

# MHS Home Health









# Agenda

-  Covered Services
-  Billing
-  Overhead Occurrence Codes
-  Web Portal/Paper Claims
-  Prior Authorization
-  Denials
-  Ambetter Home Health Billing
-  Ambetter Denials
-  Allwell Home Health Billing
-  Allwell Rejections
-  Who Do I Contact?

# Covered Services

-  Skilled Nursing
-  Home Health Aide Services
-  Skilled Therapies
-  Physical Therapy
-  Occupational Therapy
-  Speech-Language Pathology

# Home Health

-  Must be billed on a UB 04.
-  Bill type must be 32X or 34X.
-  Both Rev and CPT codes are required.
-  Each visit must be billed individually on separate service line.
-  Therapy services require a modifier.
-  Nursing services require a modifier.




# Revenue Code Crosswalk

Revenue Code	Procedure Code	Revenue Code	Procedure Code
420	G0151	439	G0152
421	G0151	440	G0153
422	G0151	441	G0153
423	G0151	442	G0153
424	97161-97163	443	G0153
429	G0151	444	92521-92524
430	G0152	449	G0153
431	G0152	552	99600 TD, 99600 TE
432	G0152	559	99601, 99602
433	G0152	572	99600
434	97165-97167		



# Home Health Services

Code	Services Performed By	Billing Unit
Occurrence code 73	Overhead	One unit per provider per member per day
Procedure code modifier 99600 TD	Registered nurse	Hourly
Procedure code modifier 99600 TE	Licensed practical nurse	Hourly
Procedure code 99600	Home Health aide	Hourly
Procedure code G0151	Physical therapist	15-minute increments
Procedure code G0152	Occupational therapist	15-minute increments
Procedure code G0153	Speech-language pathologist	15-minute increments

# Overhead Occurrence Code




-  Home health providers receive an overhead rate for administrative costs for each visit to the members home.
-  Providers must bill home health overhead with occurrence code 73.
-  Providers can only receive one overhead rate per member per date of service.

# Overhead Occurrence Codes

-  On the *UB-04* claim form, for each nonconsecutive date of service billed, providers should enter the occurrence code and the corresponding date in the Occurrence Code and Date fields (31a–34b).
-  On the Portal institutional claim, for each nonconsecutive date of service billed, in the *Occurrence Codes* panel, providers should enter the occurrence code and the corresponding date, using the same date in both the From Date and To Date fields for each entry.







# Overhead Occurrence Codes

-  If the dates of service billed **are consecutive**, and one encounter was provided every day:
-  On the *UB-04* claim form, providers should enter the appropriate occurrence code and the first and last dates of service being billed in the Occurrence Span Code, From, and Through fields (35a–36b).
-  On the Portal institutional claim, use the same occurrence code fields as are used for nonconsecutive dates, but use the From Date and To Date fields to indicate that the single code entry represents a span.

# Home Health Billing

## Web Portal

-  Occurrence codes billed on the portal are currently limited to 4 dates.
-  Enter the 61 occurrence code with the Date of Service in the From field.
-  May then add the next 61 with next date of service in From field (for a total at this time of 4 lines).
-  If you enter the “To” date, you will receive an error, and it will not let you continue without removing that date.

# Secure Web Portal Login or Registration

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



FOR MEMBERS

FOR PROVIDERS

GET INSURED

## FOR PROVIDERS

Login

Become a Provider

Prior Authorization +

Dental Providers

Pharmacy +

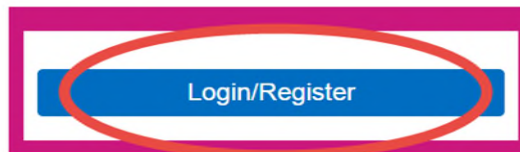
Behavioral Health +

Provider Resources +

QI Program +

Provider News

## Portal Login



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

Behavioral Health Secure Portal

[Click here for the Cenpatico 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:

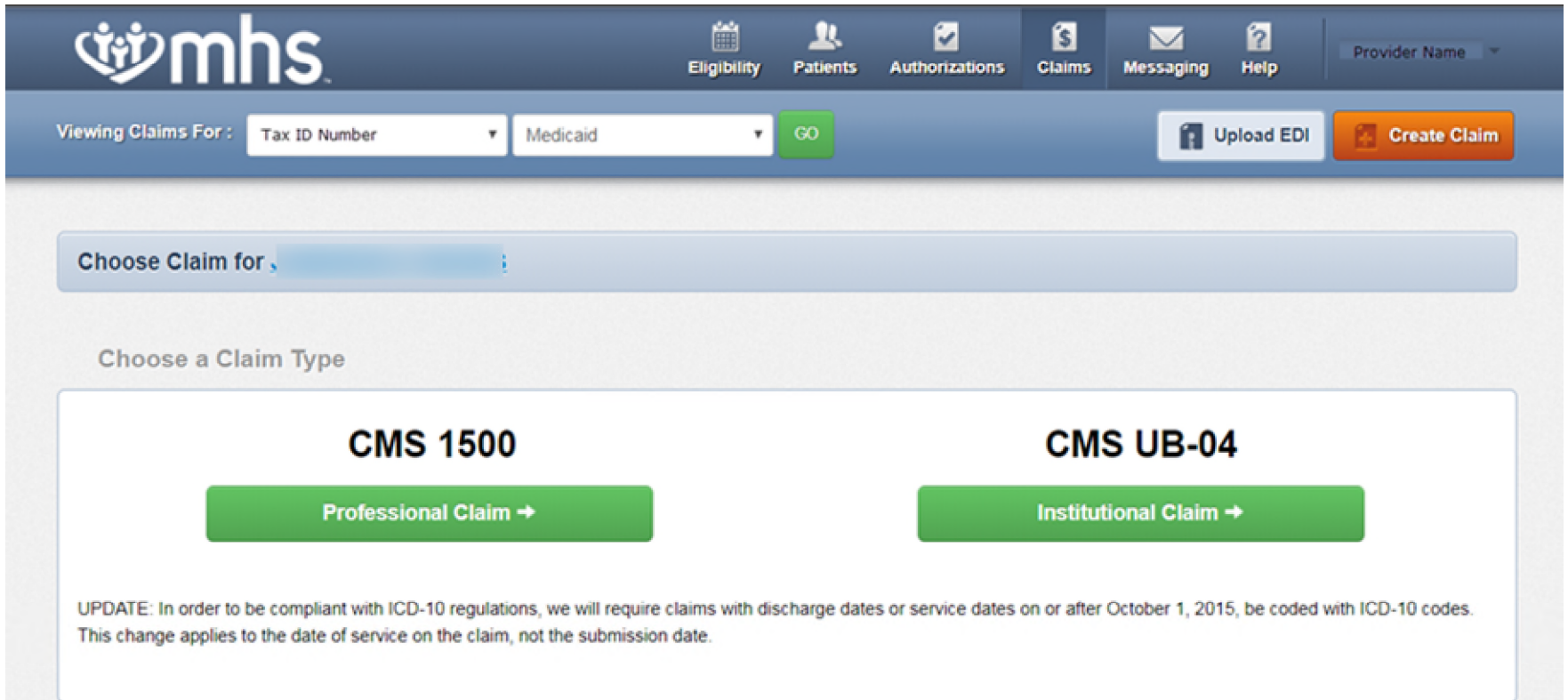
- Verify member eligibility
- Submit and check claims
- Submit and confirm authorizations
- View detailed patient list

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.

# Claim Submission

## Choose the Claim Type

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



The screenshot shows the MHS web application interface for claim submission. At the top, there is a navigation bar with the MHS logo and several menu items: Eligibility, Patients, Authorizations, Claims, Messaging, and Help. A dropdown menu for 'Provider Name' is also visible. Below the navigation bar, there 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 of this section are two buttons: 'Upload EDI' and 'Create Claim'. Below this is a large blue button labeled 'Choose Claim for'. Underneath, there is a section titled 'Choose a Claim Type' which contains two main options: 'CMS 1500' and 'CMS UB-04'. Under 'CMS 1500' is a green button labeled 'Professional Claim →'. Under 'CMS UB-04' is a green button labeled 'Institutional Claim →'. At the bottom of the page, there 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.'

# Web Submission Occurrence Codes

\* Required field

← Back
Next →

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ICD Version Indicator\*  ICD 10 Please note that for the claim statement dates entered, valid ICD-10 codes only are accepted.


---

Principal Diagnosis Code*	<input type="text" value="XXXX e.g. V87"/>	POA Indicator	<input type="text" value="Select..."/>		67.	
Diagnosis Codes (67A-Q)	<input type="text" value="XXXX e.g. 140!"/>	POA Indicator	<input type="text" value="Select..."/>	<input type="button" value="Add"/>	67.a-q	
Patient Reason for Visit	<input type="text" value="XXXX e.g. V87"/>	<input type="button" value="Add"/>			70.	
External Cause of Injury Code (ECI)	<input type="text" value="XXXX e.g. V87"/>				72.	
Prospective Payment Code	<input type="text"/>				71.	
Condition Codes	<input type="text" value="XX e.g. DI"/>	<input type="button" value="Add"/>			18-28.	
Occurrence Codes and Span Codes	<input type="text" value="XX e.g. DI"/>	From	<input type="text" value="MM/DD/YYYY"/>	To	<input type="text" value="MM/DD/YYYY"/>	31-36.
Value Code	<input type="text" value="XX"/>	Amount	<input type="text" value="XX.XX"/>		39-41.	
Procedure Codes	<input type="text" value="XXXX e.g. 140!"/>	Procedure Date	<input type="text" value="MM/DD/YYYY"/>		74.	

← Back
Next →

# Claim Submission

 In the review section, you can review the claim once again, then click **Submit**

Professional Claim for LA
IV
Your Progress 

THIS SECTION:  
**Review**  
Please review your claim and submit.

[← Back](#)
[Submit →](#)

**Almost done!**  
You can go back to review your claim or submit now.

**Claim Id: 8**      **32**  
 Member Record Number: 1      32  
 Member Claim Amount Paid:  
 Patient's Account Number: 221920

**General Info** [Edit](#)  
 Statement From Date: 02/01/2016  
 Statement To Date: 02/01/2016  
 Date of current illness, injury, pregnancy (LMP):  
 Other Date:  
 Hospitalized From:  
 Hospitalized To:  
 Outside Lab: No  
 Outside Lab Amount:  
 Prior Authorization Number:  
 CUA Number:

**Diagnosis Codes and Primary Insurance** [Edit](#)  
 Diagnosis Codes  
 V537 -- PERS OUTSD INDUST VEH INJ NT ACC

**Service Lines** [Edit](#)

Line	From	To	Place	Proc	Diagnosis	Amount	Units/Minutes/Days	Family Plan	EPSDT	NDC	Supplemental Info
1	02/01/2016	02/01/2016	11	99213	V537	\$1,000.00	1	No			

**Providers** [Edit](#)

Provider Type	Name	Tax ID	NPI	Taxonomy	Address				
Referring Provider	FARRELL, ERIN		1	73					
Rendering Provider	FARRELL, ERIN	3	14	1	73	2	X		
Billing Provider	Ferrell,	3	14	1	3	21	X		236 DIMPSON AVENUE, ELUHART, IN, 46516
Service Facility Location	Ferrell		1	3	236 DIMPSON AVENUE, ELUHART, IN, 46516				

**Attachments**



[← Back](#)
[Submit →](#)

# Home Health Billing

## Paper Claims

- Enter individual dates in box 31a-34b to claim overhead reimbursement.
- Enter span dates in fields 35a-36b (up to 4 spans).
- May NOT claim more than 1 overhead per date of service billed.
- Date billed must be represented in box 45 of the UB with correct codes; this will stop a span date from being used if not listed.
- Remember if billing within 30 days of qualified IP admit, and do not have a separate Authorization set up, be sure to bill Occurrence code 42 and date of the hospital discharge.




# Paper Claim Submission

-  Overhead individual dates must be entered in box 31a-34b for overhead reimbursement.
-  Providers can submit up to eight individual overhead dates on the paper claim form.

31	OCURRENCE	32	OCURRENCE	33	OCURRENCE	34	OCURRENCE
CODE	DATE	CODE	DATE	CODE	DATE	CODE	DATE



# Paper Claim Submission

-  Overhead span dates must be completed in fields 35a-36b.
-  Providers can submit up to four span overhead dates on the paper claim form.
-  Span dates must be consecutive dates with any gaps in care.

35 CODE	OCCURRENCE SPAN		36 CODE	OCCURRENCE SPAN	
	FROM	THROUGH		FROM	THROUGH

# Paper Claim Submission

- 👤 Dates billed must be represented in box 45 of paper claim.
- 👤 If dates of service are not listed in box 45 the span dates will be considered obsolete.



42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49



**Incorrect Claim:**






**Type of Bill Incorrect**

T087INE03203






[REDACTED]										[REDACTED]										34 PAT. CONTR. #		[REDACTED]		5 TYPE OF BILL																									
8 PATIENT NAME										9 PATIENT ADDRESS										6 FED. TAX NO.		4 STATEMENT COVERS PERIOD		7																									
10 BIRTHDATE										11 SEX		12 DATE		13 ADMISSION		14 TYPE		15 DRG		16 DHR		17 STAT		18		19		20		21		22		23		24		25		26		27		28		29 ADMIT STATE		30	
31 OCCURRENCE CODE		32 OCCURRENCE DATE		33 OCCURRENCE CODE		34 OCCURRENCE DATE		35 OCCURRENCE CODE		36 OCCURRENCE DATE		37		38		39 VALUE CODES AMOUNT		40 VALUE CODES AMOUNT		41 VALUE CODES AMOUNT																													
42		02/06/2020		73		03/16/2020																																											
43		03/07/2020																																															
44 REV. CD										43 DESCRIPTION										44 HCPCS / RATE / NPPS CODE				45 SEVN. DFE		46 SERV. UNITS		47 TOTAL CHARGES		48 NON-COVERED CHARGES		49																	
0552																				99600 TD				03/16/2020		1		273.00																					
PAGE 1 OF 1										CREATION DATE										TOTALS				273.00																									
50 PAYER NAME										51 HEALTH PLAN ID										52 NPI		53 BDL		54 PRIOR PAYMENTS		55 EST. AMOUNT DUE		56 NPI		57 OTHER PIV ID																			
CENTENE ADVANTAGE PLANS										68069										Y		Y																											
58 INSURED'S NAME										59 INSURED'S SUFFIX										60 INSURED'S SUFFIX ID										61 GROUP NAME		62 INSURANCE GROUP NO.																	
[REDACTED]										[REDACTED]										[REDACTED]										[REDACTED]		[REDACTED]																	
63 TREATMENT AUTHORIZATION CODES										64 DOCUMENT CONTROL NUMBER										65 EMPLOYER NAME																													
30 DAY GRACE																																																	
66 C4021		M90561		M89751		Z452		F419		M629		Z79899		G		H		[REDACTED]		[REDACTED]																													

# Home Health Billing

## Electronic claims through a clearinghouse:

-  Enter individual dates and Occurrence Code 73 in loop 2300 with correct Reference Designators and other required data elements (up to 8 dates).
-  Enter span dates with Occurrence Code 73 in loop 2300 with correct Reference Designators and other required data elements (up to 4 spans).
-  May NOT claim more than 1 overhead per date of service billed.
-  Date billed must be represented in line itemization of claim with correct codes; this will stop a span date from being used if not listed.
-  Remember if billing within 30 days of qualified IP admit, and do not have a separate Authorization set up, be sure to bill Occurrence code 42 and date of the hospital discharge.

# Prior Authorization (PA) Request

-  MHS strives to return a decision on **all** PA requests within **two business days** of request. Providers can **update** previously approved PAs **within 30 days** of the original date of service prior to claim denial for changes to:
  - Dates of Service
  - CPT/HCPCS codes
-  MHS has up to **seven days** to render PA decisions.
-  PA approval requires the need for medical necessity.
-  Medical Management **does not** verify eligibility or benefit limitations: Provider is responsible for eligibility and benefit verification
-  ***Denied Authorizations must follow the authorization appeal process, not the claims appeal process, claims appeals can not change the status of a denied authorization.***

*\*Providers may make corrections to the existing PA as long as the claim has not been submitted.*

# Prior Authorization

## Is Prior Authorization Needed?

- MHS website: [mhsindiana.com](http://mhsindiana.com)
- Quick reference guide
- Non-contracted provider services now align with PA requirements for contracted providers

**PROVIDER Quick Reference Guide**  
EFFECTIVE AUGUST 1, 2020

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](http://ambetter.mhsindiana.com). Coverage is subject to specific benefit package of member.

**1-877-647-4848**  
TTY/TDD: 1-800-743-3333  
[mhsindiana.com](http://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.

**CASE MANAGEMENT:**  
8 a.m. to 5 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)**

<b>ELECTRONIC PAYER ID:</b> 68069	<b>MEDICAL CLAIMS APPEALS ADDRESS:</b> Managed Health Services P.O. Box 3000 Farmington, MO 63640-3000
<b>BEHAVIORAL HEALTH PAYER ID:</b> 68068	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.
<b>MEDICAL CLAIMS ADDRESS:</b> Managed Health Services P.O. Box 3002 Farmington, MO 63640-3802	<b>MEDICAL CLAIMS REFUNDS:</b> To refund claims overpayment, please send check and documentation to: Coordinated Care Corporation 75 Remittance Dr., Suite 6446 Chicago, IL 60675-6446
Claims sent to MHS' Indianapolis address will be returned to the provider.	
<b>MEDICAL NECESSITY APPEALS ONLY ADDRESS:</b> ATTN: APPEALS P.O. Box 441667 Indianapolis, IN 46244	

**MHS FAX NUMBERS**

**MEDICAL APPEALS: 1-866-714-7993**

**CASE MANAGEMENT: 1-866-694-3653**  
Ex. Member Referrals to CM/DM

**REFERRALS AND AUTHORIZATIONS: 1-866-912-4245**




**MHS WEBSITE: MHSINDIANA.COM**

<a href="http://mhsindiana.com/providers">mhsindiana.com/providers</a>	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.
<a href="http://mhsindiana.com/health">mhsindiana.com/health</a>	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.
<a href="http://mhsindiana.com/login">mhsindiana.com/login</a>	MHS' Secure Provider Portal lets you submit prior authorization, claims, claim adjustments, and view your panel's medical records and care gaps.
<a href="http://mhsindiana.com/transactions">mhsindiana.com/transactions</a>	Information for electronic processing and payment of claims with MHS.
<b>OTHER RESOURCES</b>	
<a href="http://payspanhealth.com">payspanhealth.com</a>	MHS is pleased to partner with PaySpan to provide an innovative web based solution for Electronic Funds Transfers (EFTs) and Electronic Remittance Advice (ERAs). This service is provided at no cost to providers and allows online enrollment at <a href="http://payspanhealth.com">payspanhealth.com</a> .

You can find out more about the information in this Guide in the MHS Provider Manual, online at [mhsindiana.com/providers/resources](http://mhsindiana.com/providers/resources), or by contacting MHS at 1-877-647-4848.



0720.PR.P.FL.1

# PA Documentation Needed

-  Physician's orders and signed plan of care, including most recent MD notes about the issue at hand.
-  Home care plan, including home exercise program.
-  Progress notes for medical necessity determination.



# Home Health Authorizations

-  Providers must submit hospice, home health and biopharmacy PA requests via **fax** to **1-866-912-4245**.
-  Providers can check the authorization status on the portal.

# Fax Authorization

**MHS Medical Management Department at 1-866-912-4245**

Patient Information					
IHCP Member ID (RID):					
Date of Birth:					
Patient Name:					
Address:					
City/State/ZIP Code:					
Patient/Guardian Phone:					
PMP Name:					
PMP NPI:					
PMP Phone:					
Ordering, Prescribing, or Referring (OPR) Provider Information					
OPR Physician NPI:					
Medical Diagnosis (Use of ICD Diagnostic Code Is Required)					
Dx1		Dx2		Dx3	



Member ID/RID,  
DOB, Patient name  
= **required**



Medical Diagnosis code(s)  
= **required**



Check service category

Please check the requested assignment category below:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> DME              | <input type="checkbox"/> Inpatient            | <input type="checkbox"/> Physical Therapy |
| <input type="checkbox"/> <i>Purchased</i> | <input type="checkbox"/> Observation          | <input type="checkbox"/> Speech Therapy   |
| <input type="checkbox"/> <i>Rented</i>    | <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           |   |

# Fax Authorization

Requesting Provider Information:
NPI#:
Tax ID#:
Service Location Code:
Provider Name:
Rendering Provider Information
Ordering Physician NPI#:
Tax ID#:
Name
Address:
City/State/Zip:
Phone:
Fax:



Enter the **Requesting** provider's information






Enter the Rendering Provider's individual NPI#




# Fax Authorization

Dates of Service		Procedure/ Service Codes	Modifier(s)		Requested Service	Taxonomy	POS	Units	Dollars
Start	Stop								



# PA Exception for Hospital Discharge

-  Physicians order in writing prior to discharge.
-  RN, LPN and home aide services, not to exceed 120 units within 30 calendar days following the discharge.
-  Any combination of therapy services, not to exceed 30 units in 30 calendar days following the discharge.

# PA Exception for Hospital Discharge

-  Hospital discharge is counted as day 1.
-  Use occurrence code 42 with corresponding date of discharge in the occurrence code and occurrence date fields of the institutional claim(field 31a-34b claim form) to bypass PA requirements.
-  PA is not required for emergency visits.

# 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***

# Medical 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 the expedited appeal.
- 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.*



# Ambetter Home Health Billing

-  Providers must use type of bill (TOB) 329.
-  We only pay final claim for the 60 days. Do not bill RAP or interim claims.
-  CBSA number must be listed in box 39.
-  Treatment authorization code (TAC) must be listed in box 63.
-  A prior authorization is required for all Home Health claims.
-  Revenue code 023, with the appropriate HIPPS Code, must be billed along with any additional revenue codes that are appropriate.

# Ambetter Home Health Top Denials

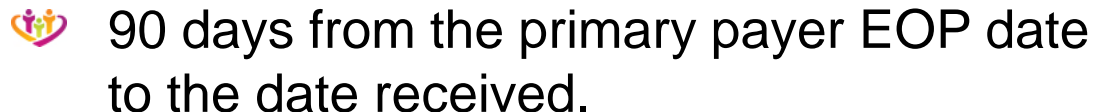
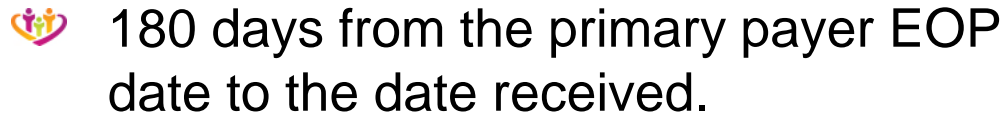
-  EX28 – Denied; Coverage not in effect when services provided.
-  EX35 – Benefit max has been reached.
-  EXMQ – Member name and DOB do not match; Resubmit claim.
-  EX29 – The timely filing has expired.
-  EXHT – No Auth on file that matches service billed.
-  EXI6 – Bill primary insurer 1<sup>st</sup>; Resubmit with EOB.

# Ambetter Timely Filing

## Initial Claims Calendar Days



## Coordination of Benefits Calendar Days



# Quick Reference Guide

## Simplify Office Administrative Tasks



Keep our Quick Reference Guide nearby to make pre-visit planning and post-visit tasks quick and easy.

### Website: [Ambetter.mhsindiana.com](http://Ambetter.mhsindiana.com)

- Patient care forms
- Pre-Auth Needed tool
- Ambetter from MHS news
- Provider Manual
- Preferred Drug List
- Member resources

### Secure Provider Portal: [Provider.mhsindiana.com](http://Provider.mhsindiana.com)

- Verify member eligibility
- Access patient health records
- View patient gaps
- Manage prior authorizations
- Submit and manage claims
- And more!

### Member Eligibility

Check member eligibility via:

- Secure Web Portal
- 24/7 Toll-Free Interactive Voice Response (IVR) Line: 1-877-687-1182
- Provider Services: 1-877-687-1182

### Patient Care Gaps

Find recommended services that a member has not completed.

1. Visit the Secure Provider Portal.
2. Review patient information for any gaps in care.
3. Plan to address care gaps during future appointment.

### Prior Authorization

Use the Pre-Auth Needed tool on our website to determine if prior authorization is required.

Submit prior authorizations via:

- Secure Provider Portal
- Medical and Behavioral Fax: 1-855-702-7337
- Phone: 1-877-687-1182

### Claims

Timely Filing guidelines: 180 days from date of service.






Claims can be submitted via:

- Secure Portal
- Clearinghouses: EDI Payor ID 68069
- Mail paper claims to: P.O. Box 5010 | Farmington, MO 63640-5010



### Pre-Visit Planning Checklist

- ✓ Verify member eligibility.
- ✓ Check for patient care gaps and address them during upcoming office visit.
- ✓ Use Pre-Auth Needed tool to determine if prior authorization is needed before appointment.









# Allwell Home Health Billing

-  Must be billed on a UB 04.
-  Bill type must be 3XX.
-  Must be billed in location 12.
-  Both Rev and CPT codes are required.
-  Each visit must be billed individually on separate service line.

# Allwell Timely Filing

-  Participating providers must submit first time claims within 180 calendar days of the date of service.
-  Claims received outside of this timeframe will be denied for untimely submission.

# Allwell Error Codes/Rejection Reasons

-  Invalid Mbr DOB
-  02 Invalid Mbr
-  06 Invalid Provider
-  07 Invalid Mbr DOB & Provider
-  08 Invalid Mbr & Provider
-  09 Mbr not valid at DOS
-  10 Invalid Mbr DOB; Mbr not valid a DOS
-  12 Provider not valid on DOS

# Quick Reference Guide

## Simplify Office Administrative Tasks



Keep our Quick Reference Guide nearby to make pre-visit planning and post-visit tasks quick and easy.

### Website: [Allwell.mhsindiana.com](http://Allwell.mhsindiana.com)

- Patient care forms
- Pre-Auth Needed tool
- MHS news
- Provider Manual
- Preferred Drug List
- Member resources

### Member Eligibility

Check member eligibility via:

- Secure Web Portal
- Provider Services: 1-855-766-1541
- TTY: 711

### Secure Provider Portal: [Allwell.mhsindiana.com](http://Allwell.mhsindiana.com)

- Verify member eligibility
- Access patient health records
- View patient gaps
- Manage prior authorizations
- Submit and manage claims
- And more!

### Patient Care Gaps

Find recommended services that a member has not completed.

1. Visit the Secure Provider Portal.
2. Review patient information for any gaps in care.
3. Plan to address care gaps during future appointment.

### Pre-Visit Planning Checklist

- ✓ Verify member eligibility.
- ✓ Check for patient care gaps and address them during upcoming office visit.
- ✓ Use Pre-Auth Needed tool to determine if prior authorization is needed before appointment.



## MHS Provider Network Territories

### Indiana

#### NORTHEAST REGION

For claims issues, email:  
 MHS\_ProviderRelations\_NE@mhsindiana.com  
 Chad Pratt, Provider Partnership Associate  
 1-877-647-4848, ext. 20454

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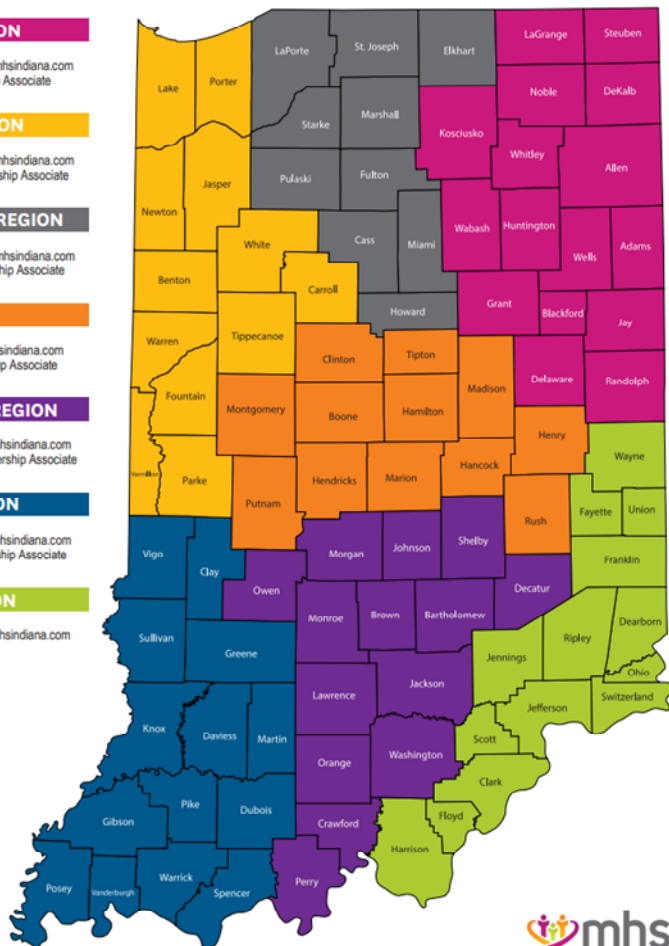
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[https://www.mhsindiana.com/content/dam/centene/mhsindiana/medicaid/pdfs/ProviderTerritory\\_map\\_2020.pdf](https://www.mhsindiana.com/content/dam/centene/mhsindiana/medicaid/pdfs/ProviderTerritory_map_2020.pdf)

## MHS Provider Network Territories

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### PROVIDER GROUPS

Beacon Medical Group  
Franciscan Alliance  
HealthLinc  
Heart City Health Center  
Indiana Health Centers  
Lutheran Medical Group  
Parkview Health System  
South Bend Clinic

### JENNIFER GARNER

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### PROVIDER GROUPS

American Health Network of Indiana  
Columbus Regional Health  
Community Physicians of Indiana  
HealthNet  
Health & Hospital Corporation of  
Marion County  
Indiana University Health  
St. Vincent Medical Group

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**Questions?**

**Thank you for being our  
partner in care.**