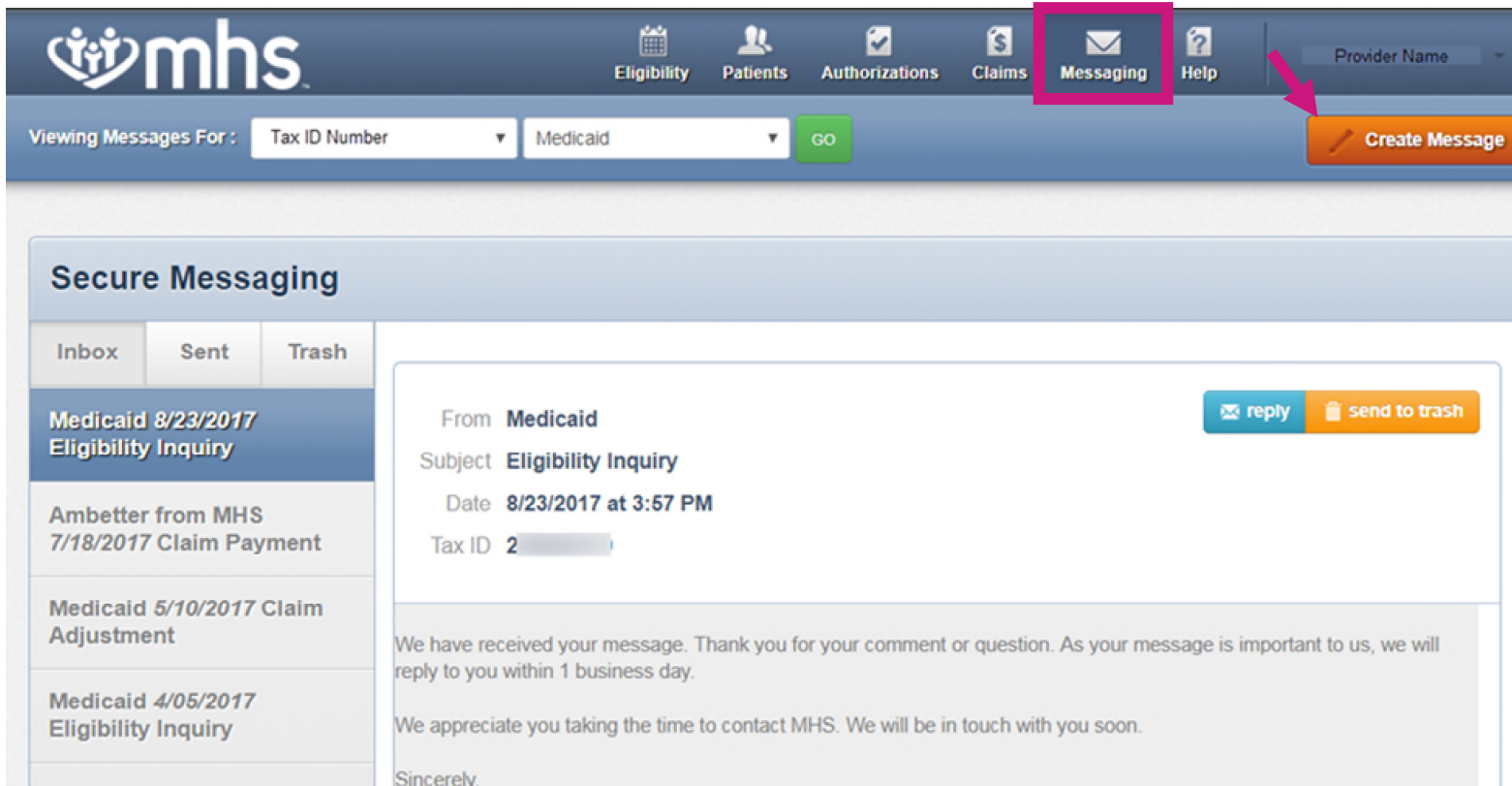
Secure Messaging

Secure Messaging



Create a New Secure Message

- Click **Messaging** tab from the Dashboard.
- Click **Create Message**



mhs

Eligibility Patients Authorizations Claims **Messaging** Help

Provider Name

Viewing Messages For: Tax ID Number Medicaid GO

Create Message

Secure Messaging

Inbox	Sent	Trash
Medicaid 8/23/2017 Eligibility Inquiry		
Ambetter from MHS 7/18/2017 Claim Payment		
Medicaid 5/10/2017 Claim Adjustment		
Medicaid 4/05/2017 Eligibility Inquiry		

From Medicaid

Subject Eligibility Inquiry

Date 8/23/2017 at 3:57 PM

Tax ID 2

reply send to trash

We have received your message. Thank you for your comment or question. As your message is important to us, we will reply to you within 1 business day.

We appreciate you taking the time to contact MHS. We will be in touch with you soon.

Sincerely,

MHS Public Website (mhsindiana.com)

MHS Website



mhsindiana.com



Provides access to Medicaid, Ambetter and Allwell



Provider directory search functionality



Pre-Auth Needed tool



Payspan / EFT information

- Convenient payments
- One year retrieval of remittance information
- No cost to providers



Printable current forms, guides and manuals

- Update billing information form
- Denial and Rejection code listings
- QRG-Quick Reference Guide



Patient education material

- KRAMES online services – MHS members have 24 hour a day access to info sheets about more than 4,000 topics relating to health and medication via MHS website. Most information is available in multiple languages including both English and Spanish: mhsindiana.kramesonline.com



Contact Us feature

Provider Enrollment

Provider Enrollment



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

Contrast ☒ On ☐ Off a a a language▼

FOR MEMBERS

FOR PROVIDERS

GET INSURED

FOR PROVIDERS

[Login](#)

[Become a Provider](#)

[Prior Authorization](#)



[Dental Providers](#)

[Pharmacy](#)



[Provider Resources](#)



[QI Program](#)



[Provider News](#)

Become a Provider

Become A Contracted Provider

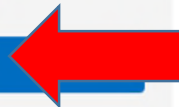
[Click Here](#)

We appreciate your interest in MHS and are excited to set up your office as a participating provider. If you would like more information, please fill out the online information request form. An MHS representative will reach out to you shortly to discuss contracting options for your office.

Existing Contracted Provider

[Click Here](#)

If you are a provider who is part of an existing contracted entity, use this online contracted enrollment form to enroll a new provider. All submissions must include a completed IHCP application.



Provider Enrollment

Non-Contracted Provider

Click Here

If you are not contracted with MHS, please complete the online non-contracted enrollment form. All submissions must include a completed W9. Set-up may take 45 – 60 days after we receive your submission.

To begin set-up with MHS, you must be enrolled with Indiana Medicaid and have an Indiana Medicaid provider number. You can enroll online at indianamedicaid.com.

Existing Behavioral Health Provider

Click Here

If you are a provider who is part of an existing contracted behavioral health entity, use this online contracted enrollment form to enroll a new provider.



Provider Enrollment

When referring patients to the hospital, do you utilize hospitalists?

☐ Yes

☐ No

Group NPI

Group Medicaid Number *

Alpha Suffix

TIN *

Please attach a copy of your completed IHCP enrollment form. Required for Medicaid (HIP, HHW or HCC).

No file chosen

If a midlevel practitioner, please attach a copy of your collaboration agreement.

No file chosen

Comments



Provider Enrollment

Enrollment Requested By:

*First Name **

*Last Name **

*Date **

*Contact Email **

*Contact Phone **

Submit

MHS Behavioral Health Provider Enrollment

*Please attach a copy of your completed IHCP enrollment form. **

No file chosen

*Please attach a copy of your Health Service Provider of Psychology (HSP) Attestation. **

No file chosen

*Please attach a copy of your Behavioral Health Specialty Profile. **

No file chosen

Demographic Updates


Provider Demographic Updates

Provider Resources

MHS provides the tools and support you need to deliver the best quality of care. Please view the listing on the left, or below, that covers forms, guidelines, helpful links, and training.

- Demographic Update Tool
- Guides and Manuals
- Electronic Transactions
- Preferred Drug Lists
- Provider Education
- Newsletters
- Helpful Links



 Providers can utilize the Demographic Update Tool to update below information.

 Address Changes

 Demographic Changes

 Update Member Assignment Limitations

 Term an Existing Provider

 Make a Change to an IRS Number or NPI Number

Provider Demographic Updates

Demographic Update Tool

MHS is committed to providing our providers with the best tools possible to support their administrative needs. We have created an easy way for you to request updates to your information and ensure we receive what we need to complete your request in a timely manner.

Need to review your existing information or have a question? If you are a contracted provider you can visit our [Provider Directory](#) to review your information. Please note that hospital-based and midlevel providers will not show in the directory. If you are a non-contracted provider, please call Provider Services at 1-877-647-4848. Our [Contact Us](#) page is always available for general questions as well.

Ambetter only provider? Visit our [Ambetter website](#).

What would you like to do?

MAKE AN ADDRESS CHANGE? 

MAKE A DEMOGRAPHIC CHANGE? 

UPDATE MEMBER ASSIGNMENT LIMITATIONS? 

TERM AN EXISTING PROVIDER? 

MAKE A CHANGE TO AN IRS NUMBER OR NPI NUMBER? 

Behavioral Health

Behavioral Health Claim Process



Electronic submission

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



Online submission through the MHS Secure Provider Portal



Paper Claims




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





Claim Inquiries

- Check status online
- Call Provider Services at 1-877-647-4848

Behavioral Health Dispute Resolution

-  Must be made in writing by using the MHS Behavioral Health Informal Claim Dispute or objection form, available at mhsindiana.com/provider-forms.
-  Submit all documentation supporting your objection.
-  Send to MHS within **67 calendar days** of receipt of the MHS on Explanation of Payment (EOP). *Please reference the original claim number.* Requests received after day 67 will not be considered.

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

-  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 67 calendar days from date on EOP to initiate a formal claim appeal.

Behavioral Health Prior Authorization



PRIOR AUTHORIZATION

- Please call Care Management for inpatient and partial hospitalization authorizations at 1-877-647-4848. Follow prompts to Behavioral Health.
- Authorization forms may be obtained on our website
 - Outpatient Treatment Request (OTR) Form/Tip-Sheet/Training
 - Intensive Outpatient/Day Treatment Form Mental Health/Chemical Dependency
 - Applied Behavioral Analysis Treatment (OTR)
 - Psychological Testing Authorization Request Form (Outpatient & Inpatient)










Medical Necessity Appeals

- Submit to:
MHS Behavioral Health
ATTN: Appeals Coordinator
12515-8 Research Blvd, Suite 400
Austin, TX 78759

Behavioral Health Services Requiring Authorization

Professional Services

-  Psychiatric Diagnostic Evaluation (Limited to 1 per member per 12 month Rolling year without authorization)
-  Electroconvulsive Therapy
-  Psychological Testing (Unless for Autism: then no auth is required)
-  Developmental Testing, with interpretation and report (non-Early Periodic Screening, Diagnosis Treatment EPSDT)
-  Neurobehavioral status exam, with interpretation and report
-  Neuropsych Testing per hour (face to face) (Unless for Autism: then no auth is required). (Non-Participating Providers only)
-  Applied Behavioral Analysis (ABA) Services

Medical Claim Processing

Claim Submission



EDI Submission

- Preferred method of claims submission
- Faster and less expensive than paper submission
- MHS Medical Electronic Payor ID: 68069
- MHS BH Electronic Payor ID: 68068



Online through the MHS Secure Provider Portal at mhsindiana.com

- Provides immediate confirmation of received claims and acceptance
- Institutional and Professional
- Batch Claims
- Claim Adjustments/Corrections



Paper Claims

Managed Health Services

PO Box 3002

Farmington, MO 63640-3802

Claim Submission

 **Claims must be received within 90 calendar days of the date of service**

 ***Exceptions (rejections do not substantiate filing limit requirements)***

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

Dispute Resolution/Appeals



Must be made in writing by using the MHS informal claim dispute/objection form, available at mhsindiana.com/provider-forms.



Submit all documentation supporting your objection.



Send to MHS within **67 calendar days** of receipt of the MHS EOP. *Please reference the original claim number.* Requests received after day 67 will not be considered*.

Medical Claims:

MHS Medical Appeals

Attn: Appeals

P.O. Box 3000

Farmington, MO 63640-3800

Behavioral Claims:

MHS BH Appeals

Attn: Appeals Department

P.O. Box 6000

Farmington, MO 63640-3809



MHS will acknowledge your appeal within 5 business days.







Provider will receive notice of determination within 45 calendar days of the receipt of the appeal.

****A call to MHS Provider Services does not reserve appeal rights***

Dispute Resolution/Appeals


Level One Appeal- Claim Objection

-  Must be made in writing by using the **MHS informal claim dispute**/objection form.
-  Submit all documentation supporting your objection.
-  Send to MHS within **67 calendar days** of receipt of the original MHS EOP.
-  Provider should proceed with level two appeal, if claim has not been overturned 30 days from initial objection submission.



A call to MHS Provider Services does not reserve appeal rights

Dispute Resolution/Appeals

Level Two Appeal (Administrative)




-  Submit the informal claims dispute or objection form with all supporting documentation to the MHS appeals address:

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

-  MHS will acknowledge your appeal within 5 business days.
-  Provider will receive notice of determination within 45 calendar days of the receipt of the appeal for a formal appeal.













MHS Partners

Partners and Vendors

-  Envolve Pharmacy Solutions: Pharmacy Benefit Manager
 - 1-844-202-6824 Phone
 - 1-800-977-8226 (Fax) PA Requests
-  Envolve Vision Benefits: Routine Eye Care Benefit & Ophthalmology Specialty Care
 - 1-800-334-3937
 - envolvevision.com
-  Envolve Dental: Dental Services
 - 1-855-609-5157
 - dental.envolvehealth.com
-  National Imaging Associates (NIA): Non-Emergent, Outpatient High-Tech Imaging
 - 1-800-424-4821
 - RadMD.com

Member & Provider Services

1-877-647-4848

-  Dedicated staff available Monday - Friday from 8 a.m. - 8 p.m.
-  Hoosier Healthwise, HIP and Hoosier Care Connect customer service
-  Eligibility verification if needed
-  Claims status and assistance
-  Translation and transportation coordination
-  Health needs screening
-  New IVR option-telephonic, self service verification of claims and eligibility
-  Spanish speaking representatives (additional languages available upon request)
-  Facilitates member disenrollment requests
-  Panel full/hold requests
-  New member tool kits
-  Member QRG

MHS Provider Network Territories

NORTHEAST REGION

Claims Issues: MHS_ProviderRelations_NE@mhsindiana.com
Chad Pratt, Provider Partnership Associate
1-877-647-4848 ext. 20454
rpratt@mhsindiana.com

CENTRAL REGION

Claims Issues: MHS_ProviderRelations_C@mhsindiana.com
Esther Cervantes, Provider Partnership Associate
1-877-647-4848 ext. 20947
Estherling.A.PimentelCervantes@mhsindiana.com

NORTHWEST REGION

Claims Issues: MHS_ProviderRelations_NW@mhsindiana.com
Candace Ervin, Provider Partnership Associate
1-877-647-4848 ext. 20187
Candace.V.Ervin@mhsindiana.com

SOUTHWEST REGION

Claims Issues: MHS_ProviderRelations_SW@mhsindiana.com
Dawn McCarty, Provider Partnership Associate
1-877-647-4848 ext. 20117
Dawnalee.A.McCarty@mhsindiana.com

SOUTHEAST REGION

Claims Issues: MHS_ProviderRelations_SE@mhsindiana.com
1-877-647-4848

NETWORK LEADERSHIP

Jill Claypool
Vice President, Network
Development & Contracting
1-877-647-4848 ext. 20855
jill.e.claypool@mhsindiana.com

Nancy Robinson
Senior Director, Provider Network
1-877-647-4848 ext. 20180
nrobinson@mhsindiana.com

Mark Vonderheit
Director, Provider Network
1-877-647-4848 Ext. 20240
mvonderheit@mhsindiana.com

NEW PROVIDER CONTRACTING

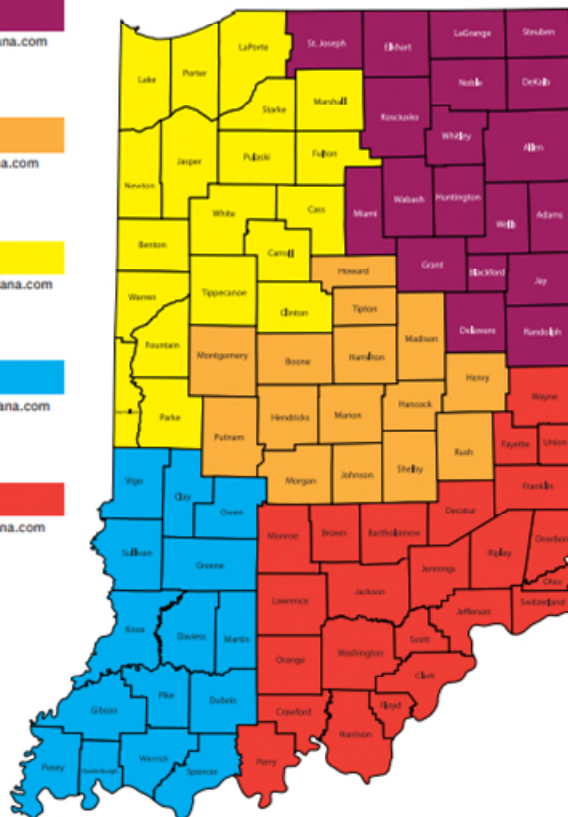
Tim Balko
Director, Network Development & Contracting
1-877-647-4848 ext. 20120
tbalko@mhsindiana.com

Michael Funk
Manager, Network Development & Contracting
1-877-647-4848 ext. 20017
michael.j.funk@mhsindiana.com

NETWORK OPERATIONS

Kelvin Orr
Director, Network Operations
1-877-647-4848 ext. 20049
kelvin.d.orr@mhsindiana.com

Indiana



MHS Provider Network Territories

TAWANNA DANZIE

Provider Partnership Associate II
1-877-647-4848 ext. 20022
tdanzie@mhsindiana.com

PROVIDER GROUPS

Beacon Medical Group
Community Care Network
Franciscan Alliance
Goshen Health System
HealthLine
Heart City Health Center
Indiana Health Centers
Lutheran Medical Group
Northshore Health Centers
Parkview Health System
South Bend Clinic

JENNIFER GARNER

Provider Partnership Associate II
1-877-647-4848 ext. 20149
jgarner@mhsindiana.com

PROVIDER GROUPS

American Health Network of Indiana
Columbus Regional Health
Community Physicians of Indiana
Good Samaritan Hospital Physician Services
HealthNet
Health & Hospital Corporation of Marion County
Indiana University Health
Little Company of Mary Hospital of Indiana
Riverview Hospital
St. Vincent Medical Group

INTERNAL REPRESENTATIVES

JENNIFER DEAN

Provider Network Specialist
1-877-647-4848 ext. 20221
jedean@mhsindiana.com

LAKISHA BROWDER

Provider Relations Specialist
1-877-647-4848 ext. 20224
lbrowder@mhsindiana.com









ENVOLVE DENTAL, INC.

MICHAEL J. WILLIAMS

Provider Relations Specialist
1-727-437-1832
Dental Provider Services: 1-855-609-5157
Michael.Williams@EnvolveHealth.com

Review

 We hope you learned more about the following topics;

-  What products are offered by MHS
-  Additional details regarding the MHS PA process and timelines
-  MHS portal functionality
-  Online provider enrollment and demographic change applications
-  Behavioral Health claims submission and appeals
-  MHS Medical claims submission and appeals
-  MHS Vendors
-  Quality measures and P4P information

Questions?

Thank you for being our partner in care.