

# MHS Secure Provider Web Portal Overview



# Agenda

## Save Time by Utilizing the MHS Secure Web Portal

### Account Creation/Login and Training Materials

- Dashboard
- MHS Member Management Forms
- Account Details
- Account Manager

### Quality Reports

- Provider Analytics
- CoC

### Member Eligibility and Overview

- Member Panel for PMPs
- Member Record

### Authorizations

- Check Status
- Submit DME Request

### Prior Authorization/Medical Necessity Appeals

### Claims

- Submit, Correct and Review Claims
- Payment History

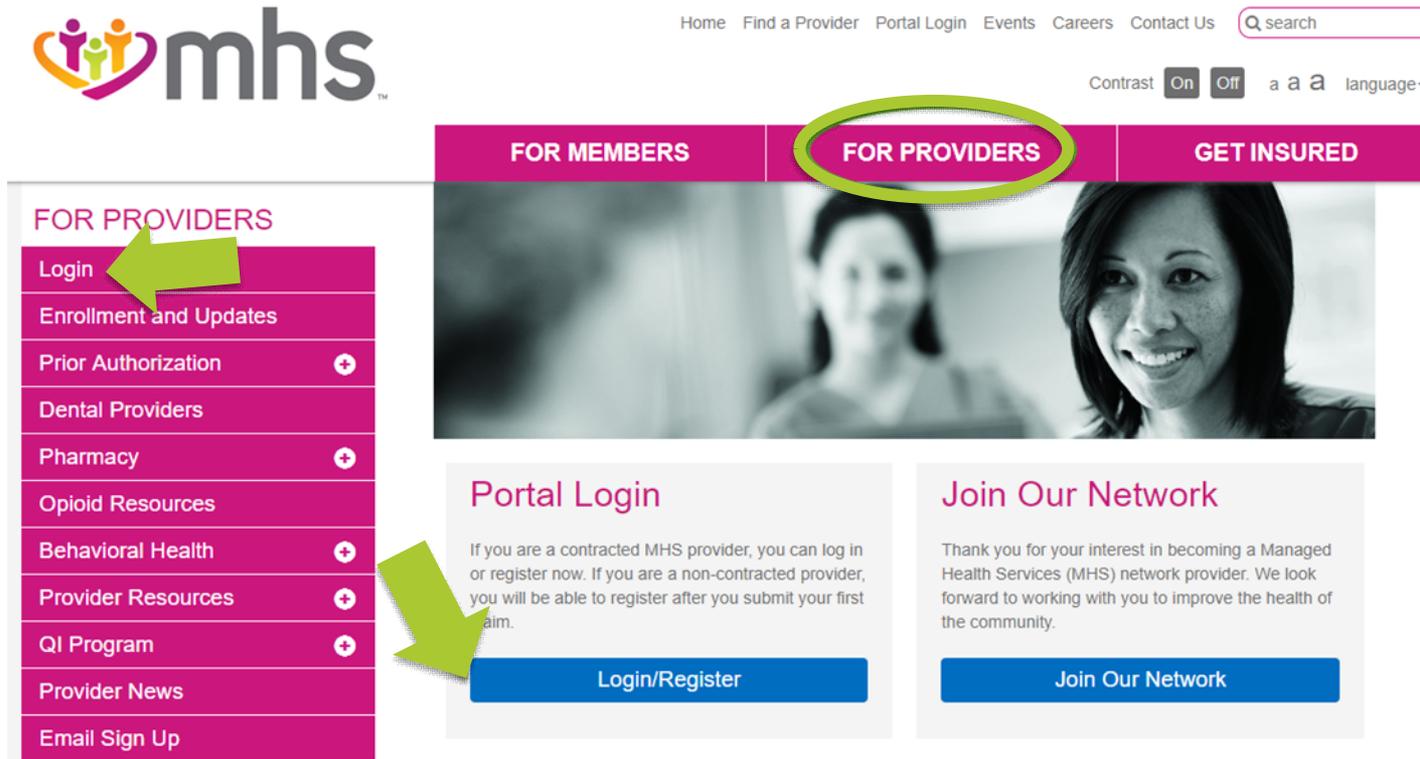
### Secure Messaging

### Online Claim Reconsiderations

# **Account Creation/Login and Training Materials**

# Provider Portal Login

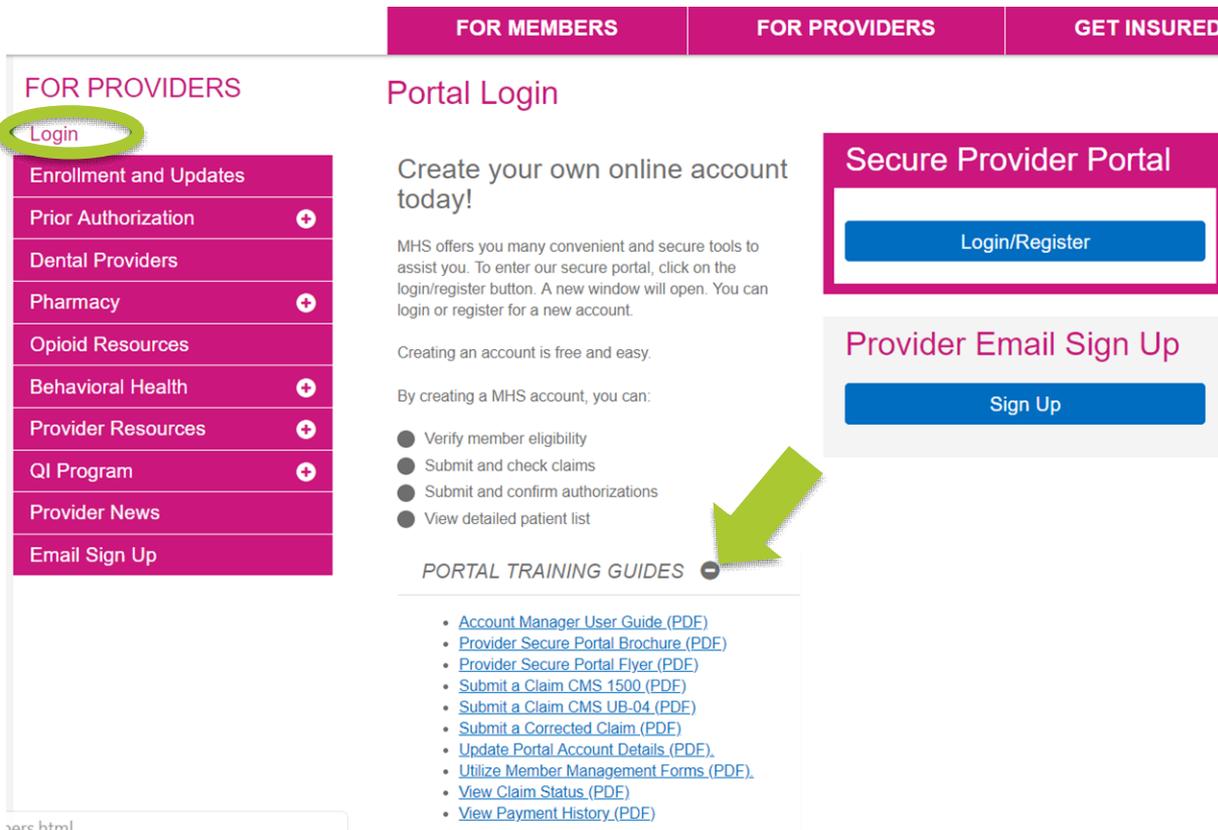
-  Go [mhsindiana.com](https://mhsindiana.com) and click on **For Providers**.
-  Then click **Login/Register** for the **MHS Secure Provider Portal**.



The screenshot shows the MHS website interface. At the top, there is a navigation bar with links for Home, Find a Provider, Portal Login, Events, Careers, and Contact Us, along with a search bar. Below the navigation bar, there are three main sections: FOR MEMBERS, FOR PROVIDERS (highlighted with a green circle), and GET INSURED. The FOR PROVIDERS section is expanded, showing a list of options: Login, Enrollment and Updates, Prior Authorization, Dental Providers, Pharmacy, Opioid Resources, Behavioral Health, Provider Resources, QI Program, Provider News, and Email Sign Up. A green arrow points to the 'Login' option. Below the list, there is a 'Portal Login' section with a blue 'Login/Register' button. A green arrow points to this button. To the right of the 'Portal Login' section is a 'Join Our Network' section with a blue 'Join Our Network' button.

# Web Portal Training Documents

 Login tab contains Portal Training Guides, Login/Register and Sign Up for emails.



**FOR MEMBERS** | **FOR PROVIDERS** | **GET INSURED**

**FOR PROVIDERS**

- Login
- Enrollment and Updates
- Prior Authorization +
- Dental Providers
- Pharmacy +
- Opioid Resources
- Behavioral Health +
- Provider Resources +
- QI Program +
- Provider News
- Email Sign Up

**Portal Login**

Create your own online account today!

MHS offers you many convenient and secure tools to assist you. To enter our secure portal, click on the login/register button. A new window will open. You can login or register for a new account.

Creating an account is free and easy.

By creating a MHS account, you can:

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

**Secure Provider Portal**

Login/Register

**Provider Email Sign Up**

Sign Up

**PORTAL TRAINING GUIDES**

- [Account Manager User Guide \(PDF\)](#)
- [Provider Secure Portal Brochure \(PDF\)](#)
- [Provider Secure Portal Flyer \(PDF\)](#)
- [Submit a Claim CMS 1500 \(PDF\)](#)
- [Submit a Claim CMS UB-04 \(PDF\)](#)
- [Submit a Corrected Claim \(PDF\)](#)
- [Update Portal Account Details \(PDF\)](#)
- [Utilize Member Management Forms \(PDF\)](#)
- [View Claim Status \(PDF\)](#)
- [View Payment History \(PDF\)](#)

## Training Documents Include:

- Account Manager Guide
- MHS Portal Brochure
- How To Guides:
  - Submit Claims
  - Correct Claims
  - View Payment History
  - Use Member Management Forms

# Complete Portal Registration or Login

**The Tools You Need Now!**  
Our site has been designed to help you get your job done. For registration or secure website questions call (866) 812-0327. Manage all products with ease in one location.

**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.

**Login**

User Name ( Email )  
name@domain.com

Password

Login

[Forgot Password / Unlock Account](#)

**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

Viewing Dashboard For Tax ID Number Medicaid

**Quick Eligibility Check**

Member ID or Last Name Birthdate  
123456789 or Smith mm/dd/yyyy Check Eligibility

**Recent Claims**

STATUS	RECEIVED DATE	MEMBER NAME	CLAIM NO.
🕒	06/07/2019	B ██████████ S	5
🕒	06/07/2019	K ██████████ N	3
🕒	06/07/2019	C ██████████ V	3
🕒	06/07/2019	F ██████████ N	3
🕒	06/07/2019	J ██████████ N	5

**Welcome**

Add a TIN to My ACCOUNT >

Manage Accounts >

Reports >

Patient Analytics >

Provider Analytics >

**Recent Activity**

Date Activity

**Quick Links**

[Provider Resources](#)

[Member Management Forms](#)

**Registration Complete!** Your Progress

Thank you for completing your registration! A Superior HealthPlan provider services specialist will be sending you an email when your profile has been activated. Please allow up to 2 business days for processing.

If you do not receive an email within 2 business days, please log in and contact us using secure messaging or call 866-895-8443 for additional assistance.

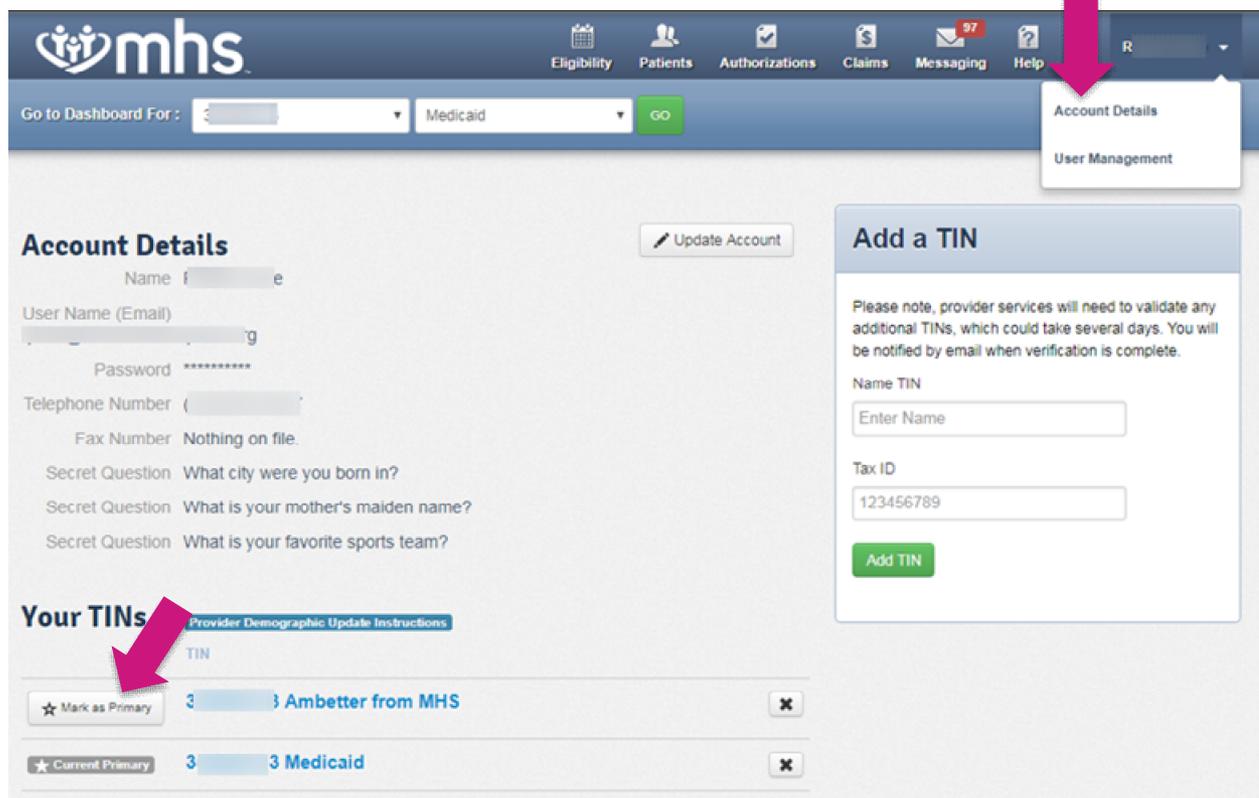
Login

# Account Details

 To view **Account Details**:

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

Note: Under Your TINs is the current **primary** default TIN for the account. Providers can select another TIN to **Mark As Primary** or **remove** a TIN (black X).



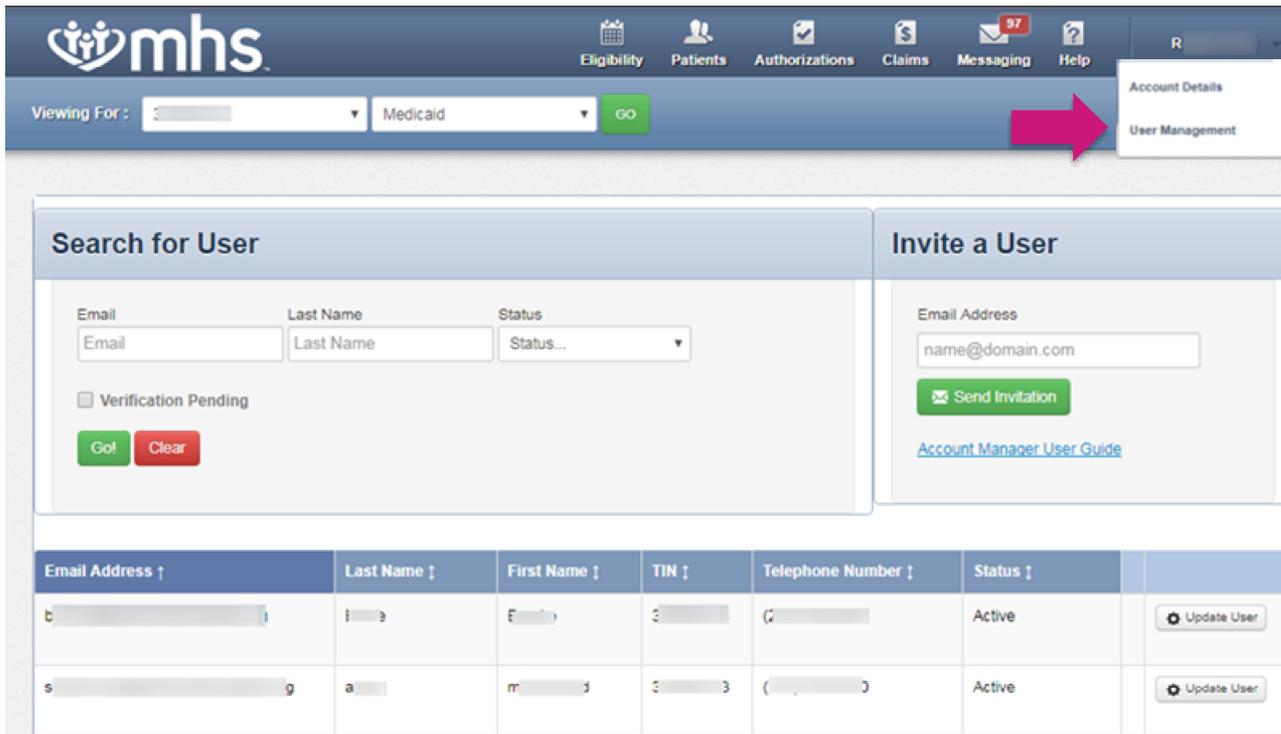
 [Update Account Details User Guide](#)

# Account Manager

## User Management

For **Account Managers** to manage office staff/users associated with their practice (disable/enable users, manage account permissions).

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.



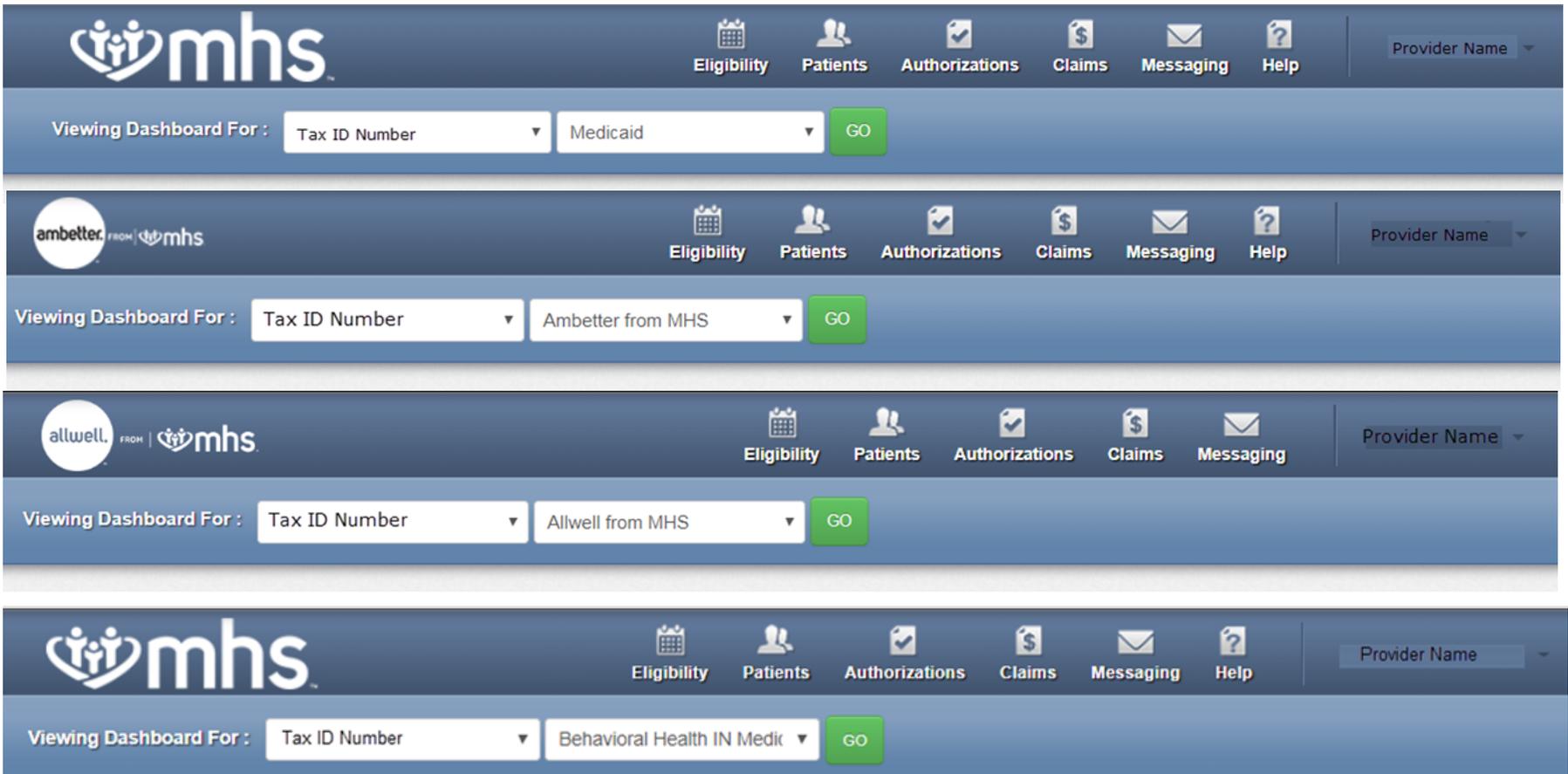
The screenshot shows the Account Manager interface. At the top, there is a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, Messaging (with a 97 notification), and Help. A user profile dropdown menu is open, showing 'Account Details' and 'User Management' (highlighted with a pink arrow). Below the navigation bar, there is 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 with 'name@domain.com', a 'Send Invitation' button, and a link to the 'Account Manager User Guide'. Below these panels is a table with columns for Email Address, Last Name, First Name, TIN, Telephone Number, and Status. Two rows of user data are visible, each with an 'Update User' button.

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

 [Account Manager User Guide](#)

# Dashboard Change

User has the ability to change between **TINs** added along with choices for: **Medicaid, Ambetter from MHS, Allwell from MHS and Behavioral Health IN Medicaid.**



The screenshot displays four instances of the MHS dashboard interface, each representing a different plan or program. Each instance features a dark blue header with the MHS logo on the left and a navigation menu on the right containing icons for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. A 'Provider Name' dropdown menu is located on the far right of the header. Below the header is a 'Viewing Dashboard For:' section with a 'Tax ID Number' dropdown menu, a plan name dropdown menu, and a green 'GO' button.

- Medicaid:** The plan name dropdown is set to 'Medicaid'.
- Ambetter from MHS:** The plan name dropdown is set to 'Ambetter from MHS'.
- Allwell from MHS:** The plan name dropdown is set to 'Allwell from MHS'.
- Behavioral Health IN Medicaid:** The plan name dropdown is set to 'Behavioral Health IN Medic'.

# Homepage – MHS (Medicaid)

Quick Eligibility Check, Recent Claims, Reports and Quick Links

**Quick Eligibility Check**

Member ID or Last Name:  Birthdate:  [Check Eligibility](#)

**Recent Claims**

STATUS	RECEIVED DATE	MEMBER NAME	CLAIM NO.
	06/07/2019	B [redacted] S	6
	06/07/2019	K [redacted] N	?
	06/07/2019	C [redacted] N	3
	06/07/2019	[redacted] N	3
	06/07/2019	[redacted] N	5

**Welcome**

- [Add a TIN to My ACCOUNT](#)
- [Manage Accounts](#)
- [Reports](#)
- [Patient Analytics](#)
- [Provider Analytics](#)

**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](#)

[Late Notification of Services Submission Form](#)

[Peer to Peer Contact Form](#)

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.

[PaySpan Site](#)

# MHS Member Management Forms

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

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



FOR MEMBERS
FOR PROVIDERS
GET INSURED

### Member Management Forms

All PMP's have the right to state the number of members they are willing to accept into their practice. The panel size for members is based on the panel size requested on the Provider Enrollment form. Member assignment is based on the member's choice and the IHCP auto-assignment process; therefore, MHS does not guarantee any PMP will receive a set number of members.

PMP's shall not refuse to treat MHS members on his or her panel as long as the panel limit has not been met. MHS must be notified 45 calendar days in advance of a PMP's inability to accept additional covered enrollees under MHS agreements. To make a change to your panel size, please contact your Provider Partnership Associate.

#### Member Disenrollment

[Click Here](#)

#### Panel Management Form

[Click Here](#)

MHS follows a state-defined process which requires MHS approval before a member can be dismissed from a PMP's panel. Please complete the Member Disenrollment form below in its entirety to request a member be removed from your panel. It can take 30 - 45 days for this removal to occur. For a list of valid reasons for a request for member disenrollment and other important information, please review the [Provider Manual](#).

If your panel is full or has been placed on hold and you would like to add a member, please use the Panel Management Form below. There is no limit on the number or frequency of additions. For additional information about when a member can change their PMP selection and other important information, please review the [Provider Manual](#).

#### FOR PROVIDERS

- [Login](#)
- [Become a Provider](#)
- [Prior Authorization](#)
- [Dental Providers](#)
- [Pharmacy](#)
- [Behavioral Health](#)
- [Provider Resources](#)
- [QI Program](#)
- [Provider News](#)

**Welcome**

- [Add a TIN to My ACCOUNT](#) >
- [Manage Accounts](#) >
- [Reports](#) >
- [Patient Analytics](#) >
- [Provider Analytics](#) >

**Recent Activity**

Date	Activity

**Quick Links**

- [Provider Resources](#)
- [Member Management Forms](#)

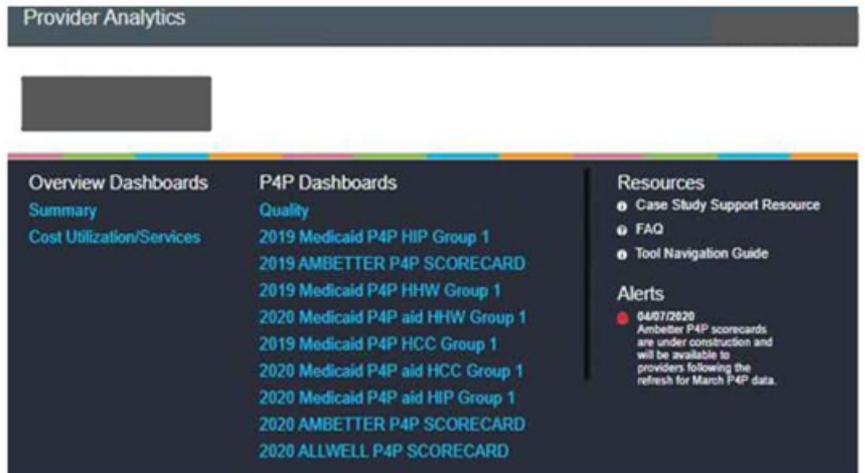
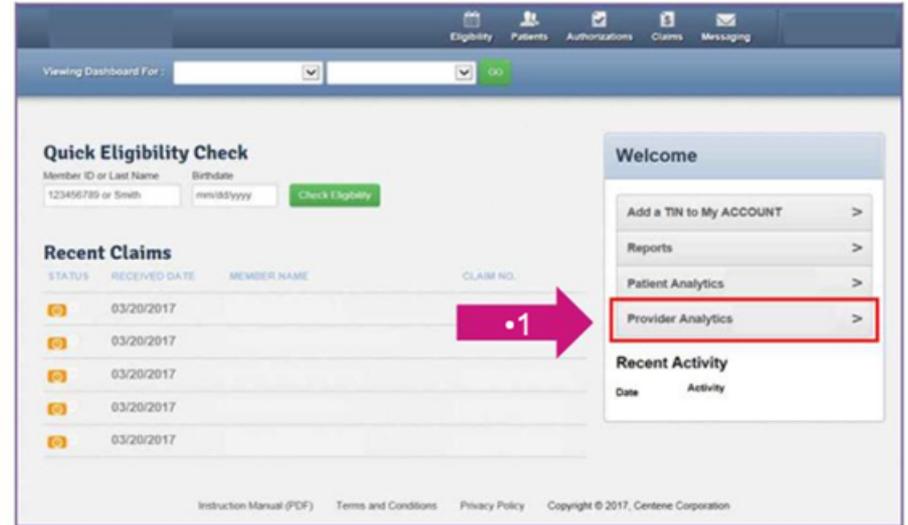


# Quality Reports

# Provider Analytics

To navigate Provider Analytics:

1. From the Provider Portal, click on the **Provider Analytics** link to be directed to the landing page.
2. Here, you will see the Provider Analytics landing page divided into 3 columns:
  - a. Overview dashboards
  - b. P4P dashboards
  - c. Resources
3. Click on the **Summary** link.



# Provider Analytics Summary Page

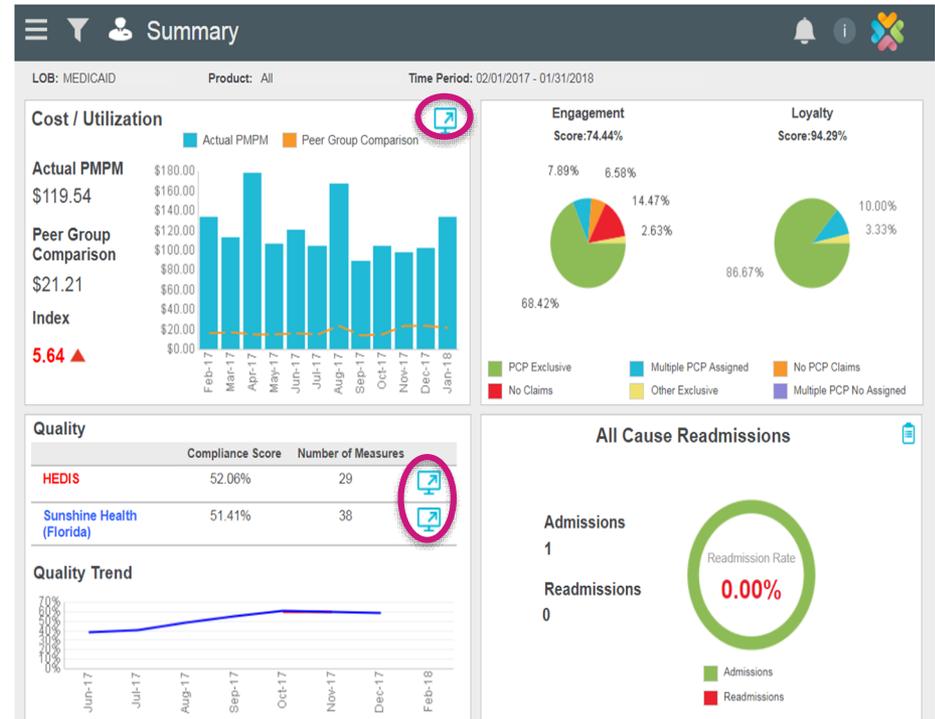
Here you will be able to view four dashboards:

- Cost/Utilization
- Engagement Analysis
- Quality
- Readmission by Disease State



# Dashboard View

- Cost/Utilization:** This dashboard will show actual Per Member Per Month (PMPM) compared to expected on a monthly basis.
- Quality:** The Quality dashboard in the lower left quadrant shows HEDIS and Value Based Contract (VBC) performance.
- Engagement Analysis:** This dashboard will show a view of members' utilization of PMP and healthcare services.
- Readmission by Disease State:** This dashboard will show total inpatient visits and total readmits. It will show the number of total readmits, and those without PMP follow-up plus the follow-up rate.
- The Cost/Utilization and Quality sections have dashboards providing more specific data down to the member level. To view this data, click on the **blue computer monitor icons**.



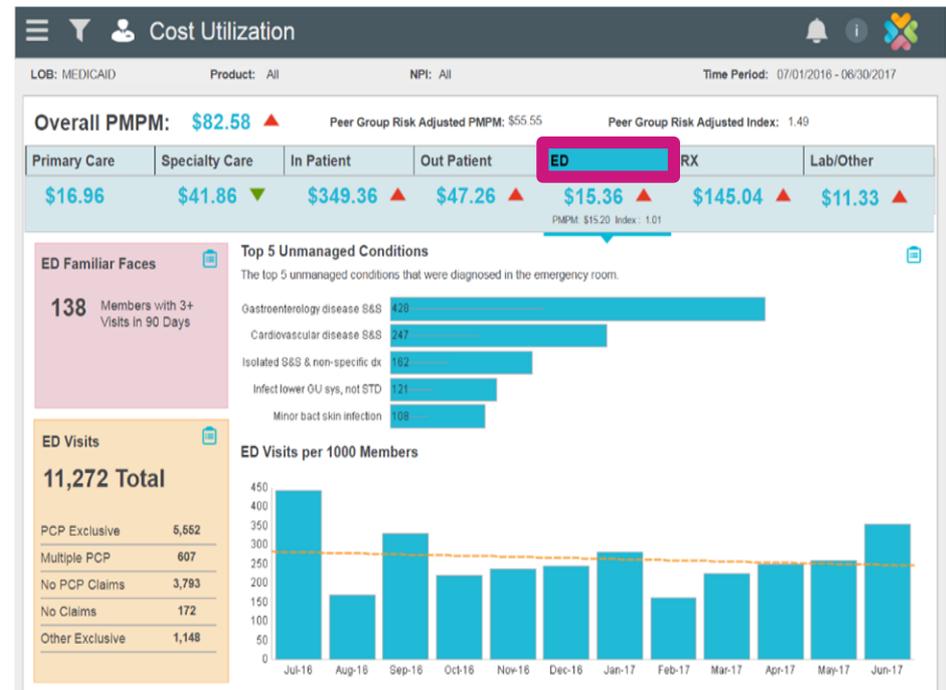
# Cost & Utilization: ED

Shows PMPM for Emergency Department (ED) visits compared to peers' risk-adjusted PMPM.

Four sections:

- Bar graph shows top five unmanaged conditions.
- Bottom of the page shows average ED visits for provider's patients compared to plan.
- Box on top left side shows number of patients with 3+ visits in the last 90 days.
- Box on bottom left side shows number of total ED visits by engagement category.

Click on the charts for patient-level detail.



# Summary Page Overview

## Summary Banner

The dark grey banner contains five icons that will help you navigate the information on the page. You can hover over each icon to view a definition of each icon's purpose.

- a. **Navigation Bar** (three horizontal lines)
- b. **Funnel** – Used to filter data
- c. **Person** – Provider information
- d. **Bell** – Alerts
- e. **An “i” with a circle** – Information
  - a. Tool Navigation Guide
  - b. Case Study Support Resource
  - c. FAQ



# Summary Page Overview

## Payment History

- Added to the drop down bar.
- PDF report only.
- Ensures all providers have access to prior VBC scorecards.
- Providers in current P4P program have access to PDF copies.
- Providers no longer participating still have access to prior months.



# Summary Page Overview

## Funnel Icon

Use this to select an option to view data specific to selected criteria.

### Line of Business

- Commercial
- Medicaid
- Medicare

### Product

- Medicaid
- Marketplace
- Medicare

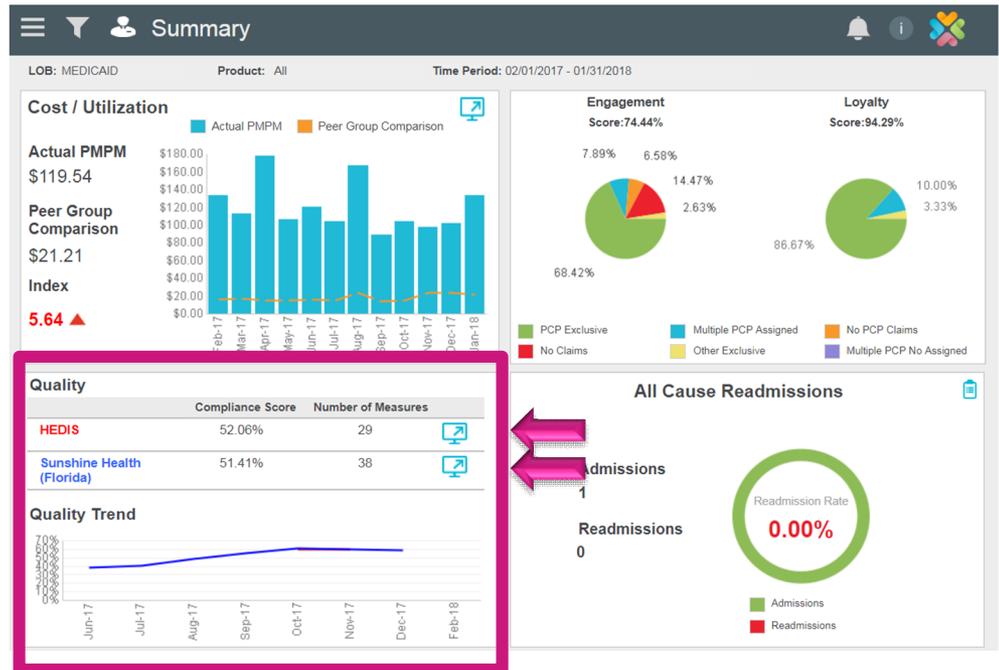
### Time Period

- Rolling 12 months from current date.
- Previous rolling 12 months.
  - Note: There is a 3-month data lag.



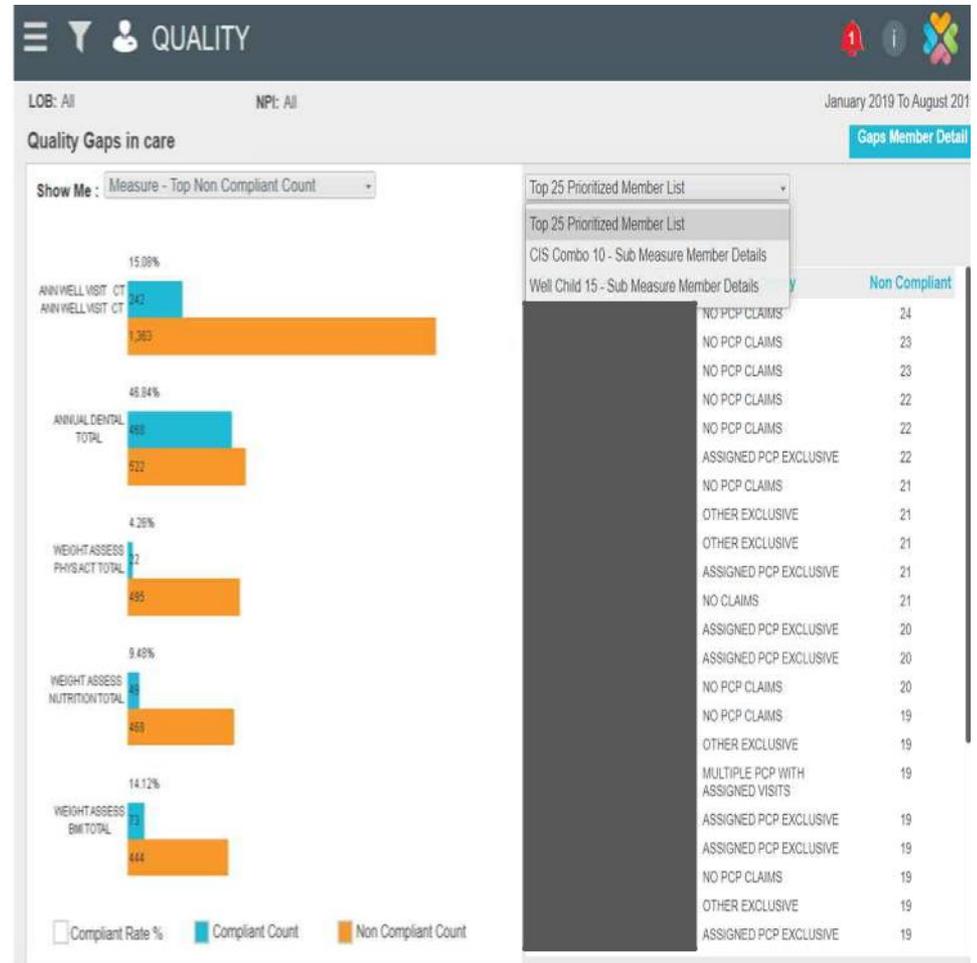
# Quality HEDIS View

- Shows trends in closing HEDIS care gaps and earnings from any Pay for Performance (P4P) programs.
- Click the blue screen next to HEDIS to view performance in 100+ care gaps and export member-level reports.
- Click the blue screen next to VBC PPM to see earnings from P4P program, amount outstanding, and amount left to earn per measure.



# Quality HEDIS View: Gaps in Care

- Left defaults to top five measures by non-compliant count.
- Drop-down arrow changes view to see:
  - Measures: Non-compliant count, compliant count, compliant rate % or all.
  - NPI: Non-compliant count, compliant count, compliant rate % or all.
- Right side displays top 25 members with the most open care gaps.
- New drop down options for Combo 10 and W15 member details.



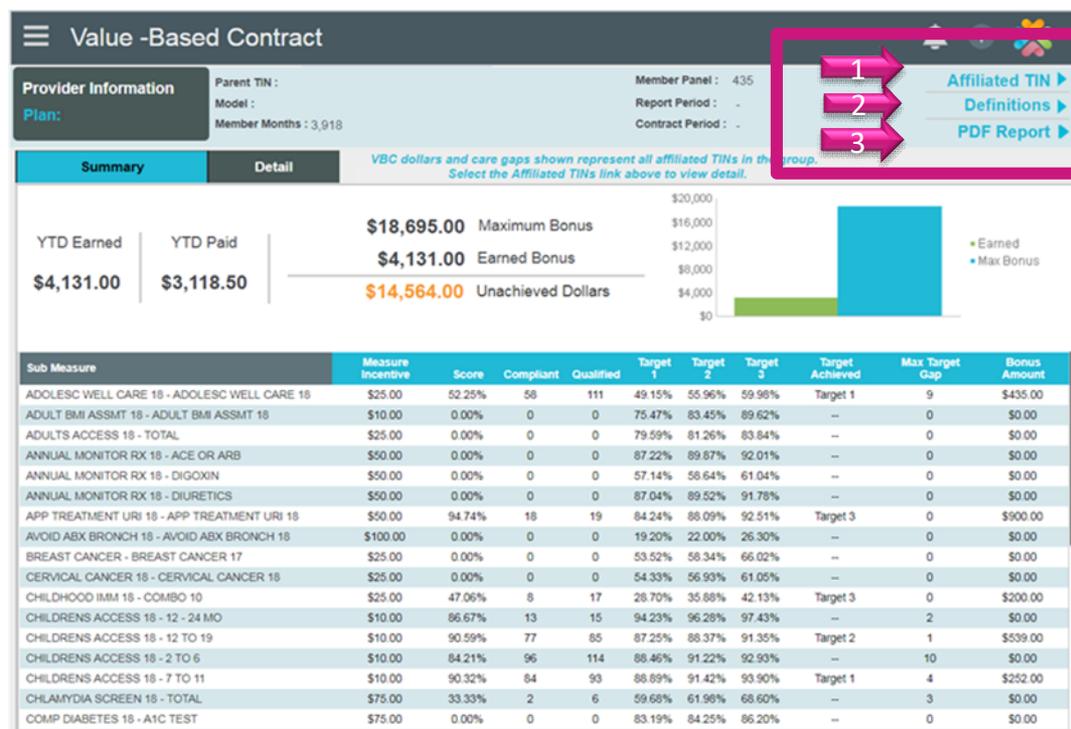
# Quality HEDIS View

For providers in a P4P arrangement.

Scorecard shows measure incentive, amount earned and unachieved dollars.

In right hand corner:

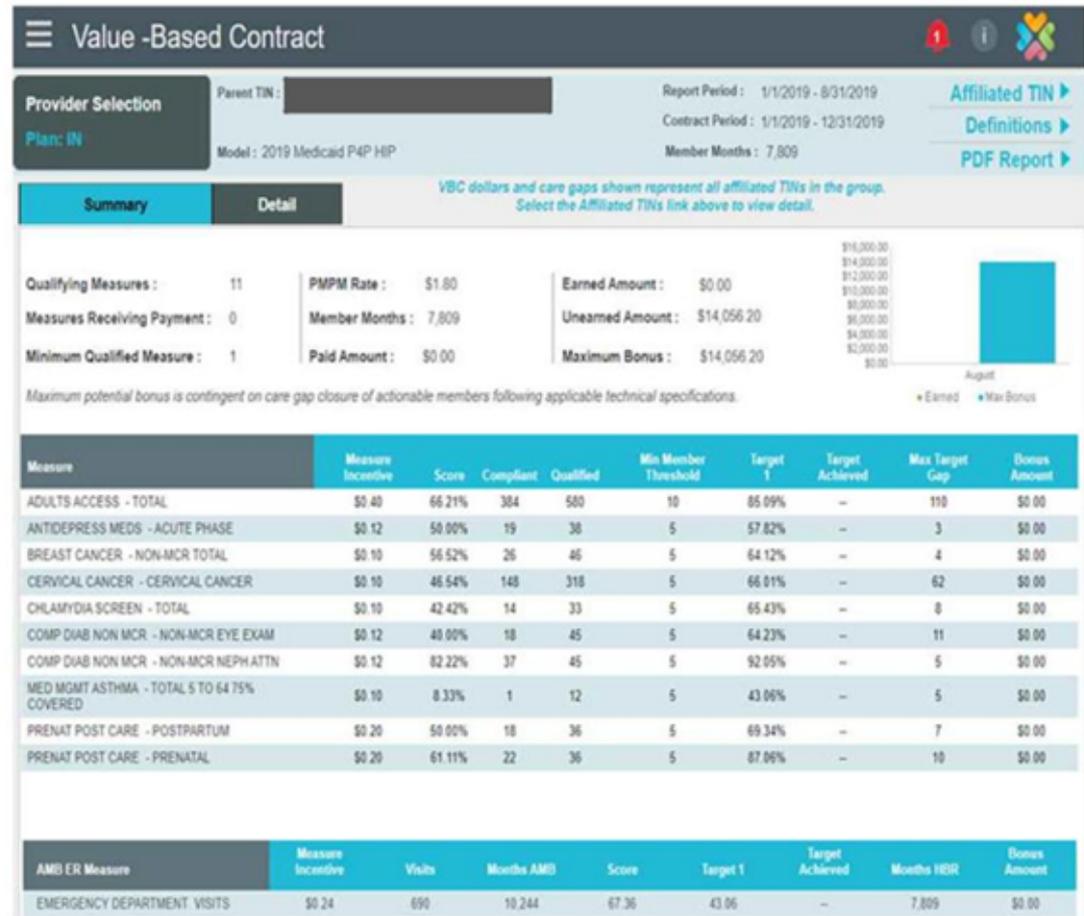
1. All TINs associated with P4P program.
2. List of definitions and meanings.
3. Scorecard summarizing provider's performance in quality.



# Quality HEDIS: Scorecards

You can also view:

- Compliant Score.
- Compliant and Qualified number per Sub Measure.
- Target levels for compliant percentage needed to earn a payout.
- Target level achieved.
- Number of gaps needed to close to reach Maximum Target Level.
- Bonus Amount earned.

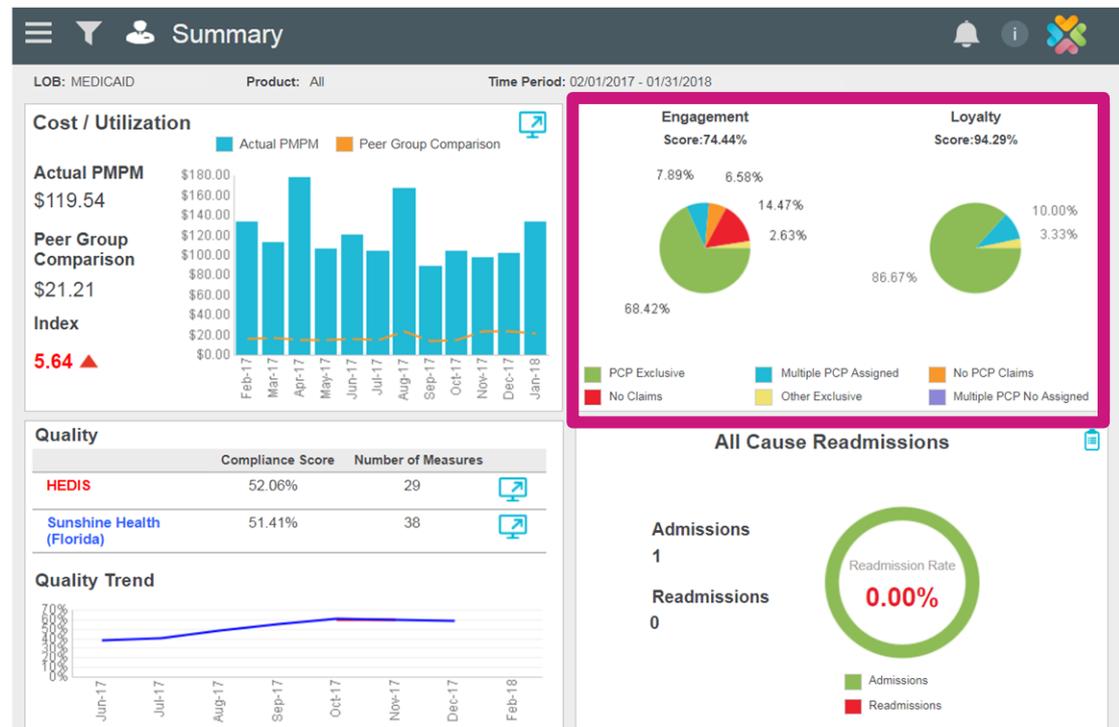


# Engagement & Loyalty Analysis

Classifies member interactions with Primary Medical Physician (PMP) services into two main categories:

**Provider Engagement:**  
Measures provider's efficiency with engaging assigned members to be seen for a primary care visit annually; ***includes all assigned members.***

**Provider Loyalty:**  
Measures the provider's ongoing effort to maintain exclusivity as the PMP for assigned panel once members have PMP activity; ***excludes assigned members without any PCP visits.***



# Engagement & Loyalty Analysis

 Provider Engagement is broken into six sub-categories to help identify patient activity and prioritize for outreach.

Patient Segment	Segment Traits	Engagement Strategy
<b>PCP Exclusive</b>	These patients have been assigned to you and have been seen by you or one of your partners.	Identify which of these members have care gaps and close at their next appointment.
<b>Multiple PCP Assigned</b>	These patients are assigned to you, but have been seen by your practice <b>AND</b> other PMP groups.	Initiate a patient outreach plan, set an appointment if appropriate, close care gaps, discuss benefits of PMP loyalty.
<b>No PCP Claims</b>	These are patients who seek all of their care from specialists, ED and urgent care.	Outreach and set an appointment for a PMP visit, identify health risks and set follow-up appointments, discuss benefits of loyalty.
<b>Other Exclusive</b>	These patients are assigned to you, but have been seeing another PMP group exclusively.	Outreach to members to discuss updating their assigned PMP to the doctor they have been seeing for care.
<b>No Claims</b>	These patients are assigned to you but have no claim data to indicate they have received any medical care from a PMP, emergency department or urgent care center.	Outreach and set an appointment for PMP visit. Identify health risks and set follow-up appointments, discuss benefits of loyalty.
<b>Multiple PCP No Assigned</b>	These patients are assigned to you, but have only been seen other PMP groups.	Outreach to members to discuss benefits of loyalty and promote hours and availability, identify members with care gaps and set appointment for PMP visit.

# **Continuity of Care Program (Former P4Q Program)**

# What is the Continuity of Care (CoC) Program?

CoC is a risk adjustment bonus program for you, our provider partner, aimed at increasing visibility into members' existing and suspected conditions, which leads to enhanced quality of care for chronic condition management and prevention.

## What is in it for members?

Members with existing or newly suspected chronic conditions will receive regular and proactive assessments to prevent chronic conditions from going undiagnosed or untreated.

## What is in it for providers?

Providers will receive incentive payments by continuously improving and maintaining performance in assessing members for conditions. Providers receive *incremental* bonuses for their *incremental* work.

# Who is Included in the CoC Program?

## Eligible providers and members

- Providers and members are loaded into the CoC Dashboard (CoC Appointment Agenda).
  - Members with disease conditions that need to be addressed annually.

## Targeted Lines of Business (LOB)

- Ambetter
- Medicare
- Medicaid

# Provider Guide for CoC

-  Log into the Provider Portal.
-  Click on CoC - Appointment Agenda.
-  Filter by LOB and/or NPI.
-  Search by Member Name, or
-  Click on a Member ID.
-  Begin Assessment.

# CoC Portal Navigation

**CoC - Appointment Agenda**

Coded Thru Claims as of: 2/2/2021    LOB: MEDICAID    TIN: [ ]    NPI: [ ]

Member: [ ]    Member List    Appointment Agendas

Excel    TIN    NPI    Member

Click the *Menu* icon to view all available provider portals.

Click the *Filter* icon to filter by:

- Company
- Line of Business
- NPI

Click the *Info* button to view a drop-down menu containing links to the *Navigation Tool*, *Case Study*, *FAQs*, *Diagnosis List* and *CoC Appointment Agenda Program Rules* documents.

Assessed	Unassessed	
0	9	
1	8	
0	6	
0	6	
0	6	0.0%
0	6	0.0%
1	6	14.3%
1	6	14.3%

NPI: [ ]    Member: [ ]    DOB: [ ]    Read Only

**Assessable**

Disease Condition	Diagnosis	Assessment Status	DOS	Mod Date	Status	Active Diagnosis & Documented	Resolved Not Present
<u>Cancer_high</u>	Z51.11 ENCOUNTER FOR ANTINEOPLASTIC CHEMO	Unassessed	12/31/9999		●	<input type="checkbox"/>	<input type="checkbox"/>
<u>Cardiac</u>	00228212750 CLONIDINE TAB 0.1MG	Coded Through Claims	01/15/2021		●	<input type="checkbox"/>	<input type="checkbox"/>
<u>Gastro_low</u>	K21.9 GERD WITHOUT ESOPHAGITIS	Unassessed	06/03/2020		●	<input type="checkbox"/>	<input type="checkbox"/>
<u>Genital_extra_low</u>	N70.11 CHRONIC SALPINGITIS	Unassessed	05/03/2018		●	<input type="checkbox"/>	<input type="checkbox"/>
<u>Hematological_low</u>	D72.0 GENETIC ANOMALIES OF LEUKOCYTES	Unassessed	05/13/2020		●	<input type="checkbox"/>	<input type="checkbox"/>

# **Member Eligibility and Overview**

# Check Member Eligibility

- The **Eligibility** tab offers an **Eligibility Check** tool designed to quickly check the status of any member.
- Update the **Date of Service**, if necessary.
  - Enter the **Member ID** or **Last Name** and **DOB (Date of Birth)**.
  - Click **Check Eligibility**.

### Eligibility Check

Date of Service 
Member ID or Last Name 
DOB

ELIGIBLE	DATE OF SERVICE	PATIENT NAME	DATE CHECKED	CARE GAPS	RIGHT CHOICE PROGRAM
Ineligible	08/28/2017	F [redacted]	08/28/2017		<input type="button" value="Remove"/>
	08/28/2017	T [redacted]	08/28/2017	Risk Category Alerts: COPD/Asthma	<input type="button" value="Emergency Room Visit?"/> <input type="button" value="Remove"/>
	08/28/2017	T P [redacted] S	08/28/2017	Risk Category Alerts: COPD/Asthma Member has had 3 or more emergency room visits in past 90 days.	<input type="button" value="Emergency Room Visit?"/> Yes <input type="button" value="Remove"/>

Eligibility status is indicated by a **Green thumbs-up** for **eligible** and an **Orange thumbs-down** for **ineligible**.

Details for any member can be viewed by clicking on the **Member's Name**.

**Care Gaps** can also be seen within the search results.

By clicking **Emergency Room Visit?**, an ED visit will be indicated.

**Right Choice Program** indicator label.

# MHS Member Overview

[Back to Patient List](#) **Member Name**

**Overview**

Cost Sharing

Assessments

Health Record

Care Plan

Authorizations

Referrals

Coordination of Benefits

Claims

Power Account Service Estimate

Document Resource Center

Notes

 This patient is eligible as of today, Jun 11, 2018.

**Patient Information**

Name S [REDACTED] S  
 Gender F  
 Birthdate [REDACTED]  
 Age 5 [REDACTED]  
 Member # 1 [REDACTED]  
 Member # U [REDACTED]  
 Address 4 [REDACTED]  
 Phone Number ( [REDACTED]  
 Email N/A

**PCP Information**

Name ANGELIQUE BROWN  
 Address 8777 BROADWAY  
 STE C  
 MERRILLVILLE, IN 46410  
 Practice Type FAMILY PRACTICE  
 Phone Number [\(219\) 738-3854](tel:2197383854)

[View PCP History](#)

[EPSDT](#)

[Care Gaps](#)

**Eligibility History**

Start Date	End Date	Program
May 1, 2018	Ongoing	State Plus, Copay - ER only

[View Clinical Information](#)

Risk Category Alerts: Ischemic Vascular Disease  
 Non-compliant for annual well visit.

[Allergies](#)

None On File

## Overview Tab

1. Patient Information
2. Eligibility History
3. PMP Information and PMP History
4. Early and Periodic Screening, Diagnostic and Treatment (EPSDT)
5. Care Gaps
6. Allergies

# View Patient List

- Click **Patients** tab at the top of the screen.
- The patient list appears displaying **Eligibility Status, Preferred Language, Member Name, Medicaid ID, DOB, Phone Number, Alerts** and **Right Choice Program**.
- To download the patient list to Excel, click **Download**. This allows for the provider to manage patient information as desired in Excel.

Viewing Patients For : Tax ID Number Medicaid GO Find Patient

Patient List as of 11/13/2017 Download Filter

This is only a list of your patients, please check eligibility to confirm the effective date and benefits for this member.

Care Gaps do not reflect claims processed after most current data refresh. Non-Compliant Pay for Performance lists do not reflect claims processed after the report run date and also excludes members who have lost HEDIS eligibility.

Eligible	Preferred Language	Member Name	Member ID	Member #	Date of Birth	Phone Number	ALERTS	Right Choice Program
👍		A	1 9 0		0	( )	CG DM	<input type="checkbox"/>
👍		E	1 9		0: 31	( ) 14	CG DM	<input checked="" type="checkbox"/>
👍		I	1 9 0		0	( ) 6	CG DM	<input type="checkbox"/>
👍		R	1 9		0 37	(7 ) 58	CG	<input type="checkbox"/>
👍		S	1 9 0		( ) 4	( )	CG DM	<input type="checkbox"/>
👍		V	1 9		1: 13	(7 ) 36	CG DM	<input type="checkbox"/>

# Authorizations

# Authorizations

View, create and filter group authorizations.

- Click on the **AUTH ID** to see additional information.

Viewing Authorizations For: **Tax ID Number** Medicaid **GO** **Create Authorization**

**Authorizations** Processed Errors Disclaimer Filter

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
DENY	4	K	07/03/2019	12/31/9999	E66.01	INPATIENT	Surgical
APPROVE	5	T	07/01/2019	01/01/2020	M81.0	OUTPATIENT	Biopharmacy
APPROVE	3	J	07/01/2019	01/01/2020	M81.0	OUTPATIENT	Biopharmacy
APPROVE	8	V	06/28/2019	07/27/2019	M51.26	OUTPATIENT	Outpatient Services
APPROVE	3	V	06/26/2019	07/26/2019	K43.9	OUTPATIENT	DME
APPROVE		C	06/18/2019	12/31/9999	E66.01	INPATIENT	Surgical
APPROVE	4	C	06/18/2019	06/18/2019	E66.01	OUTPATIENT	Inpatient Services (S&P)

# Authorization Details

View Auth Status, Auth Number, Service, Provider of Service(s), Diagnosis Code(s), Explanation, Auth Type, From Date, To Date, Procedure Code and Notes & Attachments.

Back to Authorizations

Member Name

- Overview
- Cost Sharing
- Assessments
- Health Record
- Care Plan
- Authorizations
- Referrals
- Coordination of Benefits
- Claims

**Auth Status:** APPROVE

**Auth Nbr:** C-3

**Service:** DME

**Provider of Service(s):** RI

**Diagnosis Code(s):** K43.9

**Explanation:** Pay

**Auth Type:** OUTPATIENT

**From Date:** 06/26/2019

**To Date:** 07/26/2019

**Procedure Code(s):** 49652

**Notes & Attachments:** [View](#)

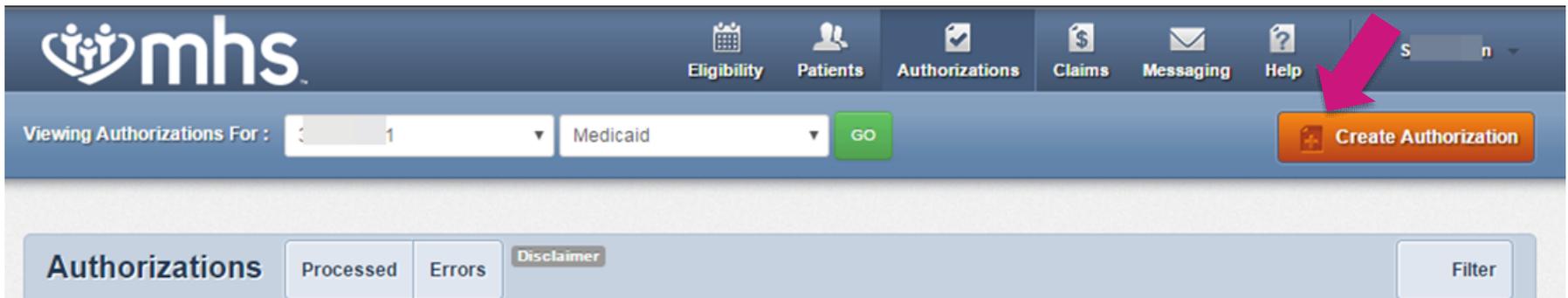
Line Item	Service type	Start Date	End Date	Units Req.	Units Apprd	Servicing Provider	Location	Status	Medical Necessity	Decision Date
1	DME	06/26/2019	07/26/2019	1	1	F	Unspecified	APPROVE	Met as requested	06/09/2019
2	DME	06/26/2019	07/26/2019	1	1	F	Unspecified	APPROVE	Met as requested	06/09/2019

[Back to Authorization List](#)

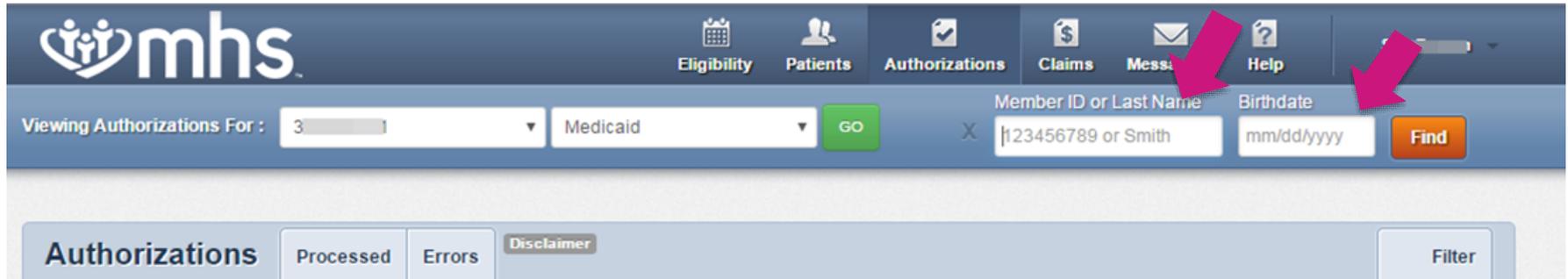
# Create a New Authorization

## New Authorization

- Click **Create Authorization**.
- Enter **Member ID** or **Last Name** and **Birthdate**.



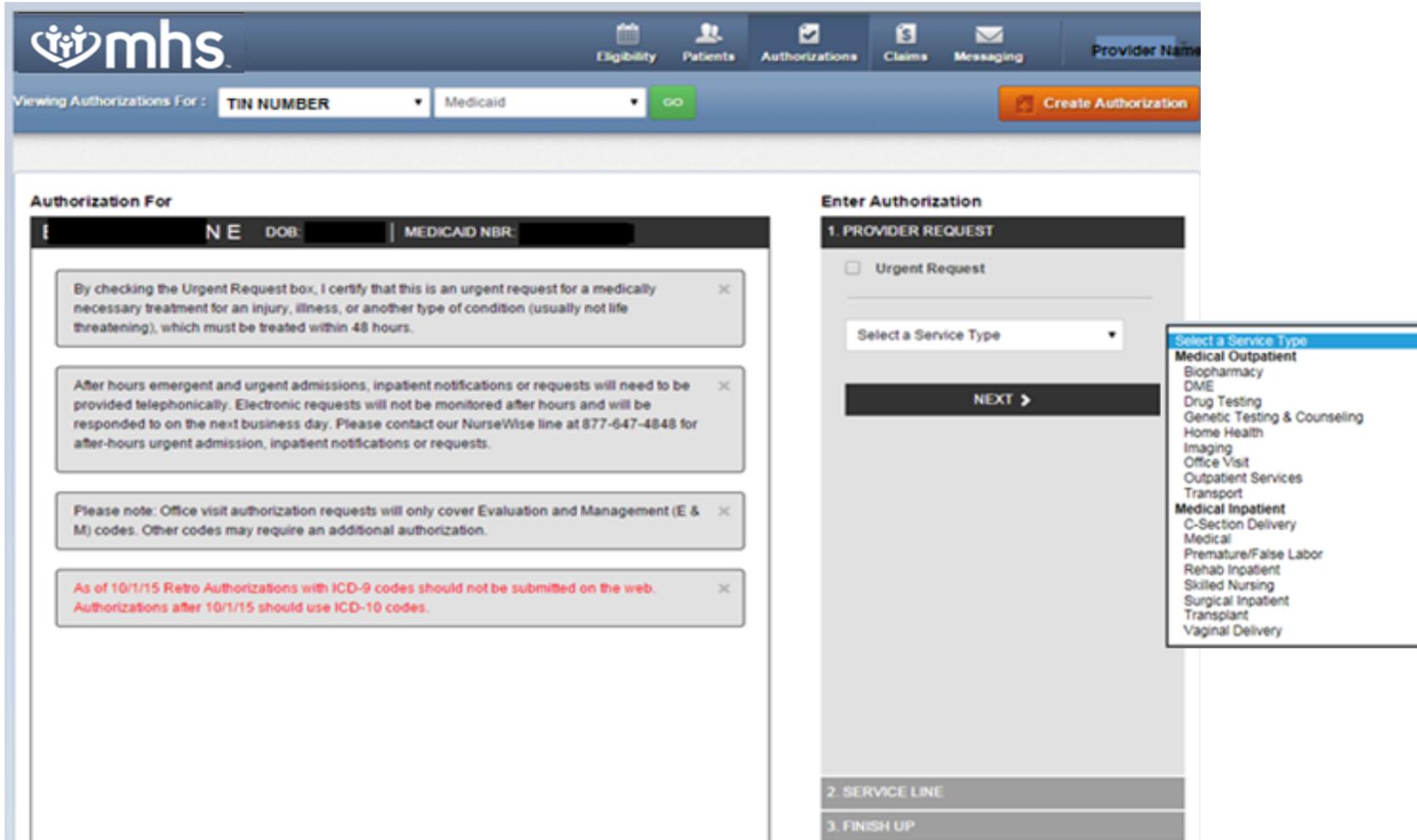
The screenshot shows the MHS navigation bar with icons for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below the navigation bar, there are two dropdown menus for 'Viewing Authorizations For:' with values '1' and 'Medicaid', and a green 'GO' button. A prominent orange button labeled 'Create Authorization' is highlighted with a pink arrow pointing to it from the right.



The screenshot shows the MHS navigation bar with icons for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below the navigation bar, there are two dropdown menus for 'Viewing Authorizations For:' with values '3' and 'Medicaid', and a green 'GO' button. To the right, there are two input fields: 'Member ID or Last Name' containing '||23456789 or Smith' and 'Birthdate' containing 'mm/dd/yyyy'. A pink arrow points to the 'Member ID or Last Name' field, and another pink arrow points to the 'Birthdate' field. An orange 'Find' button is located to the right of the input fields.

# Creating a New Authorization

 Select a Service Type.



The screenshot shows the MHS web application interface for creating a new authorization. The top navigation bar includes links for Eligibility, Patients, Authorizations, Claims, and Messaging. The main content area is divided into two columns: 'Authorization For' and 'Enter Authorization'.

**Authorization For:** This section contains four informational boxes with close buttons (X):

- By checking the Urgent Request box, I certify that this is an urgent request for a medically necessary treatment for an injury, illness, or another type of condition (usually not life threatening), which must be treated within 48 hours.
- After hours emergent and urgent admissions, inpatient notifications or requests will need to be provided telephonically. Electronic requests will not be monitored after hours and will be responded to on the next business day. Please contact our NurseWise line at 877-647-4848 for after-hours urgent admission, inpatient notifications or requests.
- Please note: Office visit authorization requests will only cover Evaluation and Management (E & M) codes. Other codes may require an additional authorization.
- As of 10/1/15 Retro Authorizations with ICD-9 codes should not be submitted on the web. Authorizations after 10/1/15 should use ICD-10 codes.

**Enter Authorization:** This section is titled '1. PROVIDER REQUEST' and includes:

- An 'Urgent Request' checkbox.
- A 'Select a Service Type' dropdown menu.
- A 'NEXT >' button.

The dropdown menu is open, showing a list of service types:

- Medical Outpatient**
  - Biopharmacy
  - DME
  - Drug Testing
  - Genetic Testing & Counseling
  - Home Health
  - Imaging
  - Office Visit
  - Outpatient Services
  - Transport
- Medical Inpatient**
  - C-Section Delivery
  - Medical
  - Premature/False Labor
  - Rehab Inpatient
  - Skilled Nursing
  - Surgical Inpatient
  - Transplant
  - Vaginal Delivery

Below the dropdown menu, the next steps are listed: '2. SERVICE LINE' and '3. FINISH UP'.

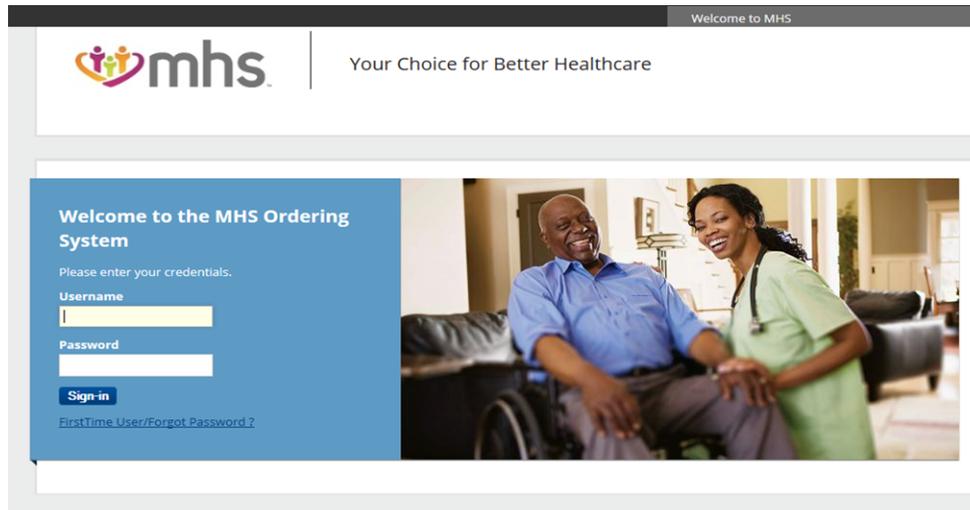
# Inpatient Prior Authorization

-  To ensure timely and accurate medical necessity review of a Medicaid inpatient admission, **MHS will accept notification of an inpatient admission and any clinical information submitted for medical necessity review via fax, using the IHCP universal prior authorization form or via the MHS Secure Provider Portal.**
-  Please submit timely notification and clinical information to support an inpatient admission via fax to 1-866-912-4245 or upload via the MHS Secure Provider Portal.

# Authorization for Durable & Home Medical Equipment

 Requests should be initiated via **MHS Secure Portal** on **mhsindiana.com**.

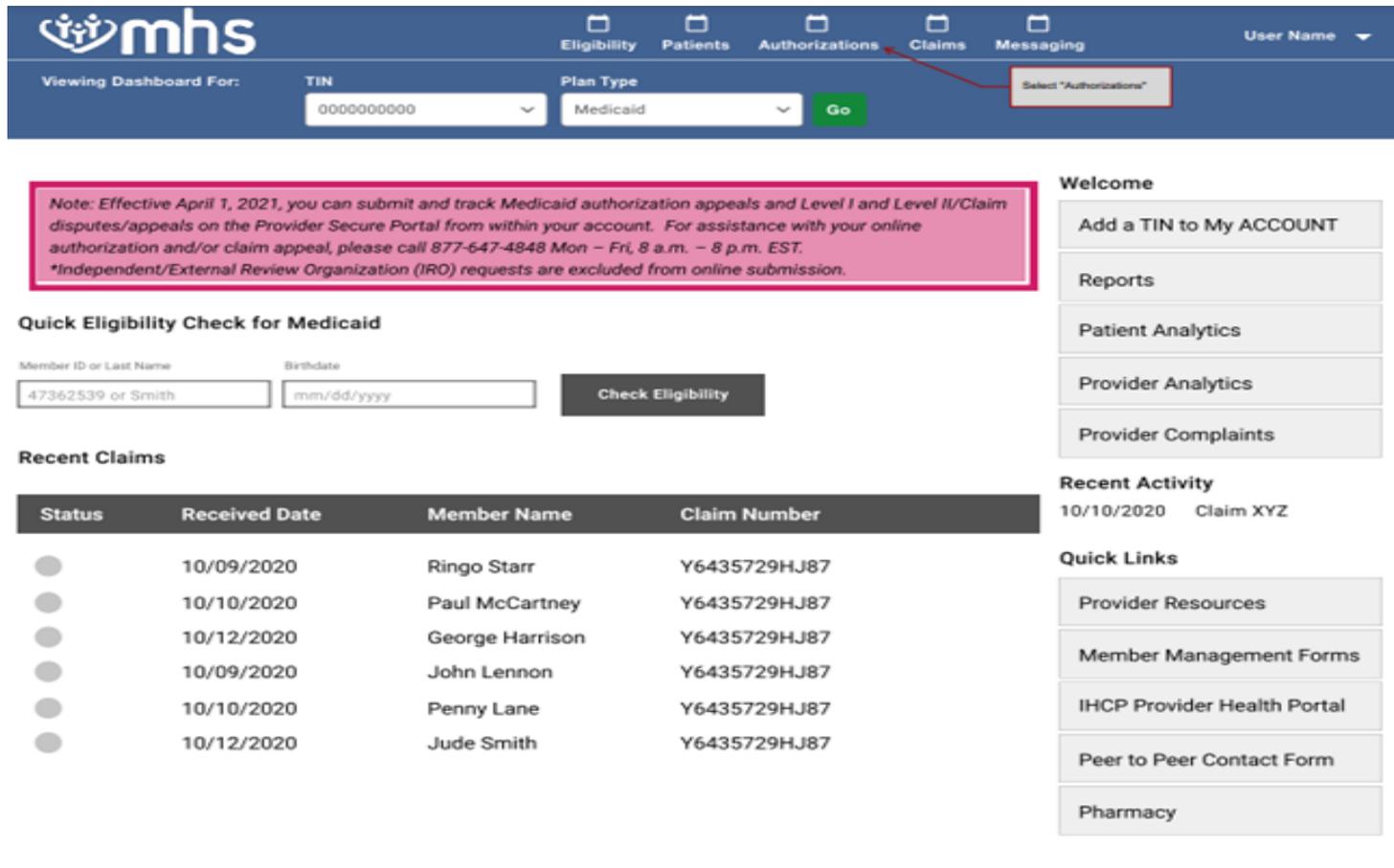
1. Select **Authorizations** tab and click on **Create Authorization**.
2. Enter **Member ID** or **Last Name** and **Date of Birth**.
3. Choose **DME** and you will be directed to the Medline portal for order entry.



The screenshot shows the MHS Ordering System login page. At the top, there is a navigation bar with the MHS logo and the text "Your Choice for Better Healthcare". Below this, there is a blue box containing the login form. The form includes a "Welcome to the MHS Ordering System" heading, a "Please enter your credentials." instruction, and fields for "Username" and "Password". A "Sign-in" button is located below the password field. A link for "First Time User/Forgot Password?" is also present. To the right of the login form is a photograph of a healthcare professional in green scrubs assisting an elderly man in a wheelchair.

# **Prior Authorization/Medical Necessity Appeals**

# Prior Authorization/Medical Necessity Appeals



The screenshot shows the MHS Provider Secure Portal dashboard. At the top, there are navigation tabs for Eligibility, Patients, Authorizations, Claims, and Messaging. Below these are search filters for TIN (0000000000) and Plan Type (Medicaid), with a 'Go' button. A red box highlights the 'Authorizations' tab and a 'Select "Authorizations"' button. A pink note box contains the following text:

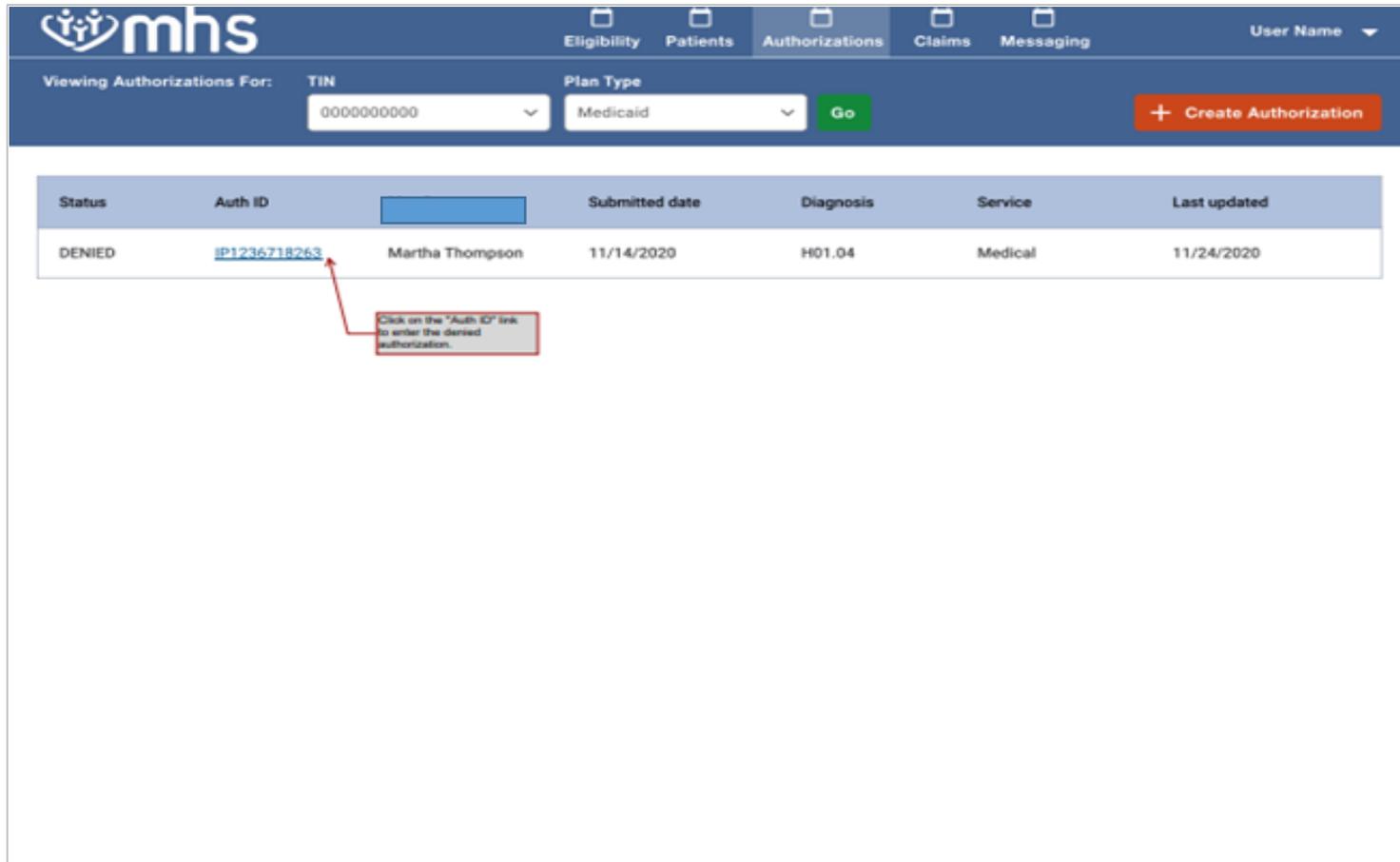
*Note: Effective April 1, 2021, you can submit and track Medicaid authorization appeals and Level I and Level II/Claim disputes/appeals on the Provider Secure Portal from within your account. For assistance with your online authorization and/or claim appeal, please call 877-647-4848 Mon – Fri, 8 a.m. – 8 p.m. EST. \*Independent/External Review Organization (IRO) requests are excluded from online submission.*

Below the note is a 'Quick Eligibility Check for Medicaid' section with input fields for Member ID or Last Name (47362539 or Smith) and Birthdate (mm/dd/yyyy), and a 'Check Eligibility' button. To the right is a 'Welcome' sidebar with buttons for 'Add a TIN to My ACCOUNT', 'Reports', 'Patient Analytics', 'Provider Analytics', and 'Provider Complaints'. Below that is a 'Recent Activity' section showing '10/10/2020 Claim XYZ'. At the bottom is a 'Quick Links' sidebar with buttons for 'Provider Resources', 'Member Management Forms', 'IHCP Provider Health Portal', 'Peer to Peer Contact Form', and 'Pharmacy'.

**Recent Claims**

Status	Received Date	Member Name	Claim Number
●	10/09/2020	Ringo Starr	Y6435729HJ87
●	10/10/2020	Paul McCartney	Y6435729HJ87
●	10/12/2020	George Harrison	Y6435729HJ87
●	10/09/2020	John Lennon	Y6435729HJ87
●	10/10/2020	Penny Lane	Y6435729HJ87
●	10/12/2020	Jude Smith	Y6435729HJ87

# Prior Authorization/Medical Necessity Appeals



The screenshot shows the mhs web application interface. At the top, there are navigation tabs for Eligibility, Patients, Authorizations, Claims, and Messaging. The 'Authorizations' tab is active. Below the navigation, there are search filters for TIN (0000000000) and Plan Type (Medicaid), with a 'Go' button and a '+ Create Authorization' button. A table displays a list of authorizations with the following columns: Status, Auth ID, Submitted date, Diagnosis, Service, and Last updated. One row is highlighted with a blue background, indicating it is selected. A red arrow points from a callout box to the 'Auth ID' link in this row.

Status	Auth ID	Submitted date	Diagnosis	Service	Last updated
DENIED	<a href="#">IP1236718263</a>	11/14/2020	H01.04	Medical	11/24/2020

Click on the "Auth ID" link to enter the denied authorization.

# Prior Authorization/Medical Necessity Appeals

Viewing Authorizations For: TIN: 000000000 Plan Type: Medicaid Go + Create Authorization

Back to Authorizations

Overview  
Cost Sharing  
Assessments  
Health Record  
Care Plan  
**Authorizations**  
Referrals  
Coordination of Benefits  
Claims  
Document Center

**Auth Status:** DENIED  
**Auth Nbr:** IP1236718263  
**Amit Date:** 03/27/2019  
**Service Date:** 03/27/2019  
**Provider of Service(s):** Mary Littlelamb, MD  
**Diagnosis Code(s):** H10.04

**Explanation:** Does not meet medical necessity criteria per CH.EH.123 Section 4  
**Auth Type:** INPATIENT  
**Service:** Medical  
**Discharge:** 04/02/2019  
**Procedure Code(s):** 92002  
**Note & Attachments:** [View](#)

Line Item	Service Type	From Date	To Date	Stay Level	Location	Status	Medical Necessity	Decision Date
1	Medical	03/27/2019	03/27/2019	N/A	St. Louis Children's Hospital	DENY	N/A	N/A
2	Medical	03/27/2019	03/27/2019	N/A	St. Louis Children's Hospital	DENY	N/A	N/A

**Appeal Requests for Authorization IP1236718263** [REQUEST APPEAL](#)

The next screen that will open will list the denied authorization details for the authorization you selected.

Status	Request ID	Type	Requested by	Submitted
No appeal requests have been submitted for this authorization.				

# Prior Authorization/Medical Necessity Appeals on the Provider Secure Portal

Back
Submit Appeal Request

**Authorization Detail**

Authorization Number  
IP1236718263

Patient Full Name  
...

Patient DOB  
06/20/1981

Admittance Date  
03/27/2019

Service Date  
03/27/2019

Discharge Date  
04/02/2019

Provider of Service  
Mary Littlelamb, MD

Authorization Type  
Inpatient

Service  
Medical

Diagnosis Code(s)  
H01.04

Procedure Code(s)  
92002

## Appeal Request Form

Appeal Request for Authorization IP1236718263

**Appeal type\***  
Please select one or more appeal types.

Administrative The "Appeal Request Form" page will open. Select the type of appeal for your appeal request.

Medical Necessity

DENIED

Explanation  
Does not meet medical necessity criteria per CH.EH.123 Section 4. The denial reason will give the reason for the denial.

[View Notes & Attachments](#)

**Provider Submitting the Appeal\***

Enter last name or NPI

**Office Contact Name\***

Enter full name

**Phone\***

Enter ten-digit number

**Rationale\***  
Provide a detailed explanation with new information for this appeal.

Lorem Ipsum is simply dummy text of the printing and typesetting industry. Lorem Ipsum has been the industry's standard dummy text ever since the 1500s, when an unknown printer took a galley of type and scrambled it to make a type specimen book. Enter the reason for the appeal in the "Rationale" box.

2000 characters remaining

**Evidence Materials & Attachments\***  
Submit new evidence that will help support your appeal.

.../Folder 1/Folder 2/Folder 3/File.pdf UPLOAD FILE

2000 characters remaining

File	Type	Size	
PatientHistory_1.pdf	PNG	230kb	<input type="checkbox"/>
	PNG	9.1mb	<input type="checkbox"/>

Upload the supporting documentation such as clinical and letter of medical necessity.

SAVE & REVIEW

Click "Save & Review" to submit the appeal.

# Prior Authorization/Medical Necessity Appeals


User Name

Eligibility Patients Authorizations Claims Messaging

Back
Review Appeal Request

The "Review Appeal Request" screen will open to allow you to preview the appeal information prior to submitting.

## Review

Appeal request for Authorization IP1236718263

---

**Original Authorization**

Authorization Number IP1236718263	Member Martha Thompson	Member DOB 12/32/1921
--------------------------------------	---------------------------	--------------------------

---

**Appeal Request**

Appeal Request Type Administrative, Medical Necessity	Office Contact Name Jimmy Johnson
Provider Mary Littlelamb, MD	Office Contact Phone (555) 555-5555

Rationale  
Lorem Ipsum is simply dummy text of the printing and typesetting industry. Lorem Ipsum has been the industry's standard dummy text ever since the 1500s, when an unknown printer took a galley of type and scrambled it to make a type specimen book.

---

Evidence Materials & Attachments

File	Type	Size	
PatientHistory_1.pdf	PDF	230kb	🗑️
	PNG	9.1mb	🗑️

After verifying the appeals entry information is correct, click "Send Request".

➔
SEND REQUEST

# Prior Authorization/Medical Necessity Appeals

Eligibility Patients Authorizations Claims Messaging User Name

Thank you! Your Appeal Request has been successfully submitted! After clicking the "Send Request" button, a message appears at the top of the screen to confirm the appeal has been submitted.

[Back to Authorizations](#)

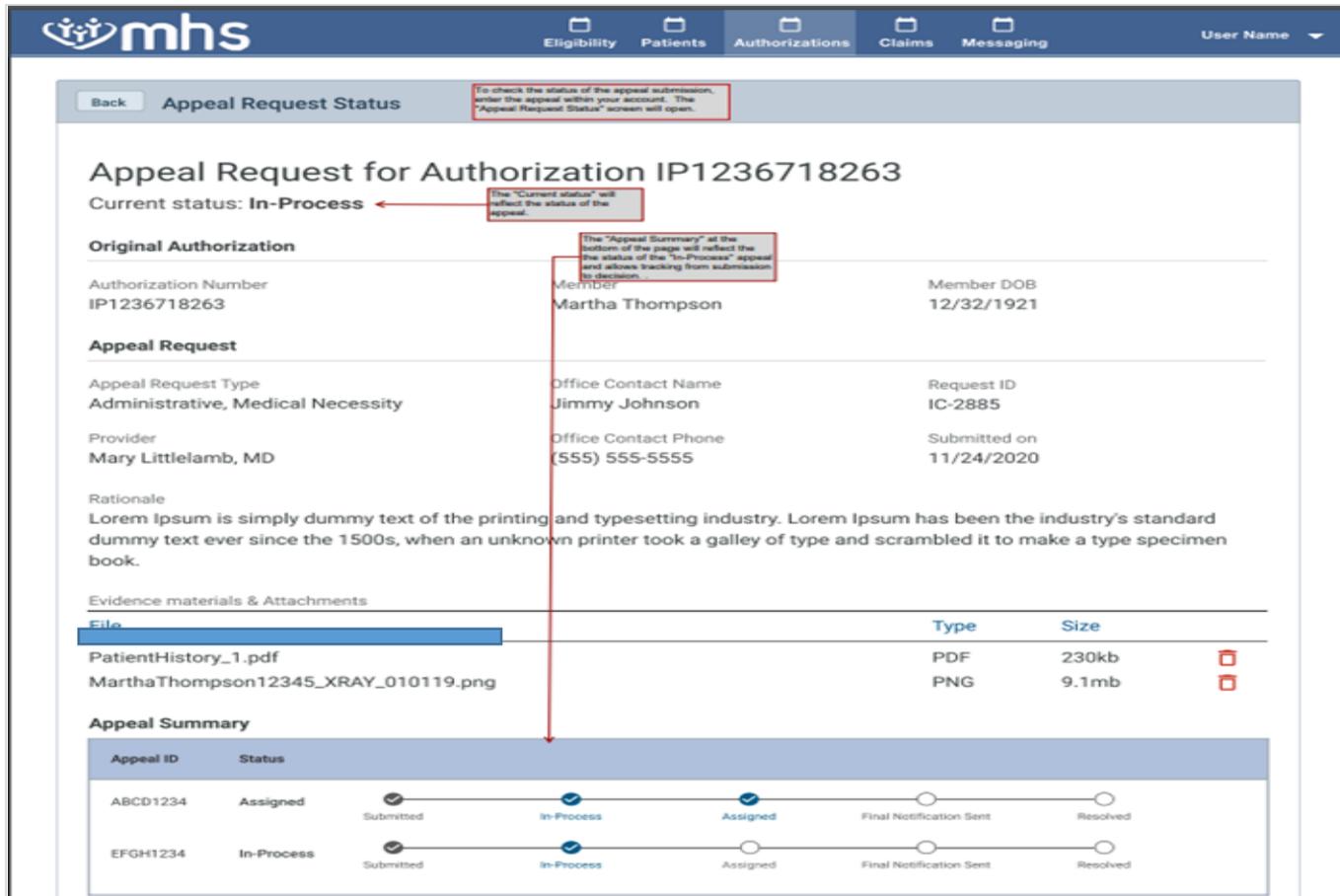
Overview	<b>Auth Status:</b> DENIED <b>Auth Nbr:</b> IP1236718263 <b>Amit Date:</b> 03/27/2019 <b>Service Date:</b> 03/27/2019 <b>Provider of Service(s):</b> Mary Littlelamb, MD <b>Diagnosis Code(s):</b> H10.04	<b>Explanation:</b> Does not meet medical necessity criteria per CHEH.123 Section 4 <b>Auth Type:</b> INPATIENT <b>Service:</b> Medical <b>Discharge:</b> 04/02/2019 <b>Procedure Code(s):</b> 92002 <b>Note &amp; Attachments:</b> <a href="#">View</a>
----------	--	---

Line Item	Service Type	From Date	To Date	Stay Level	Location	Status	Medical Necessity	Decision Date
1	Medical	03/27/2019	03/27/2019	N/A	St. Louis Children's Hospital	DENY	N/A	N/A
2	Medical	03/27/2019	03/27/2019	N/A	St. Louis Children's Hospital	DENY	N/A	N/A

**Appeal Requests for Authorization IP1236718263** REQUEST APPEAL

Status	Request ID	Type	Requested by	Submitted
In-Process	<a href="#">IC-2885</a>	Administrative, Medical Necessity	Mary Littlelamb	11/24/2020

# Prior Authorization/Medical Necessity Appeals



**Back** Appeal Request Status

To check the status of the appeal submission, enter the appeal within your account. The "Appeal Request Status" screen will open.

## Appeal Request for Authorization IP1236718263

Current status: **In-Process**

The "Current status" will reflect the status of the appeal.

The "Appeal Summary" at the bottom of the page will reflect the status of the "In-Process" appeal and allow tracking from submission to decision.

**Original Authorization**

Authorization Number IP1236718263	Member Martha Thompson	Member DOB 12/32/1921
--------------------------------------	---------------------------	--------------------------

**Appeal Request**

Appeal Request Type Administrative, Medical Necessity	Office Contact Name Jimmy Johnson	Request ID IC-2885
Provider Mary Littlelamb, MD	Office Contact Phone (555) 555-5555	Submitted on 11/24/2020

Rationale  
Lorem Ipsum is simply dummy text of the printing and typesetting industry. Lorem Ipsum has been the industry's standard dummy text ever since the 1500s, when an unknown printer took a galley of type and scrambled it to make a type specimen book.

Evidence materials & Attachments

File	Type	Size
PatientHistory_1.pdf	PDF	230kb
MarthaThompson12345_XRAY_010119.png	PNG	9.1mb

**Appeal Summary**

Appeal ID	Status	Submitted	In-Process	Assigned	Final Notification Sent	Resolved
ABCD1234	Assigned	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
EFGH1234	In-Process	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

# Claims

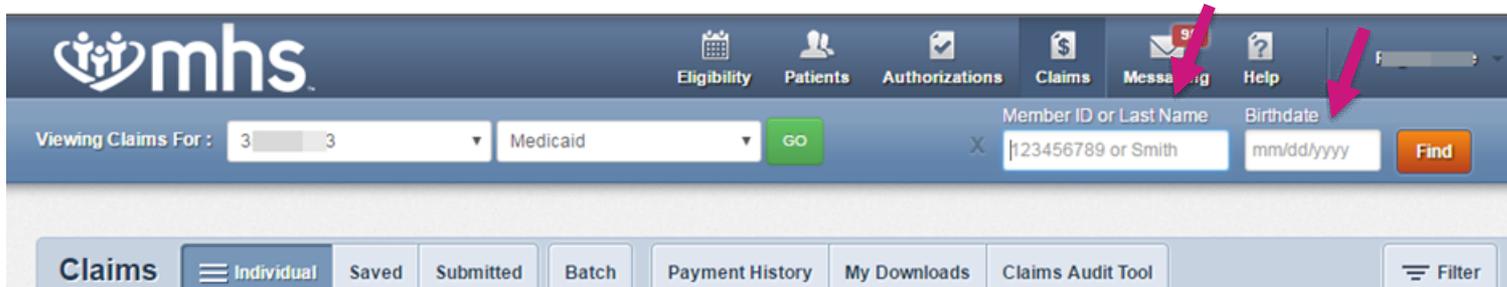
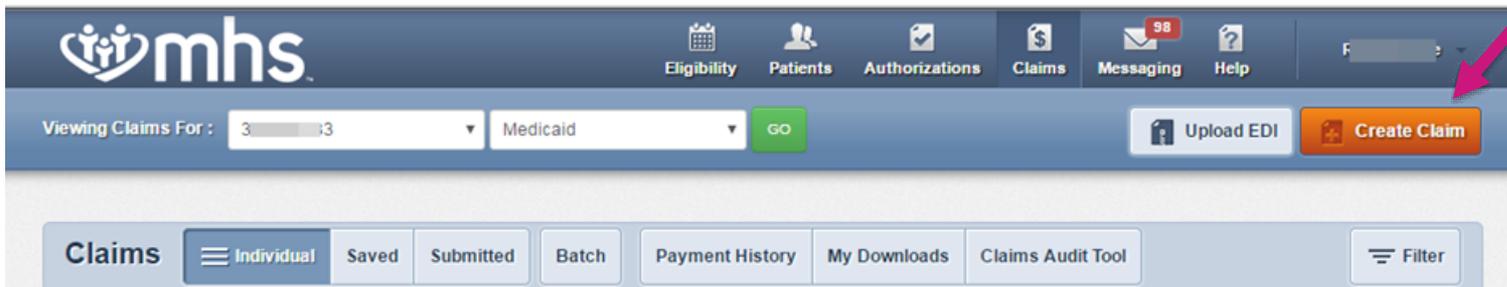
# Claims

## Claims Features:

- **Submit** new claim.
- **Review claims** submitted for members.
- **Correct** claims.
- View **Payment History**.

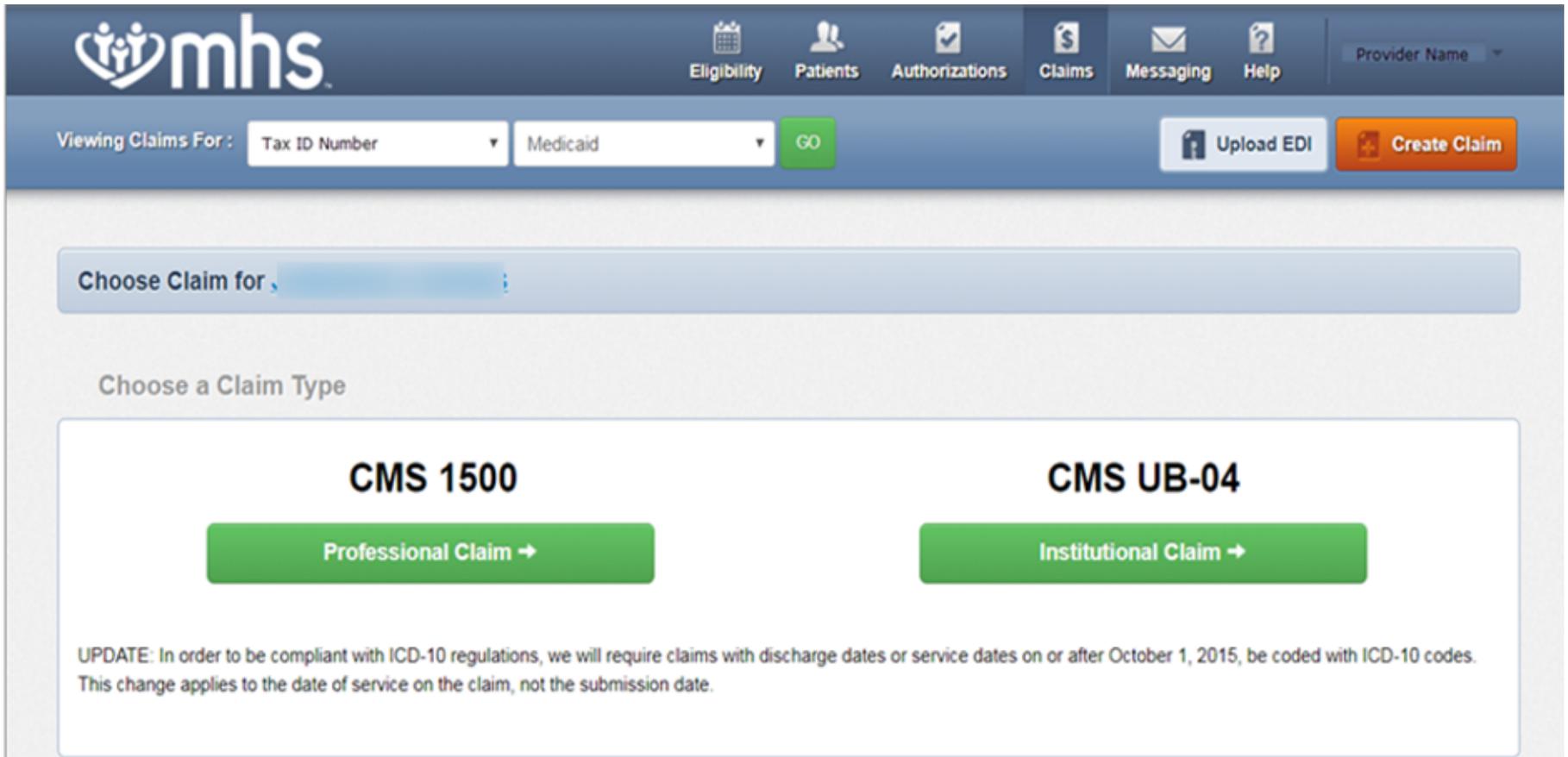
## Submit a New Claim:

- Click **Create Claim** and enter **Member ID** or **Last Name** and **Birthdate**.



# Claim Submission

 Choose the **Claim Type**.



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 light blue box with the text 'Choose Claim for ,'. Underneath, there is a section titled 'Choose a Claim Type' with two options: 'CMS 1500' with a green button labeled 'Professional Claim →', and 'CMS UB-04' with 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.'

# Professional Claim Submission

 Follow **Your Progress** to see [Professional Claim](#) steps and submission.

Professional Claim for £

Your Progress



THIS SECTION:

## Review

Please review your claim and submit.

[← Back](#)

This claim is eligible for Real Time Editing and Pricing.  
Please click on the Validate button to proceed to the next step.

[Validate →](#)

## Almost done!

You can go back to review your claim or submit now.

**Claim Id:** 8

Member Record Number: 3

Member Claim Amount Paid:

Patient's Account Number: 1

# Institutional Claim Submission

 Follow **Your Progress** to see [Institutional Claim](#) steps and submission.

Institutional Claim for E [redacted] E

Your Progress



THIS SECTION:

## Review and Submit

Please review your claim before submitting.

### Almost done!

You can go back to review your claim or submit now.

[Submit →](#)

Claim ID: E [redacted]

General Info [Edit](#)

# 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 (Real Time Editing and Pricing)** claims also show if eligible. (i.e. Line 3 was submitted, but was not eligible for RTEP.)

Viewing Claims For: Tax ID Number Medicaid Upload EDI Create Claim

Claims Individual Saved Submitted Batch Payment History My Downloads Claims Audit Tool Filter

SUBMITTED STATUS ↑	DATE SUBMITTED ↑	WEB #/ REF # ↑	CLAIM NUMBER ↑	CLAIM TYPE ↑	MEMBER NAME ↑	MEMBER ID ↑	ORIGINAL CLAIM # ↑	TOTAL CHARGES ↑	
	08/16/2017	8/16/17	C-1500	CMS-1500	S. J.	1-1500	6	\$150.00	
	08/10/2017	8/10/17	C-1500	CMS-1500	C. H.	1-1500		\$150.00	RTEP
	08/02/2017	8/2/17	C-1500	CMS-1500	S. M.	1-1500		\$150.00	RTEP
	07/24/2017	7/24/17	C-1500	CMS-1500	S.	1-1500		\$150.00	RTEP

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

# Individual Claims

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

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

Viewing Claims For :

Claims: **Individual** | Saved | Submitted | Batch | Payment History | My Downloads | Claims Audit Tool

Claims: Recent

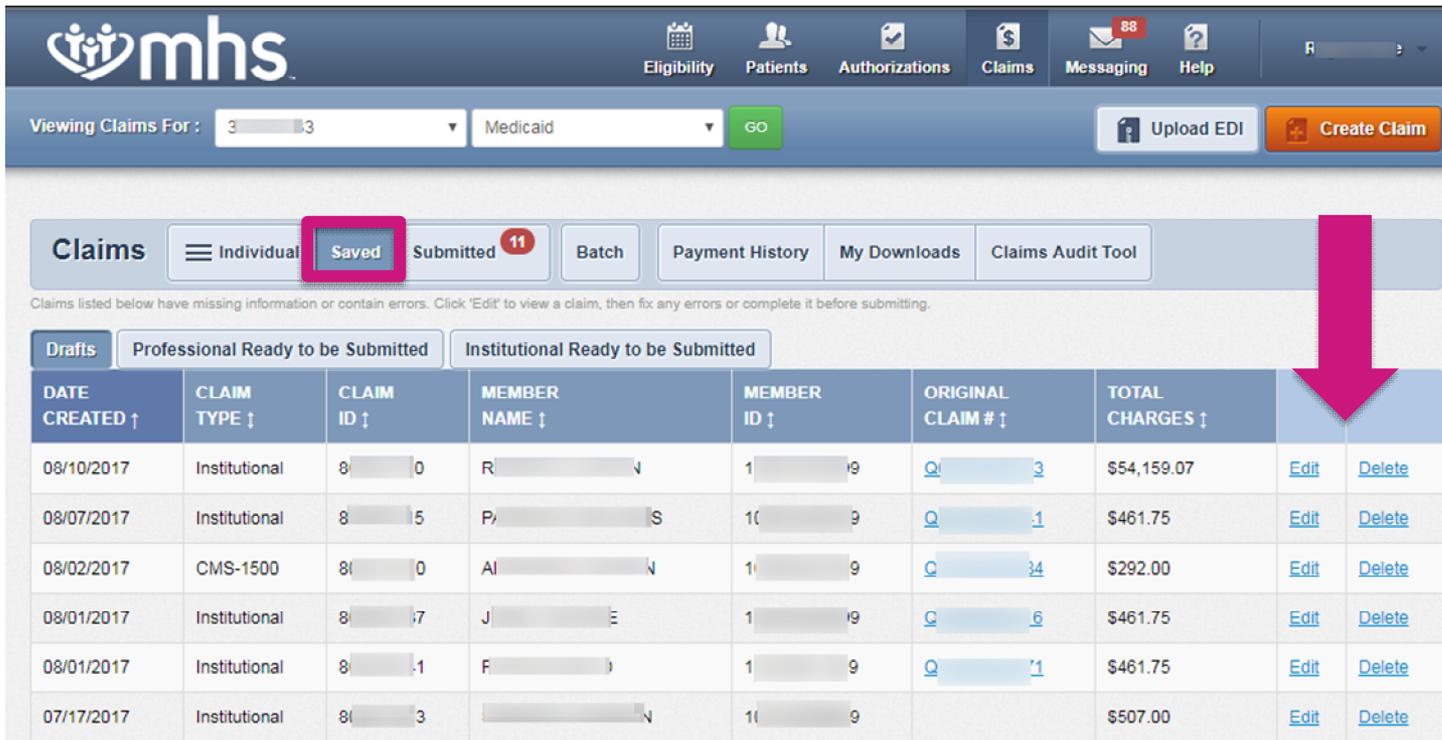
Search:  [Change dates](#)

CLAIM NO. ↑	CLAIM TYPE ↓	MEMBER NAME ↓	SERVICE DATE(S) ↓	BILLED/ PAID ↓	CLAIM STATUS ↓
8	CMS-1500	L	02/14/2019 - 02/14/2019	\$100.00 / \$0.00	Pending
3	CMS-1500	C	02/14/2019 - 02/14/2019	\$100.00 / \$0.00	Pending
2	CMS-1500	S	02/14/2019 - 02/14/2019	\$100.00 / \$0.00	Pending
1	CMS-1500	C	02/14/2019 - 02/14/2019	\$149.00 / \$0.00	Pending
3	CMS-1500	K	02/14/2019 - 02/14/2019	\$229.00 / \$0.00	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 screenshot shows the MHS Claims Management interface. At the top, there is a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below this is a search bar for 'Viewing Claims For' with a dropdown set to '3' and a 'Medicaid' filter. A 'GO' button and 'Upload EDI' and 'Create Claim' buttons are also present.

The main content area has a 'Claims' section with tabs for 'Individual', 'Saved', 'Submitted' (with a '11' notification), 'Batch', 'Payment History', 'My Downloads', and 'Claims Audit Tool'. The 'Saved' tab is highlighted with a red box.

Below the tabs, there is a table of claims. The table has columns for DATE CREATED, CLAIM TYPE, CLAIM ID, MEMBER NAME, MEMBER ID, ORIGINAL CLAIM #, and TOTAL CHARGES. Each row has 'Edit' and 'Delete' links. A large red arrow points to the 'Edit' and 'Delete' links in the first row of the table.

DATE CREATED ↑	CLAIM TYPE ↓	CLAIM ID ↓	MEMBER NAME ↓	MEMBER ID ↓	ORIGINAL CLAIM # ↓	TOTAL CHARGES ↓		
08/10/2017	Institutional	8100	R...	109	Q03	\$54,159.07	<a href="#">Edit</a>	<a href="#">Delete</a>
08/07/2017	Institutional	815	P...	109	Q01	\$461.75	<a href="#">Edit</a>	<a href="#">Delete</a>
08/02/2017	CMS-1500	8100	AI...	109	Q04	\$292.00	<a href="#">Edit</a>	<a href="#">Delete</a>
08/01/2017	Institutional	817	J...	109	Q06	\$461.75	<a href="#">Edit</a>	<a href="#">Delete</a>
08/01/2017	Institutional	811	F...	109	Q01	\$461.75	<a href="#">Edit</a>	<a href="#">Delete</a>
07/17/2017	Institutional	813	...	109		\$507.00	<a href="#">Edit</a>	<a href="#">Delete</a>

# Correcting Claims

 After clicking on a **Claim #** link:

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

Back to Claims
Claim Details

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

Claim #S158INE03385: Paid

+ Copy Claim
✎ Correct Claim



**Member**

Member Name: A [redacted] EY

Member ID: 1 [redacted]

Member DOB: 1 [redacted] 7

**Provider**

Ref/Acct No.: E [redacted] 0

Servicing Provider: C [redacted] Y

Servicing NPI: 15 [redacted] 2

**Claim**

DOS Range: 06/06/2019 - 06/06/2019

Received Date: 06/07/2019

Billed Amount: \$120.00

**Service Lines**

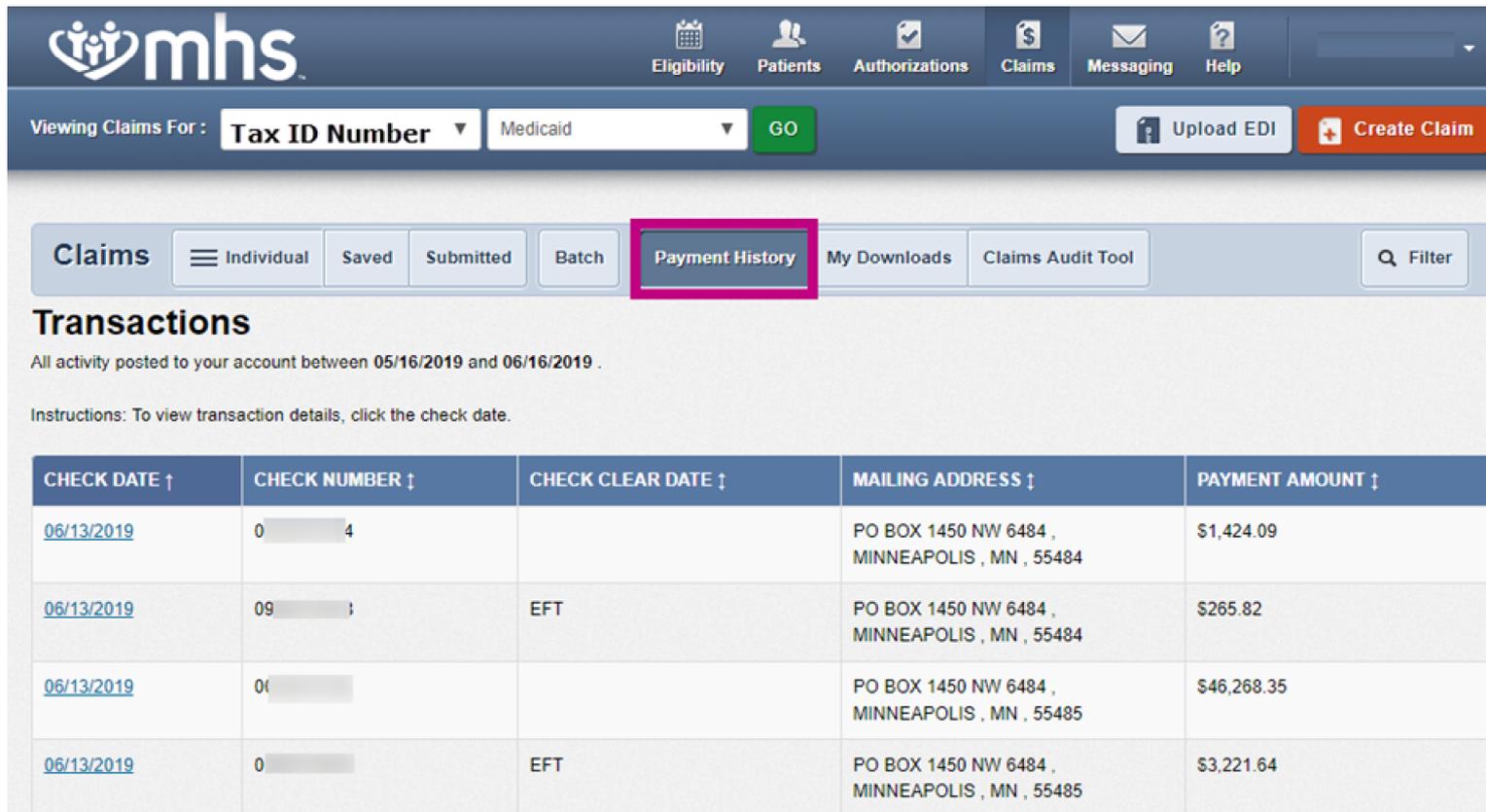
Line	DOS	Proc	Dx	Modifiers	Place of Service	Charged	Payment Amount	Payment Date	Check No.	Status	Payment Codes
1	06/06/2019	99213	K120		11	\$120.00	\$51.99	06/13/2019	00103717 46	 PAID	92

 [Submit a Correct Claim Guide](#)

# Payment History

Click on **Payment History** to view Check Date, Check Number, Check Clear Date, Mailing Address and Payment Amount.

- Click on **Check Date** to view Explanation of Payment.



The screenshot shows the MHS web application interface. At the top, there is a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below this, a search bar shows 'Viewing Claims For: Tax ID Number' and 'Medicaid'. A green 'GO' button is next to it. To the right are buttons for 'Upload EDI' and 'Create Claim'. Below the search bar, there is a 'Claims' section with tabs for 'Individual', 'Saved', 'Submitted', 'Batch', 'Payment History' (highlighted with a red box), 'My Downloads', and 'Claims Audit Tool'. A 'Filter' button is also present. The main content area is titled 'Transactions' and shows a list of transactions with columns for Check Date, Check Number, Check Clear Date, Mailing Address, and Payment Amount. The transactions are listed as follows:

CHECK DATE ↑	CHECK NUMBER ↓	CHECK CLEAR DATE ↓	MAILING ADDRESS ↓	PAYMENT AMOUNT ↓
<a href="#">06/13/2019</a>	0 [REDACTED] 4		PO BOX 1450 NW 6484 , MINNEAPOLIS , MN , 55484	\$1,424.09
<a href="#">06/13/2019</a>	09 [REDACTED] :	EFT	PO BOX 1450 NW 6484 , MINNEAPOLIS , MN , 55484	\$265.82
<a href="#">06/13/2019</a>	0 [REDACTED]		PO BOX 1450 NW 6484 , MINNEAPOLIS , MN , 55485	\$46,268.35
<a href="#">06/13/2019</a>	0 [REDACTED]	EFT	PO BOX 1450 NW 6484 , MINNEAPOLIS , MN , 55485	\$3,221.64

# Payment History

 Click on **View Service Line Details**.

Explanation of Payment Details

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

Check/Trace Number: 0    Check Date: 02/28/2019

Insured Name: E R

Patient Name: E R

Control Number: S 9

Service Provider: F D

Group: T S

ID: 1 )

Account: F )

NPI: 1 )

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	02/13/2019	76820	26	0/1	100.00	24.86	0.00/0.00	0.00	0.00/0.00	0.00/0.00	0.00	0.00	92	24.86
20	02/13/2019	76818	26	0/1	130.00	52.32	0.00/0.00	0.00	0.00/0.00	0.00/0.00	0.00	0.00	92	52.32
Sub Total:					\$230.00	\$77.18	\$0.00/\$0.00	\$0.00	\$0.00/\$0.00	\$0.00/\$0.00	\$0.00	\$0.00		\$77.18

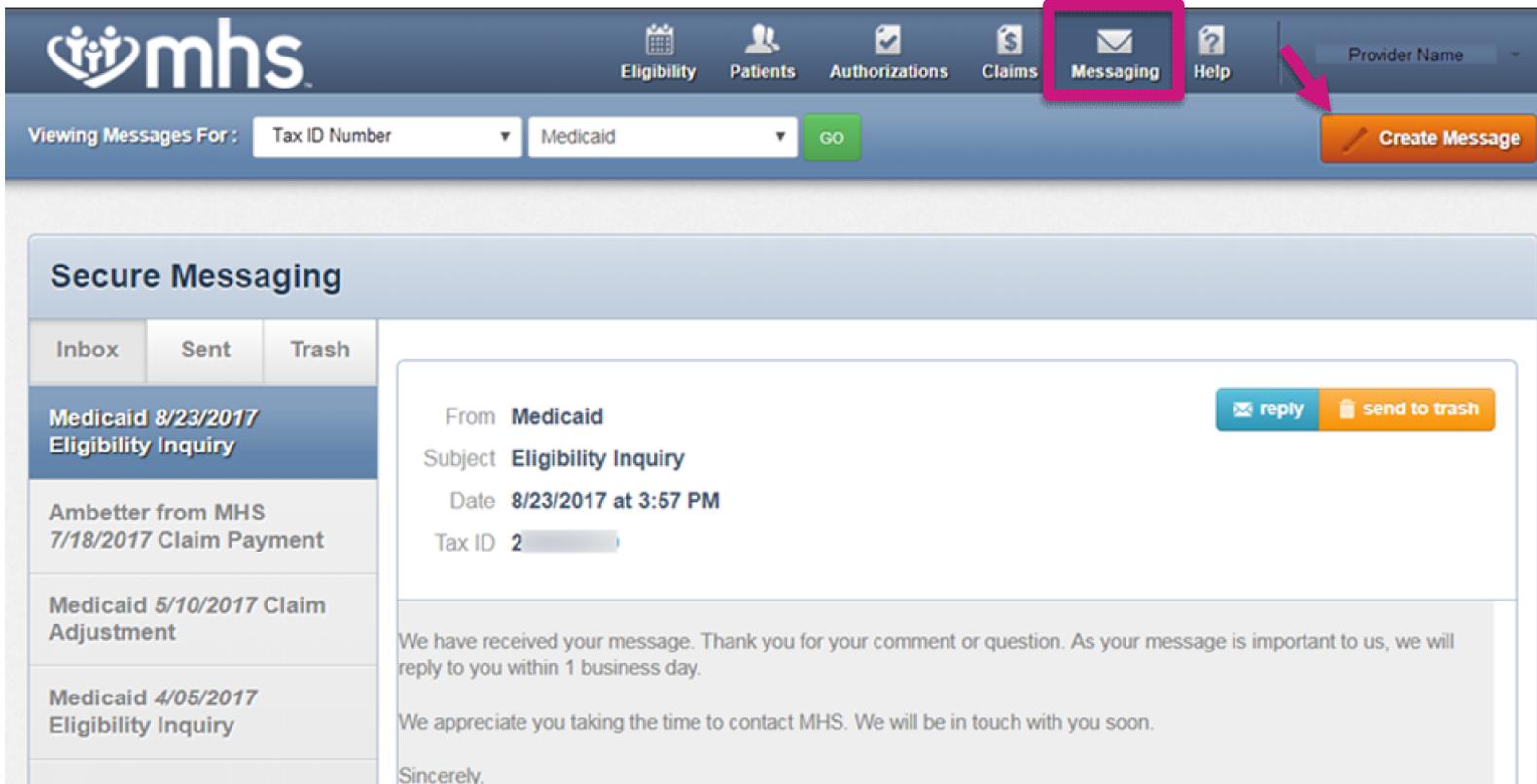
**Remit Code Descriptions**

92  
PAID IN FULL

# Secure Messaging

## Create a new secure message:

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



The screenshot shows the MHS dashboard with the 'Messaging' tab highlighted in a pink box. A pink arrow points to the 'Create Message' button. Below the navigation bar, there are filters for 'Viewing Messages For' (Tax ID Number) and 'Medicaid', with a 'GO' button. The main content area is titled 'Secure Messaging' and shows an inbox with several messages. The selected message is from Medicaid, dated 8/23/2017 at 3:57 PM, with the subject 'Eligibility Inquiry' and tax ID '2'. The message body contains a response from MHS.

**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,

# Online Claim Reconsiderations

# Summary Of Online Reconsiderations

## Skip the phone call.

- Providers make their case directly on the portal.

## Make the case.

- Providers submit informal dispute/reconsideration comments using expanded text fields.

## Add context.

- Providers can easily attach supporting documentation when filing an informal dispute/reconsideration.

## Stay current.

- Providers may opt in/out for informal dispute/reconsideration status change emails.
- Providers may also view status online.

# Submit Reconsideration

-  **Step 1:** Provider will search for the claim from the claims tab.
-  **Step 2:** The **Reconsider Claim** button will be visible from the claims sub navigation screen.
-  **Note:** This option is only available to those claims that do not already have a web-initiated reconsideration already in progress.

# Submit Reconsideration

The screenshot shows the MHS Claims Management System interface. At the top, there is a navigation bar with the MHS logo and several menu items: Eligibility, Patients, Authorizations, Claims, and Messaging. A pink arrow points to the 'Claims' menu item. Below the navigation bar, there is a search area for 'Viewing Claims For' with a dropdown menu set to 'Nebraska Total Care' and a 'GO' button. To the right of the search area are two buttons: 'Upload EDI' and 'Create Claim'.

The main content area is titled 'Claim Details' and includes a 'Back to Claims' link. The claim status is shown as 'Denied' with a red 'X' icon. Below the status, there are three buttons: '+ Copy Claim', 'Correct Claim', and 'Reconsider Claim'. A pink arrow points to the 'Reconsider Claim' button. Below the buttons is a progress bar with three stages: 'Claim Accepted' (green checkmark), 'In Process' (green checkmark), and 'Denied' (red 'X').

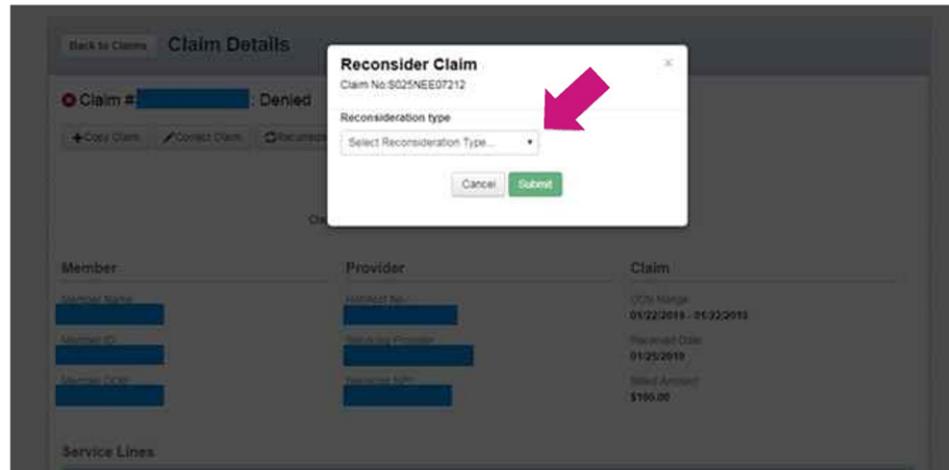
The 'Member' section includes fields for Member Name, Member ID, and Member DOB. The 'Provider' section includes fields for Ref/Act No., Servicing Provider, and Servicing NPI. The 'Claim' section includes fields for DOS Range (01/22/2019 - 01/22/2019), Received Date (01/25/2019), and Billed Amount (\$160.00).

The 'Service Lines' section contains a table with the following data:

Line	DOS	Proc.	Dx	Modifiers	Place of Service	Charged	Payment Amount	Payment Date	Check No.	Status	Payment Codes
1	01/22/2019	99213	S8213Z D. S8211Z D. W010X XD		22	\$160.00	\$0.00	02/01/2019		VOID	L6

# Submit Reconsideration – Pop-Up Window

-  Once **Reconsider Claim** is selected, a pop up window will show.
-  The pop-up window displays a **Reconsideration Type** dropdown menu.

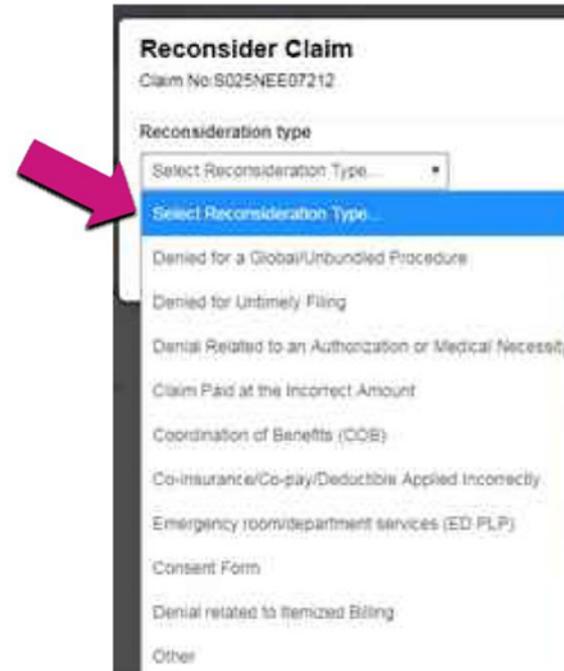


# Submit Reconsideration – Select Reconsideration Type

 Providers will select a **Reconsideration Type.**

- Examples include:
  - “Denied for Global/Unbundled Procedure”
  - “Denied for Untimely Filing”
  - “Other”

 Providers should choose the option that is related to their reconsideration reason.



**Reconsider Claim**  
Claim No: S025NEE07212

Reconsideration type

Select Reconsideration Type...

Select Reconsideration Type...

Denied for a Global/Unbundled Procedure

Denied for Untimely Filing

Denial Related to an Authorization or Medical Necessity

Claim Paid at the Incorrect Amount

Coordination of Benefits (COB)

Co-insurance/Co-pay/Deductible Applied Incorrectly

Emergency room/department services (ED PLP)

Consent Form

Denial related to Itemized Billing

Other

# Submit Reconsideration – Enter Information

-  Once the provider selects the **Reconsideration Type**, the provider has two options:
  - Add notes.
  - Upload documents.
-  The form is dynamic; depending on the dropdown item selected, notes and/or documents may be required.
-  Select **Submit** after populating all required fields.

# Submit Reconsideration – Updated Tracker

 Upon submission, a success banner will be displayed.



The screenshot displays the 'Claim Details' page for a 'Reconsideration' claim. At the top, there is a 'Back to Claims' button and the title 'Claim Details'. Below this, the claim number is redacted with a blue box, followed by the word 'Reconsideration'. There are two buttons: 'Copy Claim' and 'Correct Claim'. A green success banner with a checkmark icon contains the text: 'Your Reconsideration request has been submitted Successfully.' A large pink arrow points to this banner. Below the banner is a process flow diagram with five steps: 'Claim Accepted' (green checkmark), 'In Process' (green checkmark), 'Denied' (red X), 'Submitted' (green checkmark), and 'Outcome TBD' (white circle). A bracket labeled 'RECONSIDERATION' spans the 'Submitted' and 'Outcome TBD' steps.

# Submit Reconsideration – Updated

 Reconsideration is tracked as in progress.



The screenshot displays the 'Claim Details' page for a 'Reconsideration' claim. At the top, there is a 'Back to Claims' button and the title 'Claim Details'. Below this, the claim number is redacted with a blue box, and the word 'Reconsideration' is displayed. There are two buttons: '+ Copy Claim' and 'Correct Claim'. A green success message states: 'Your Reconsideration request has been submitted Successfully.' Below the message is a progress bar with five stages: 'Claim Accepted' (green checkmark), 'In Process' (green checkmark), 'Denied' (red X), 'Submitted' (green checkmark), and 'Outcome TBD' (grey circle). A bracket labeled 'RECONSIDERATION' spans the 'Submitted' and 'Outcome TBD' stages. A large pink arrow points down to the 'Submitted' stage.

# **Provider Relations Team**

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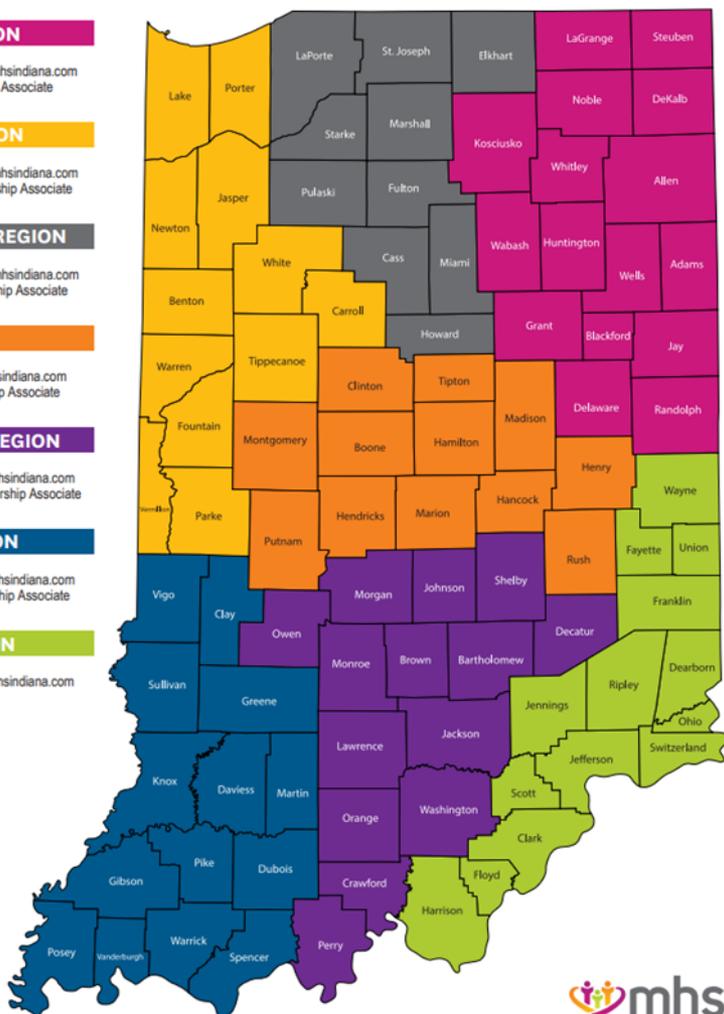
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Available online:

<https://www.mhsindiana.com/content/dam/centene/mhsindiana/medicaid/pdfs/508-ProviderTerritory-map-2021.pdf>



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

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

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