MHS Secure Provider Web Portal Overview

mhs™

NCQA ACCREDITED HEALTH PLAN

ambetter.

Hoosier Healthwise

HIP HEALTHY INDIANA PLAN

Hoosier CARE CONNECT

allwell.™

Agenda

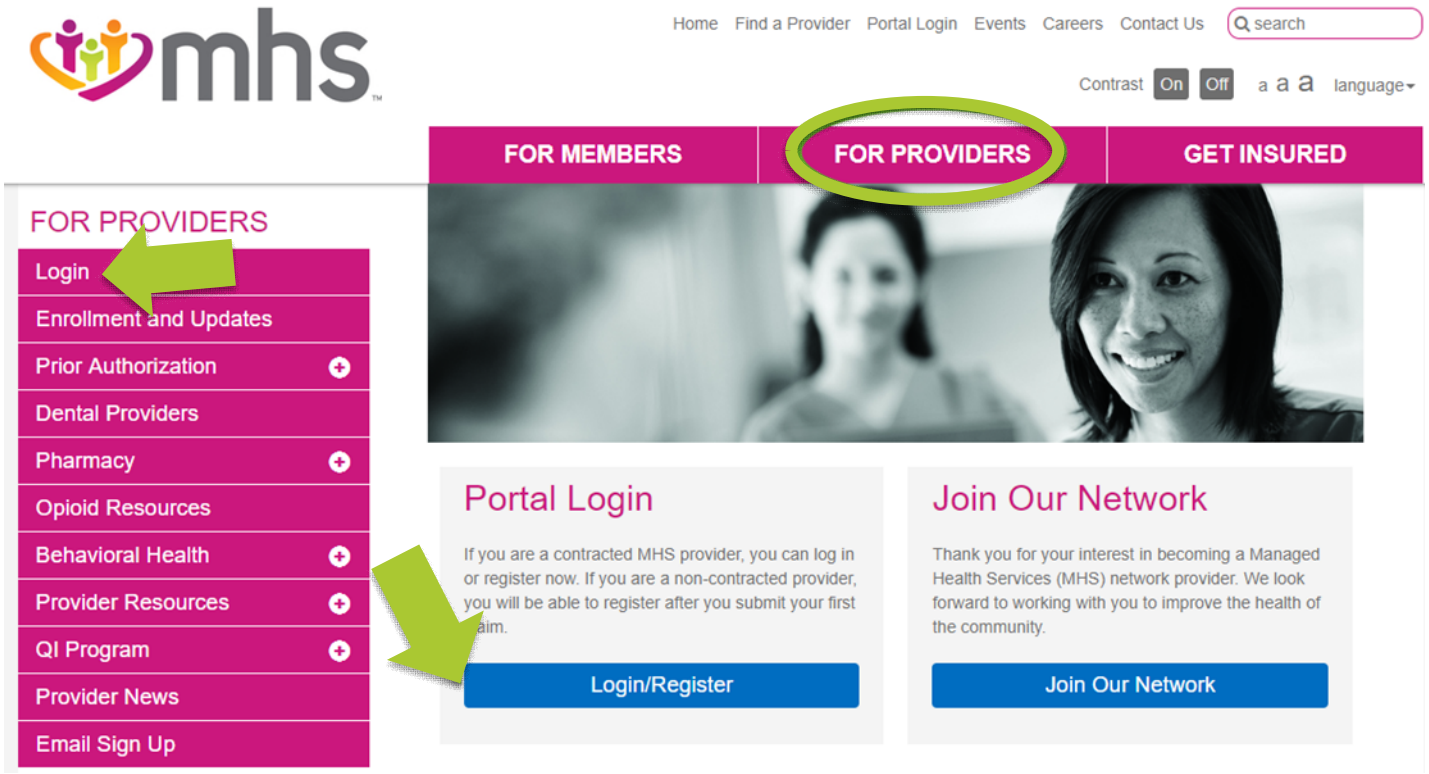
Save Time by Utilizing the MHS Secure Web Portal

- **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

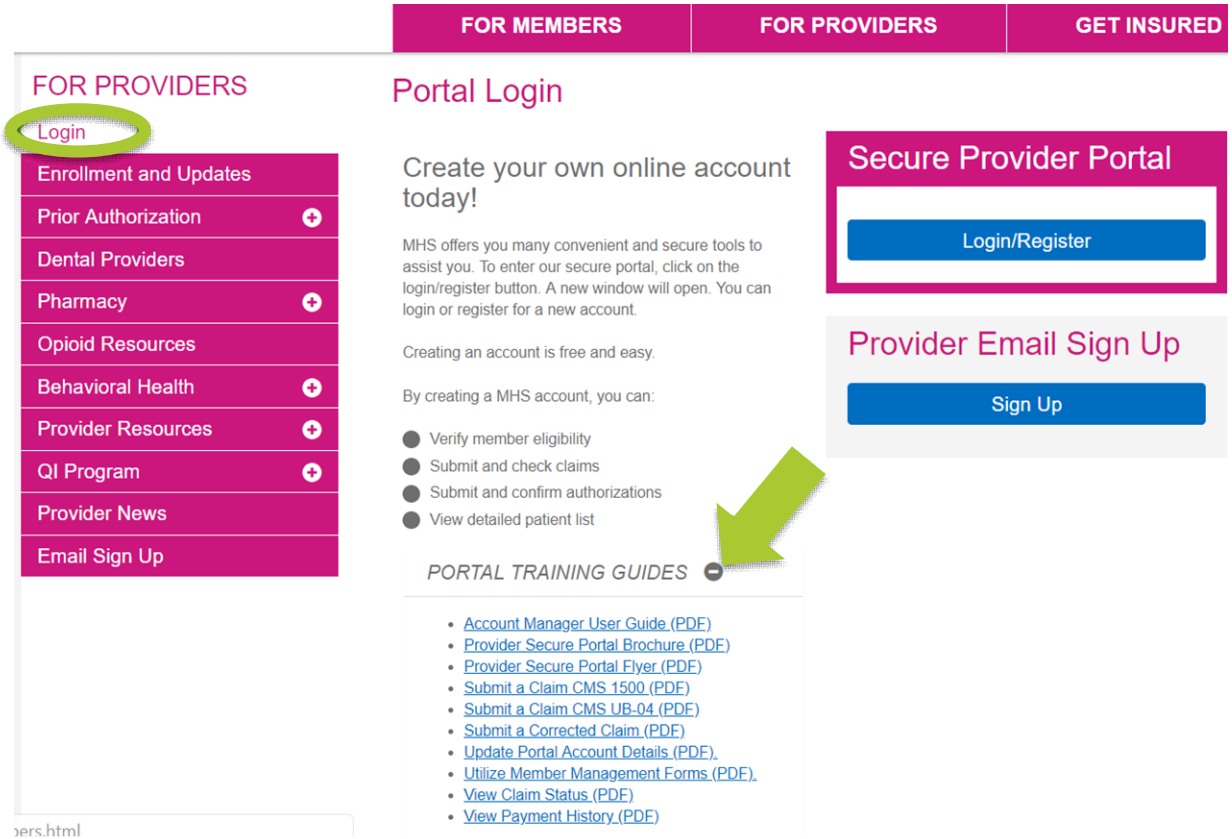
Provider Portal Login

- Go mhsindiana.com and click on **For Providers.**
- Then click **Login/Register** for the **MHS Secure Provider Portal.**



Web Portal Training Documents

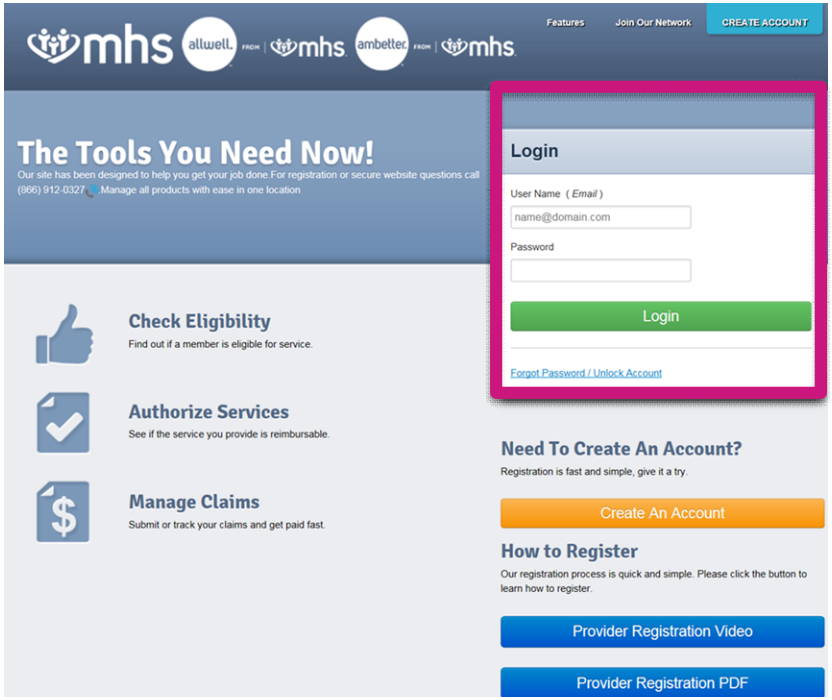
- **Login** tab contains **Portal Training Guides, Login/Register** and **Sign Up** for emails.

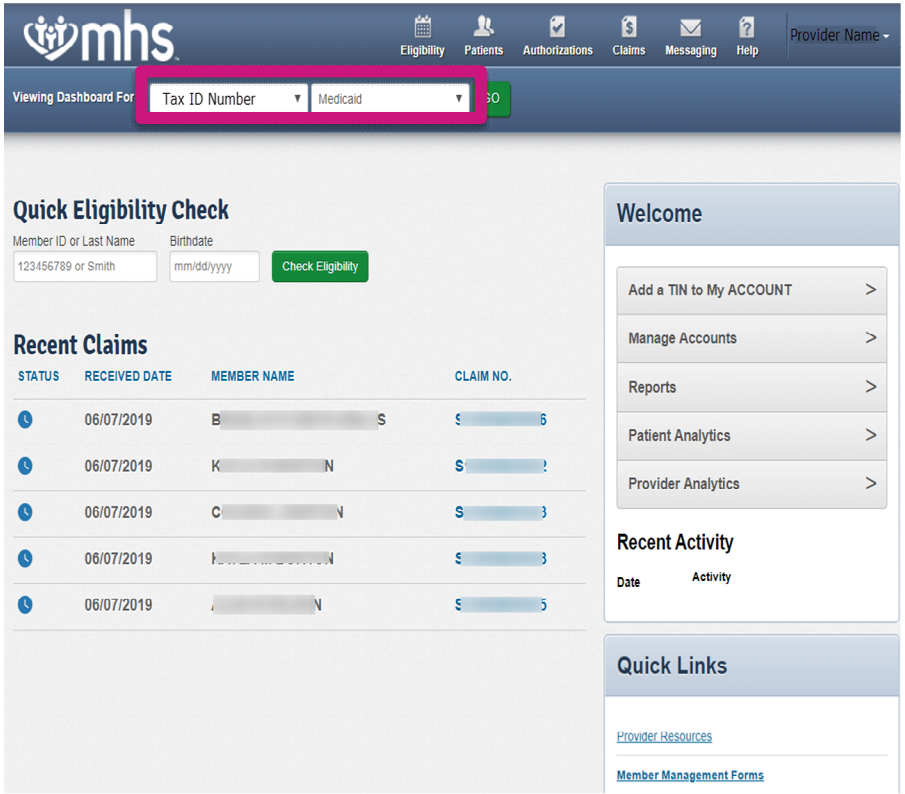


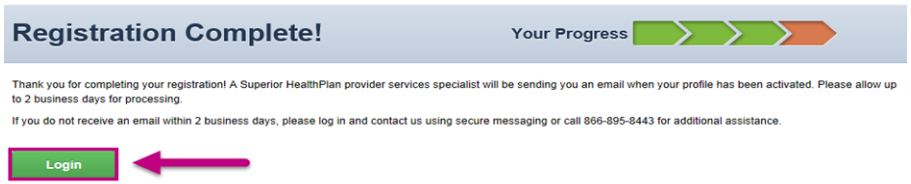
Training Documents Include:

- 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





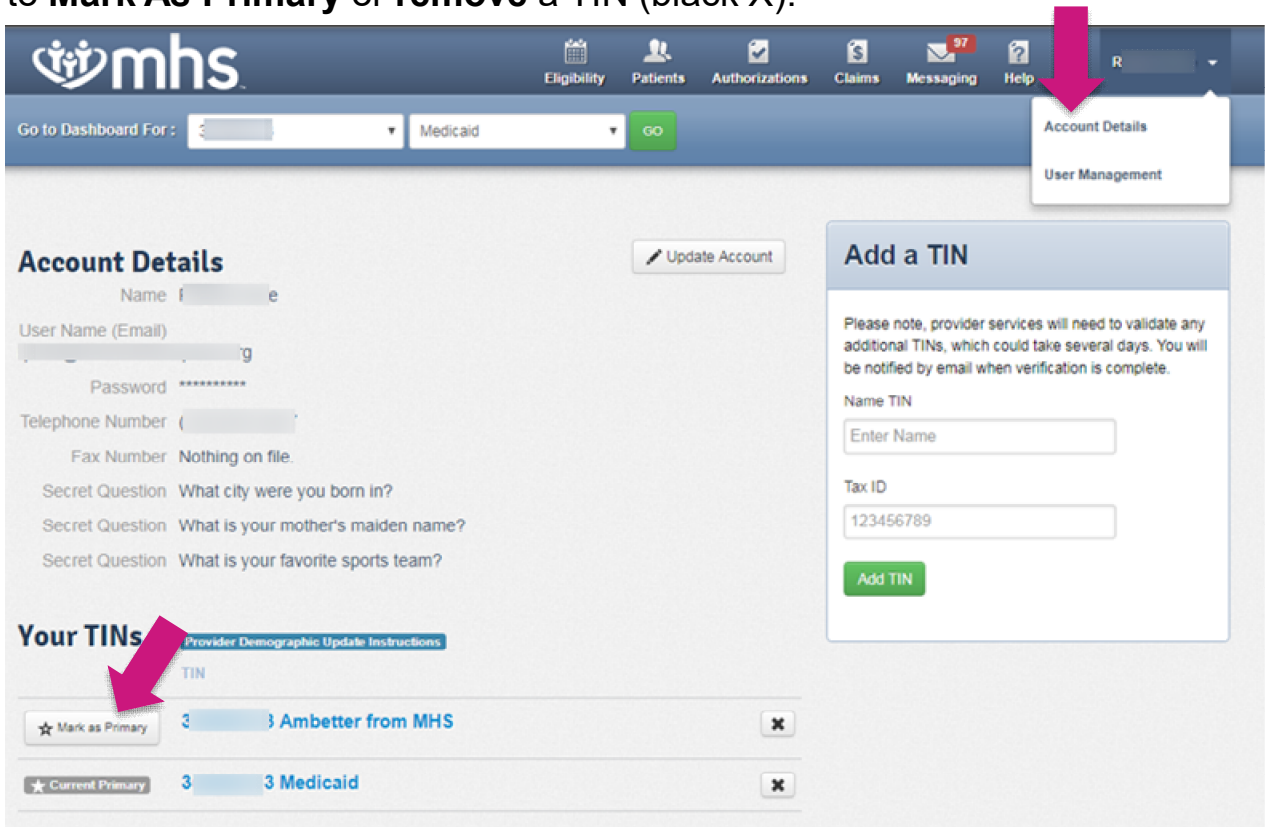


Account Details

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).



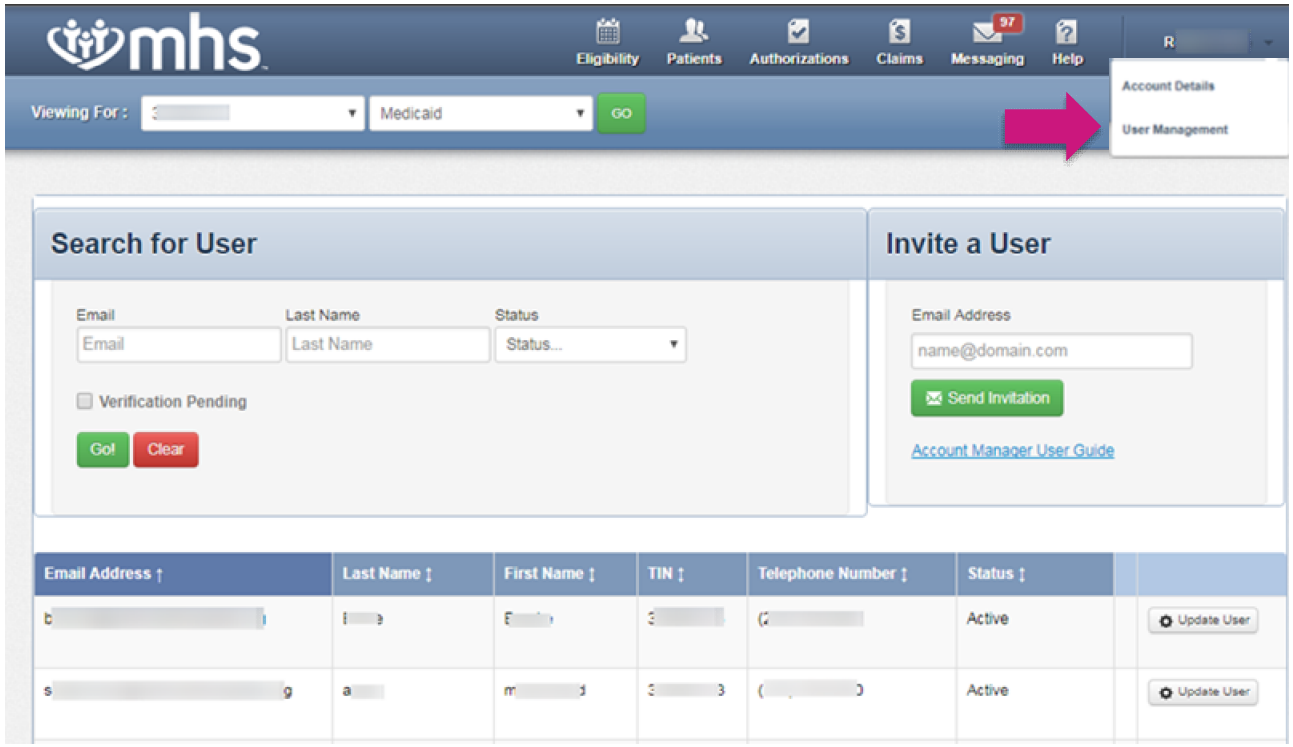
[Update Account Details User Guide]

Account Manager

User Management

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

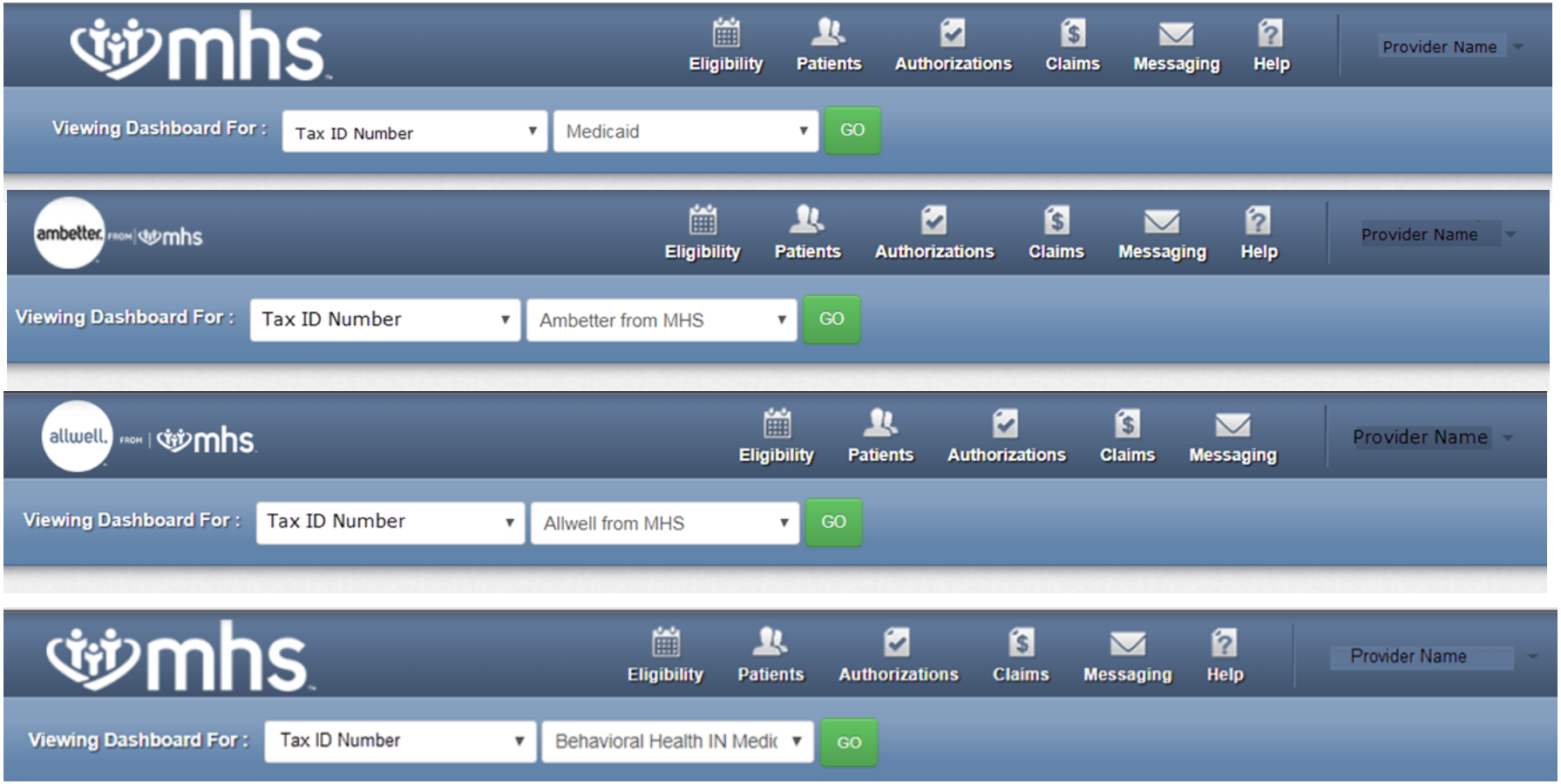
1. Select the drop-down arrow next to your name in the upper right corner.
2. Select **User Management.**
3. Click **Update User** next to the user name.



[Account Manager User Guide]

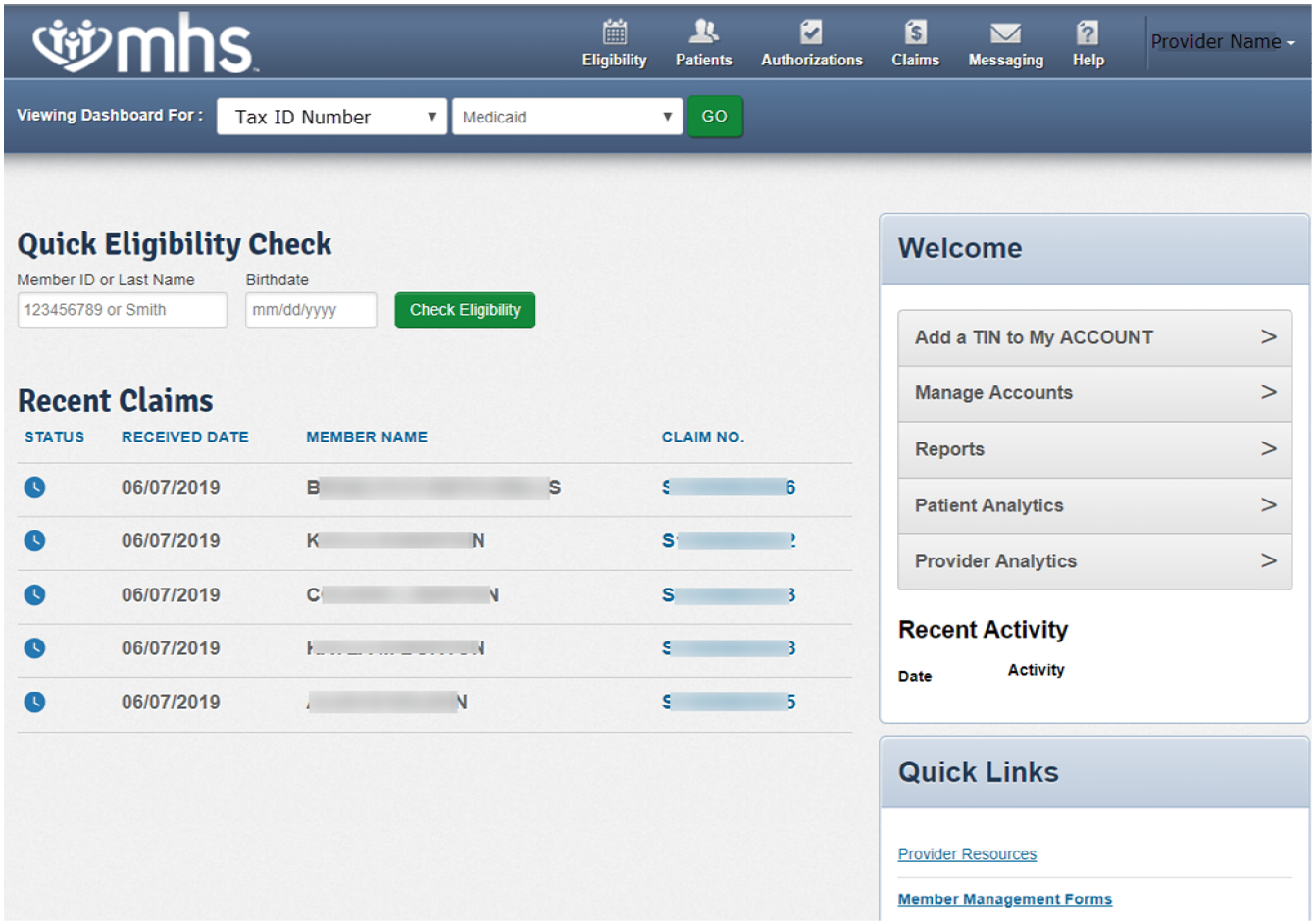
Dashboard Change

- 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.**



Homepage – MHS (Medicaid)

- Quick Eligibility Check, Recent Claims, Reports and Quick Links



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 submtting 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.

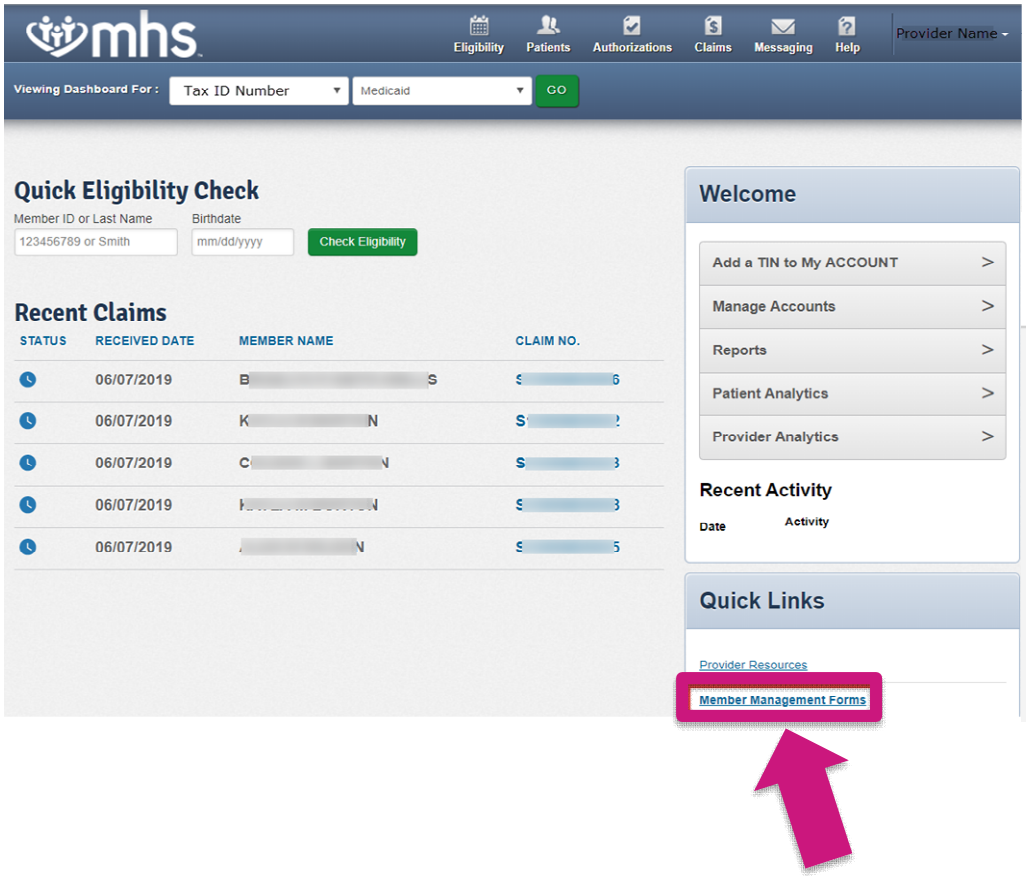
Go Paperless

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

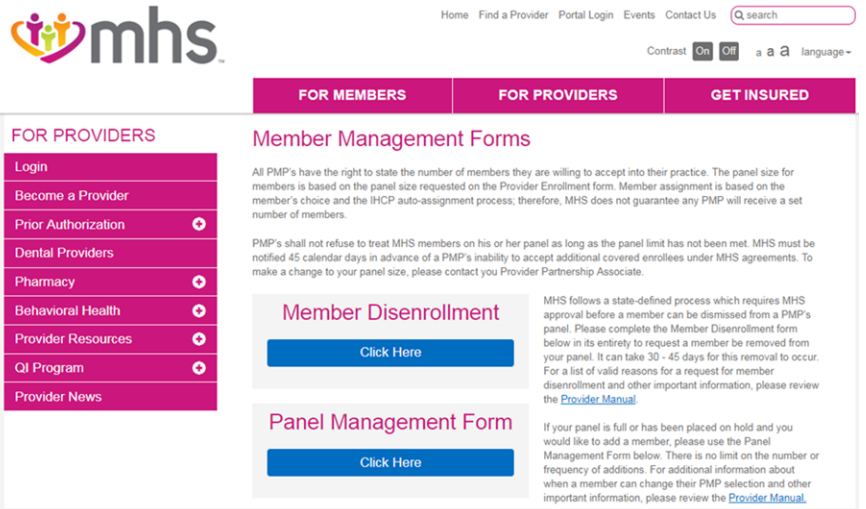
MHS Member Management Forms

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



Choose between:

- Member Disenrollment Form
- Panel Management Form

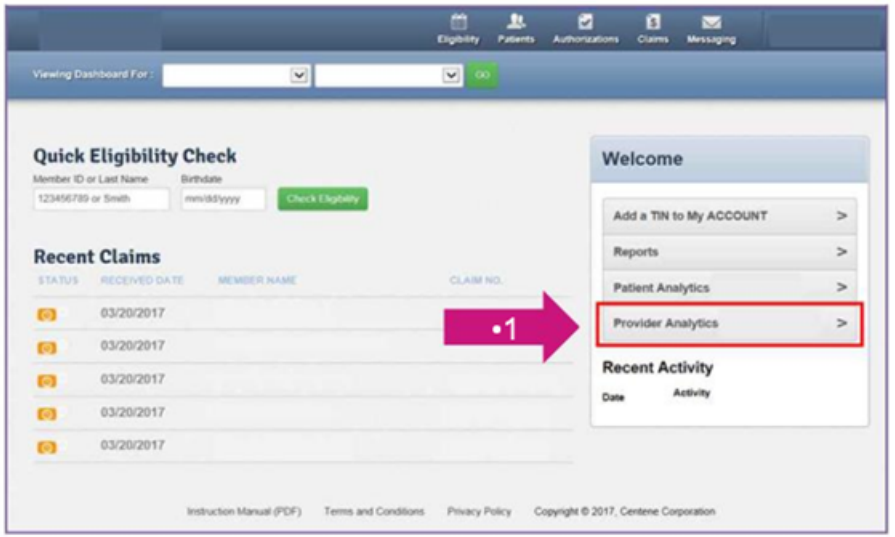


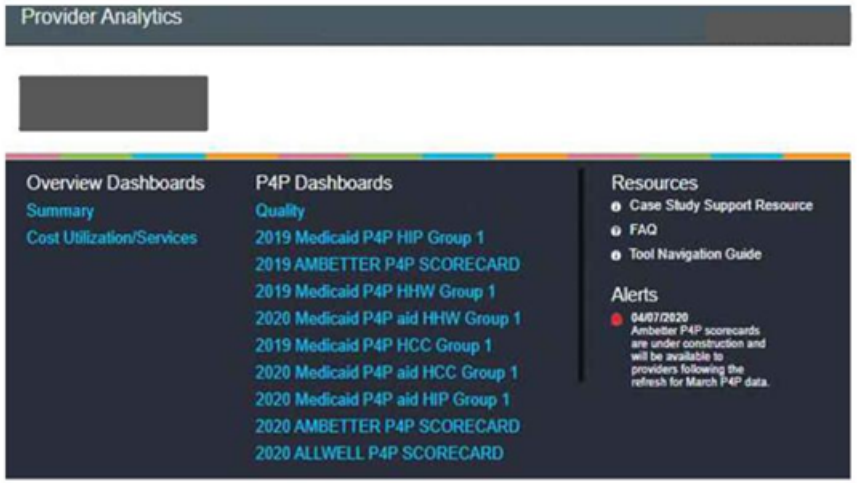
Quality Reports

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:

a. Cost/Utilization
b. Engagement Analysis
c. Quality
d. Readmission by Disease State

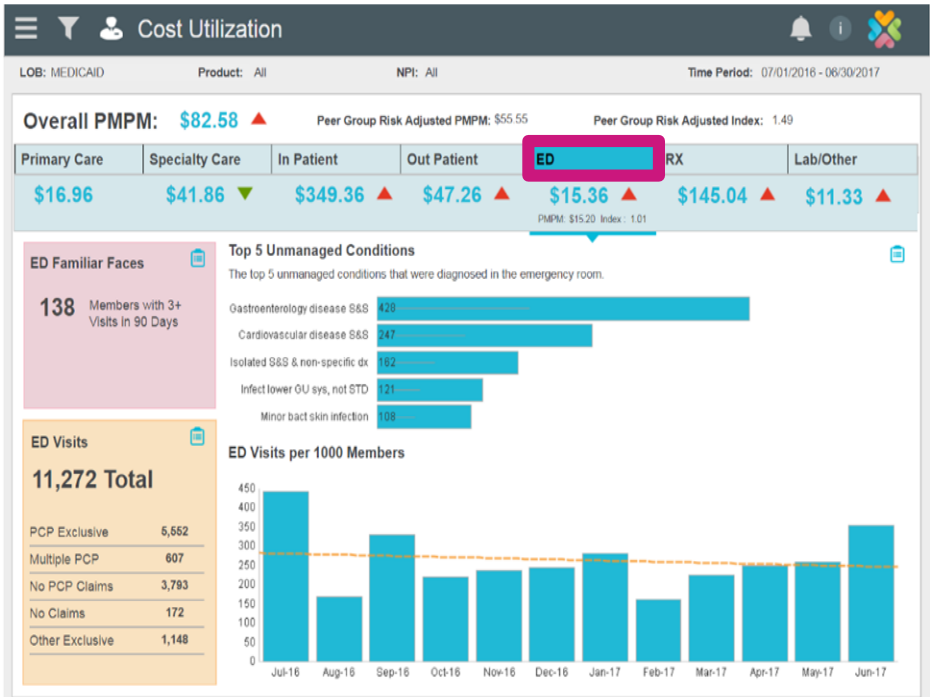
Dashboard View

- **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

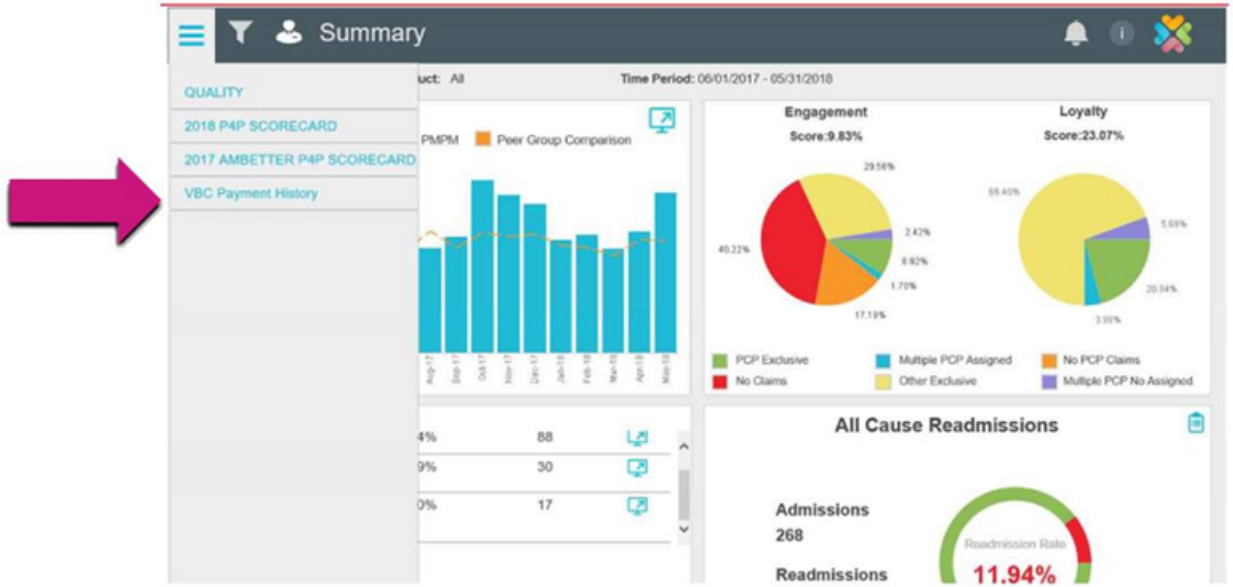
   b. Case Study Support Resource

   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

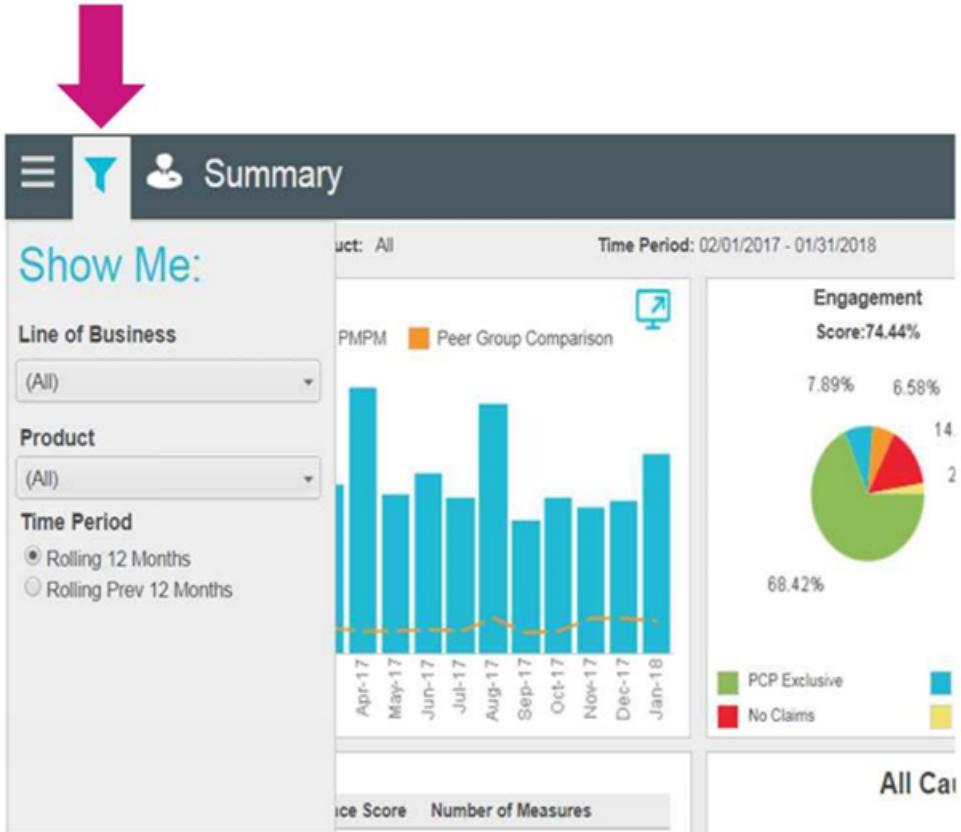
- Commercial
- Medicaid
- Medicare

Product

- Medicaid
- Marketplace
- Medicare

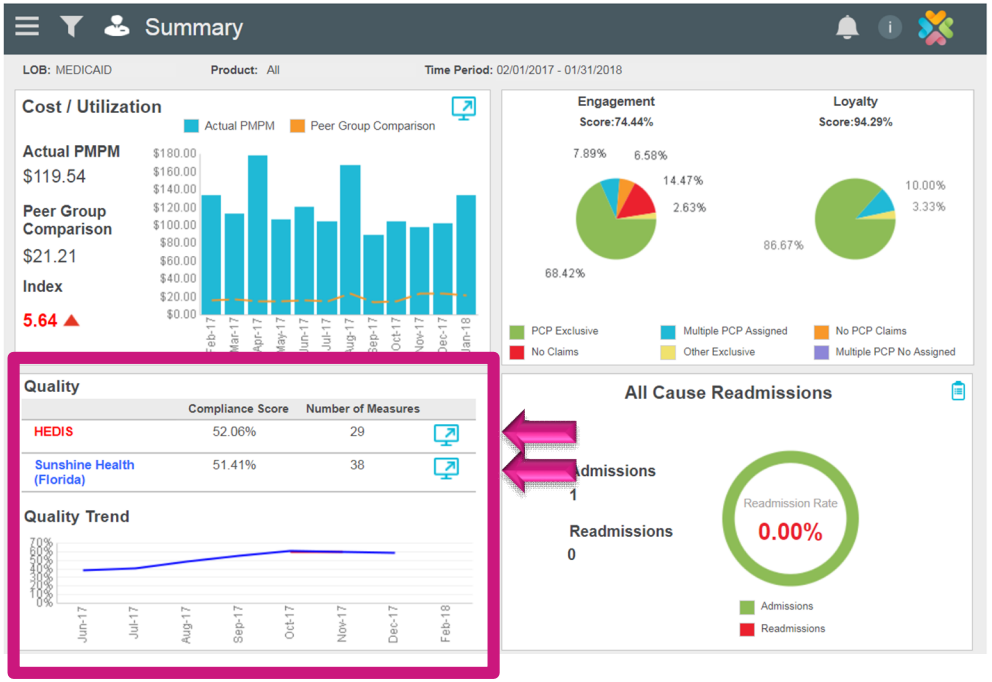
Time Period

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



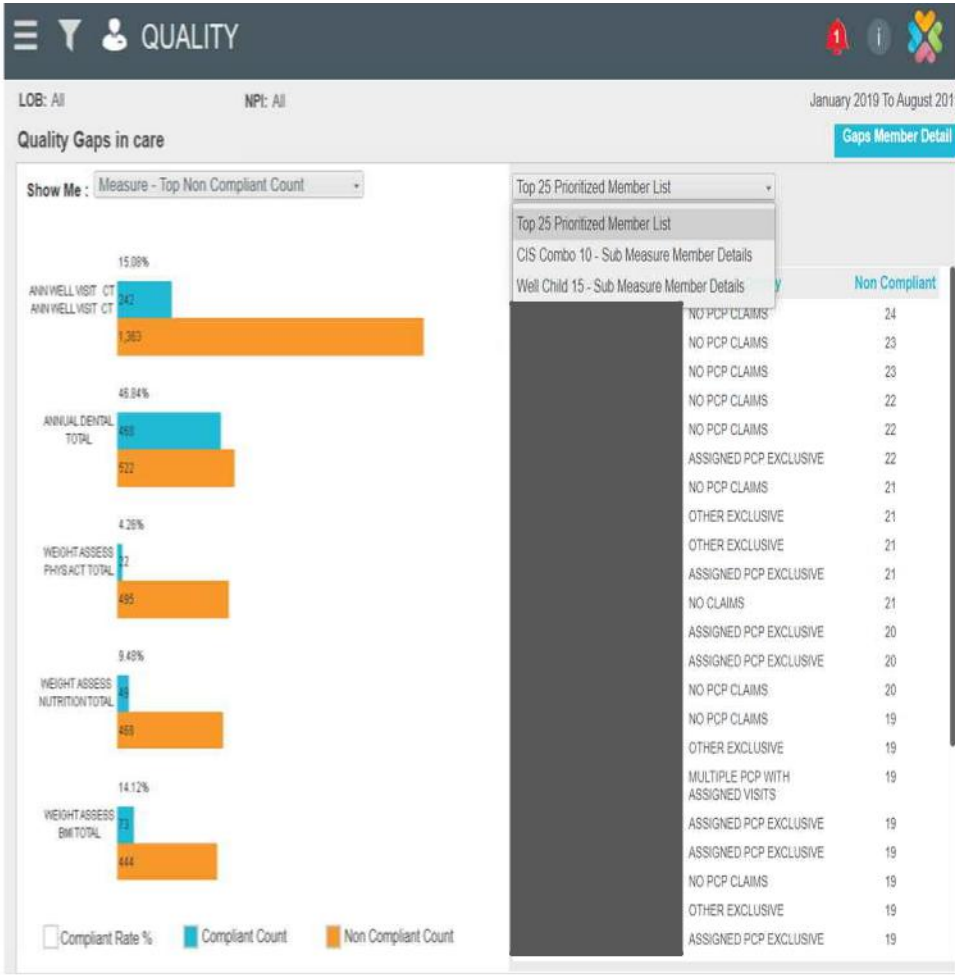
Quality HEDIS View

- 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.



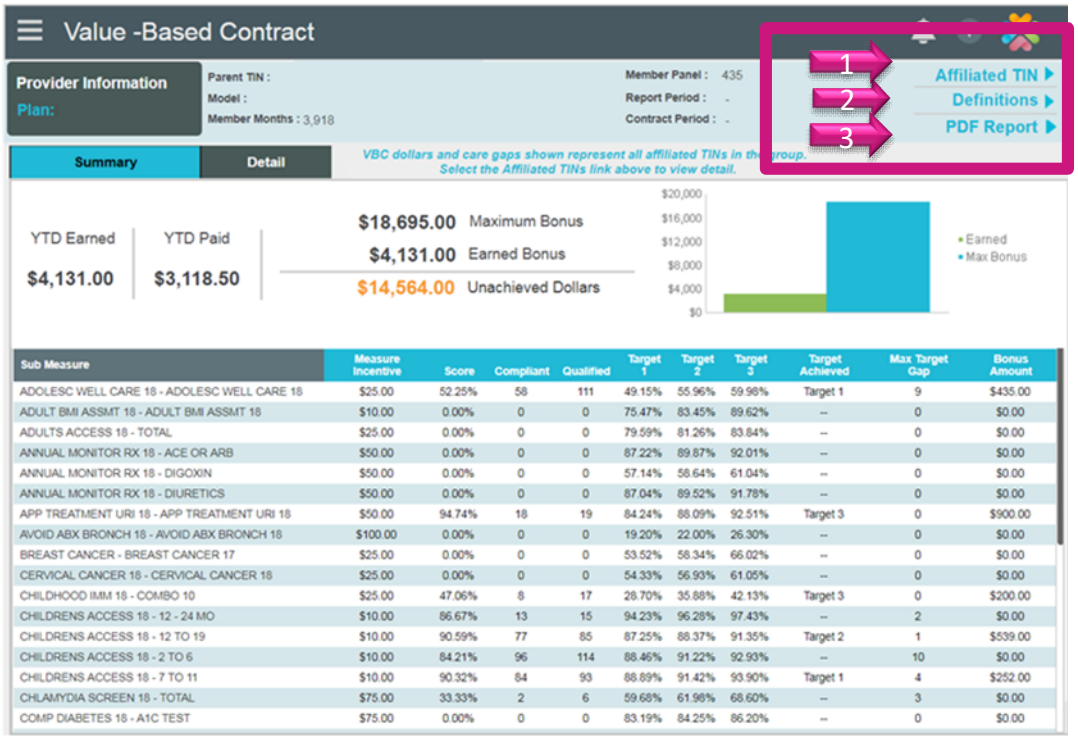
Quality HEDIS View: Gaps in Care

- 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.

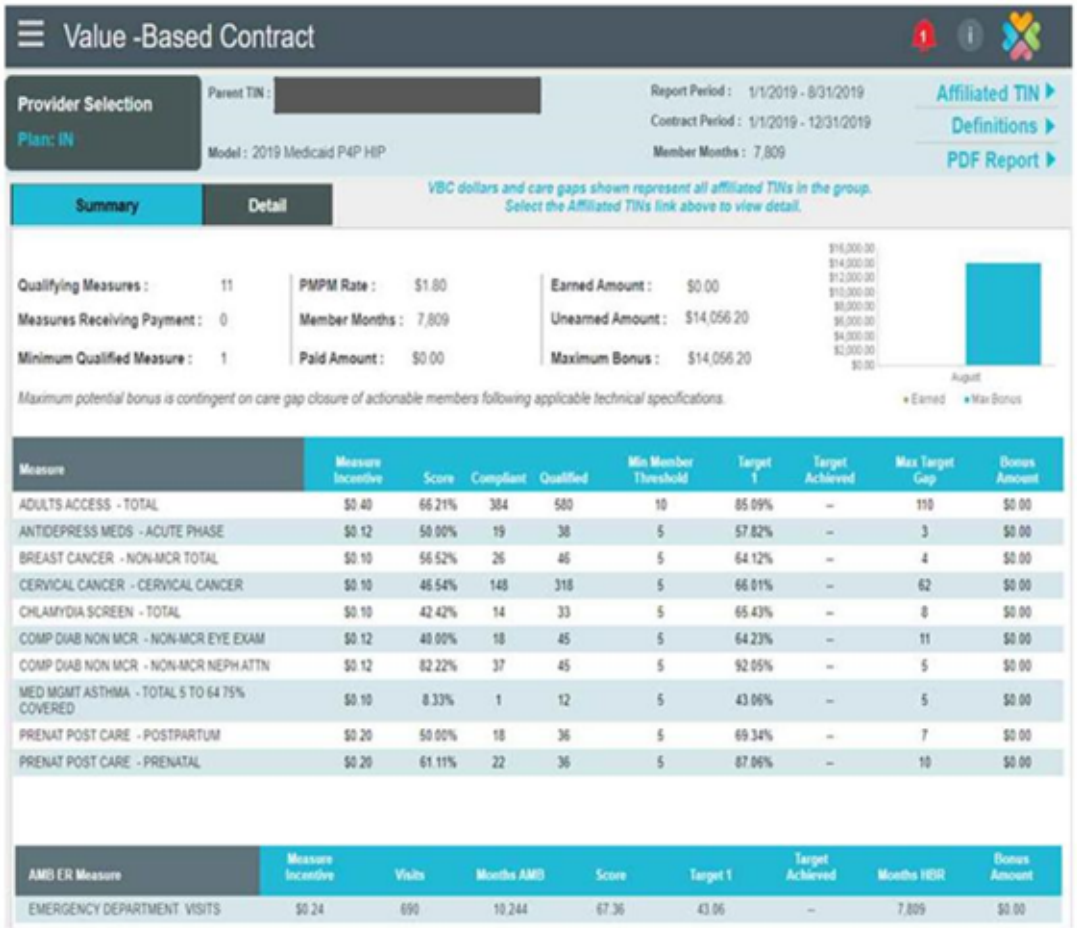


Sub Measure	Measure Incentive	Score	Compliant	Qualified	Target 1	Target 2	Target 3	Target Achieved	Max Target Gap	Bonus Amount
ADOLESC WELL CARE 18 - ADOLESC WELL CARE 18	$25.00	52.25%	58	111	49.15%	55.96%	59.98%	Target 1	9	$435.00
ADULT BMI ASSMT 18 - ADULT BMI ASSMT 18	$10.00	0.00%	0	0	75.47%	83.45%	89.62%	--	0	$0.00
ADULTS ACCESS 18 - TOTAL	$25.00	0.00%	0	0	79.59%	81.26%	83.84%	--	0	$0.00
ANNUAL MONITOR RX 18 - ACE OR ARB	$50.00	0.00%	0	0	87.22%	89.87%	92.01%	--	0	$0.00
ANNUAL MONITOR RX 18 - DIGOXIN	$50.00	0.00%	0	0	57.14%	58.64%	61.04%	--	0	$0.00
ANNUAL MONITOR RX 18 - DIURETICS	$50.00	0.00%	0	0	87.04%	89.52%	91.78%	--	0	$0.00
APP TREATMENT URI 18 - APP TREATMENT URI 18	$50.00	94.74%	18	19	84.24%	88.09%	92.51%	Target 3	0	$900.00
AVOID ABX BRONCH 18 - AVOID ABX BRONCH 18	$100.00	0.00%	0	0	19.20%	22.00%	26.30%	--	0	$0.00
BREAST CANCER - BREAST CANCER 17	$25.00	0.00%	0	0	53.52%	58.34%	66.02%	--	0	$0.00
CERVICAL CANCER 18 - CERVICAL CANCER 18	$25.00	0.00%	0	0	54.33%	56.93%	61.05%	--	0	$0.00
CHILDHOOD IMM 18 - COMBO 10	$25.00	47.06%	8	17	28.70%	35.68%	42.13%	Target 3	0	$200.00
CHILDRENS ACCESS 18 - 12 - 24 MO	$10.00	86.67%	13	15	94.23%	96.28%	97.43%	--	2	$0.00
CHILDRENS ACCESS 18 - 12 TO 19	$10.00	90.59%	77	85	87.25%	88.37%	91.35%	Target 2	1	$539.00
CHILDRENS ACCESS 18 - 2 TO 6	$10.00	84.21%	96	114	88.46%	91.22%	92.93%	--	10	$0.00
CHILDRENS ACCESS 18 - 7 TO 11	$10.00	90.32%	84	93	88.89%	91.42%	93.90%	Target 1	4	$252.00
CHLAMYDIA SCREEN 18 - TOTAL	$75.00	33.33%	2	6	59.68%	61.98%	68.60%	--	3	$0.00
COMP DIABETES 18 - A1C TEST	$75.00	0.00%	0	0	83.19%	84.25%	86.20%	--	0	$0.00

Quality HEDIS: Scorecards

You can also view:

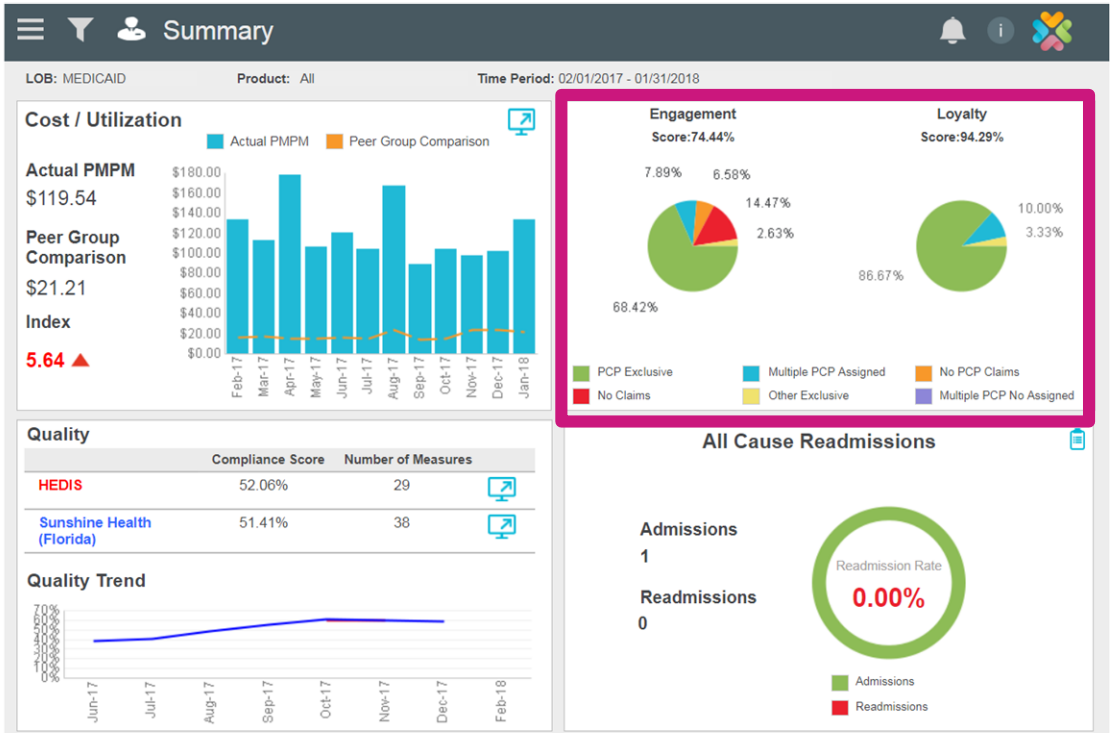
- Compliant Score.
- Compliant and Qualified number per Sub Measure.
- Target levels for compliant percentage needed to earn a payout.
- Target level achieved.
- Number of gaps needed to close to reach Maximum Target Level.
- Bonus Amount earned.



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
PCP Exclusive	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.
Multiple PCP Assigned	These patients are assigned to you, but have been seen by your practice ***AND*** other PMP groups.	Initiate a patient outreach plan, set an appointment if appropriate, close care gaps, discuss benefits of PMP loyalty.
No PCP Claims	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.
Other Exclusive	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.
No Claims	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.
Multiple PCP No Assigned	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.

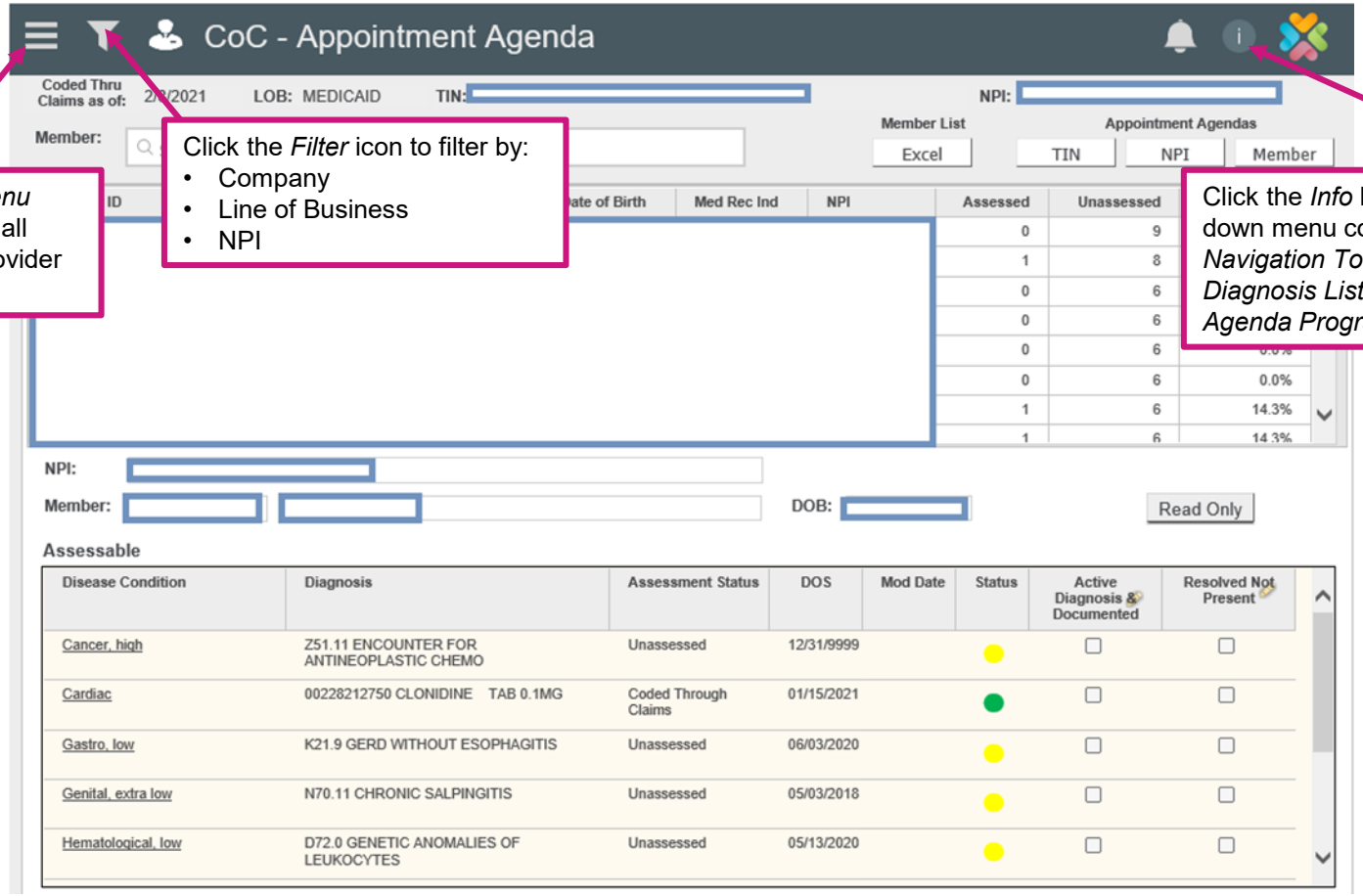
Who is Included in the CoC Program?

- 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



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

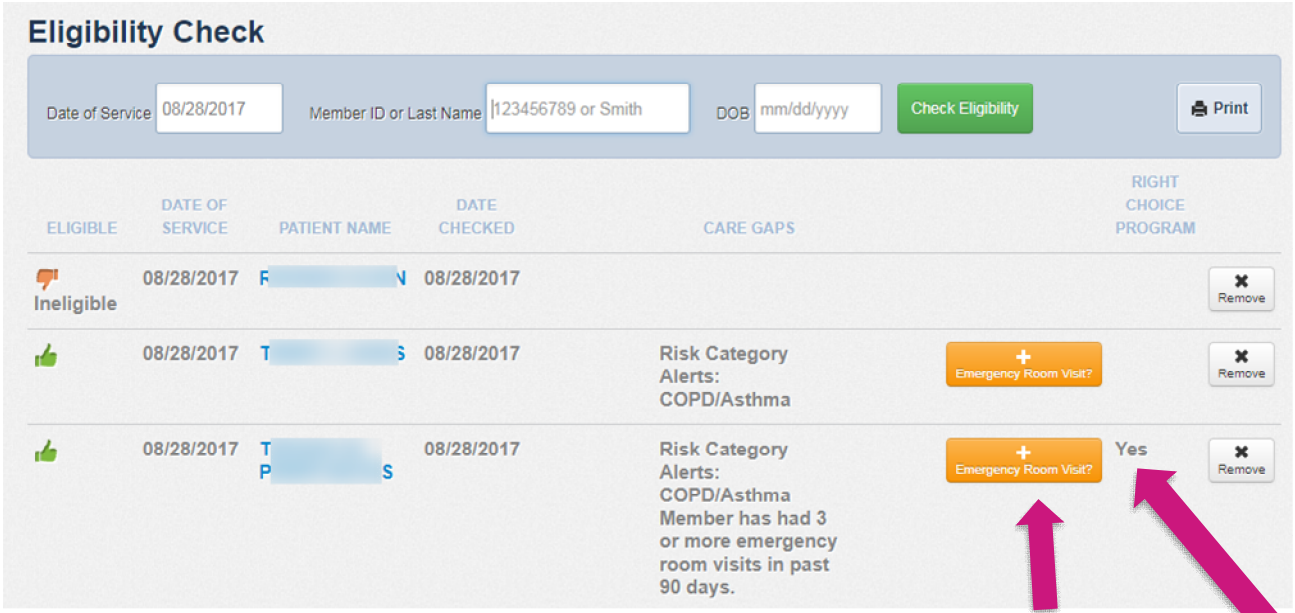
Click the *Filter* icon to filter by:
- Company
- Line of Business
- NPI

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.

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

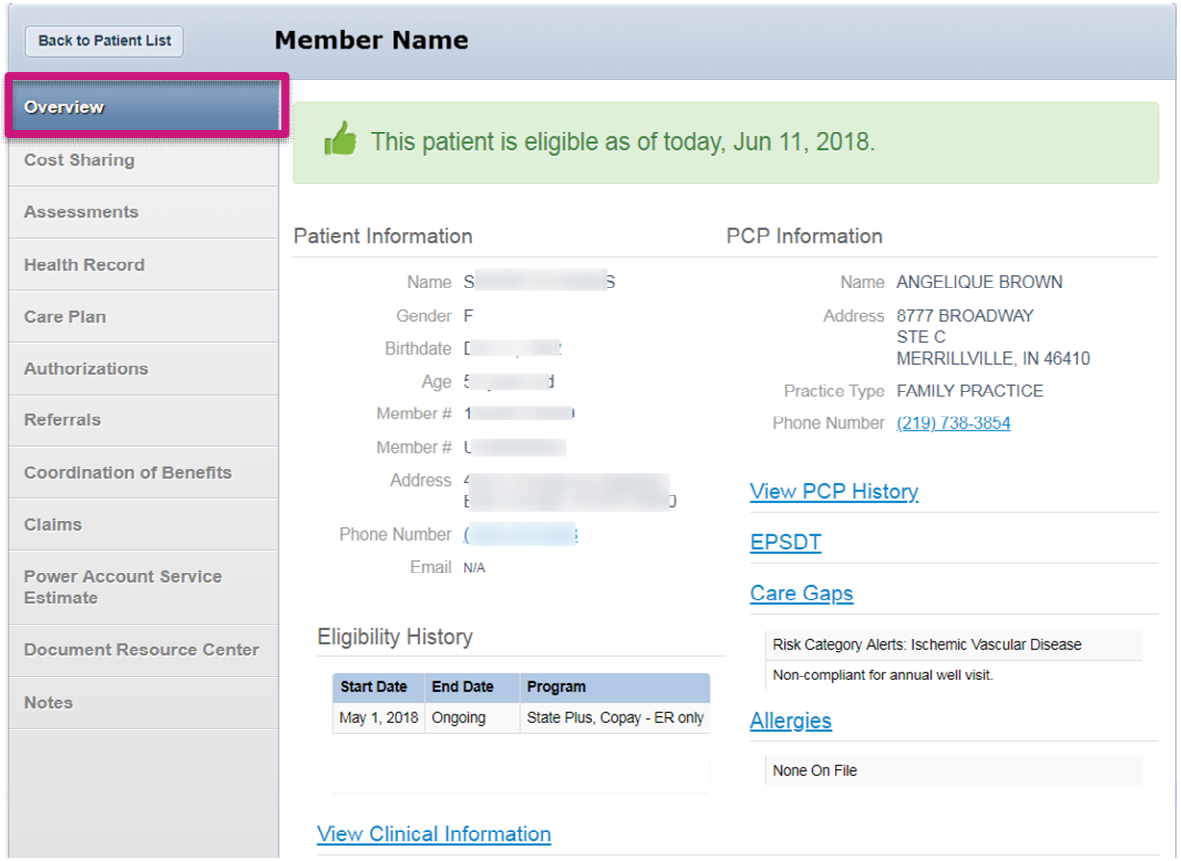
Details for any member can be viewed by clicking on the **Member's Name**.

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

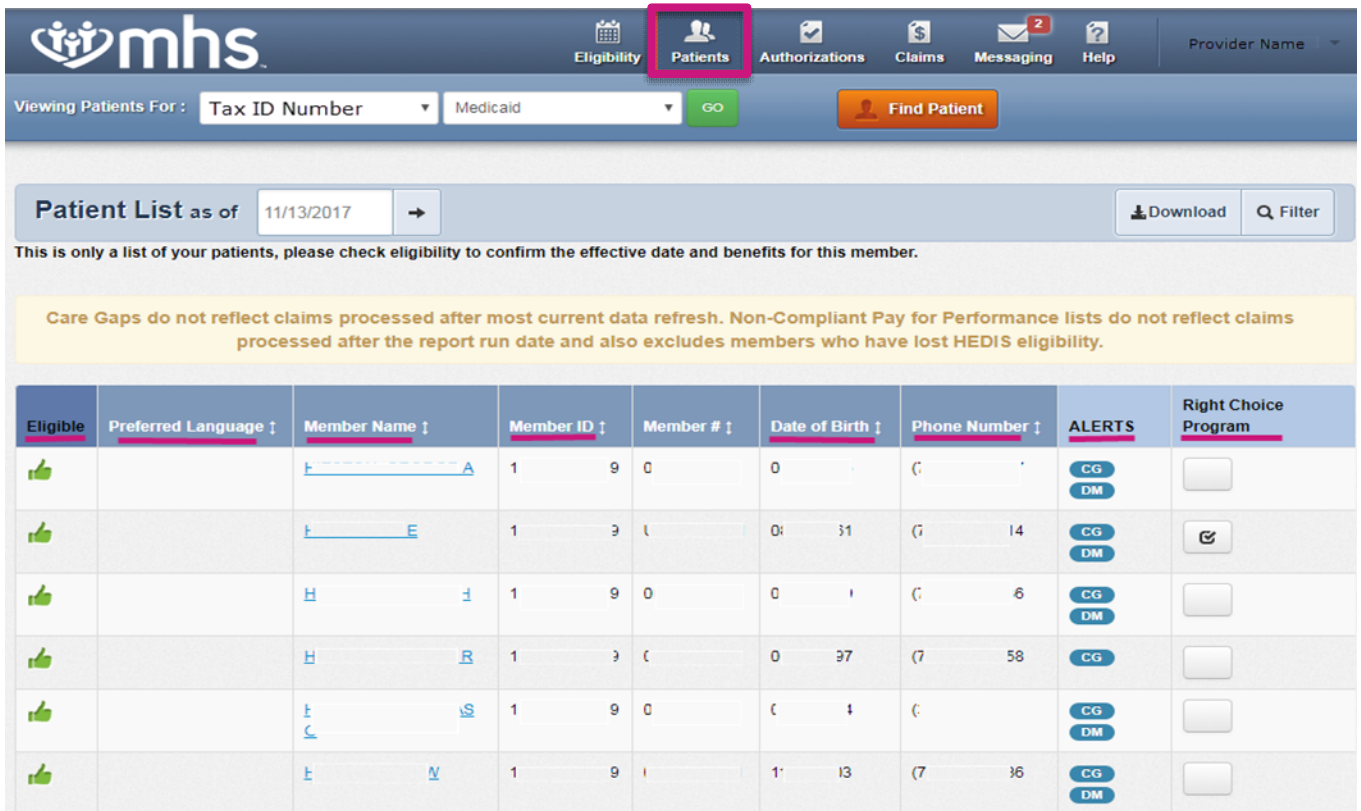


Overview Tab

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

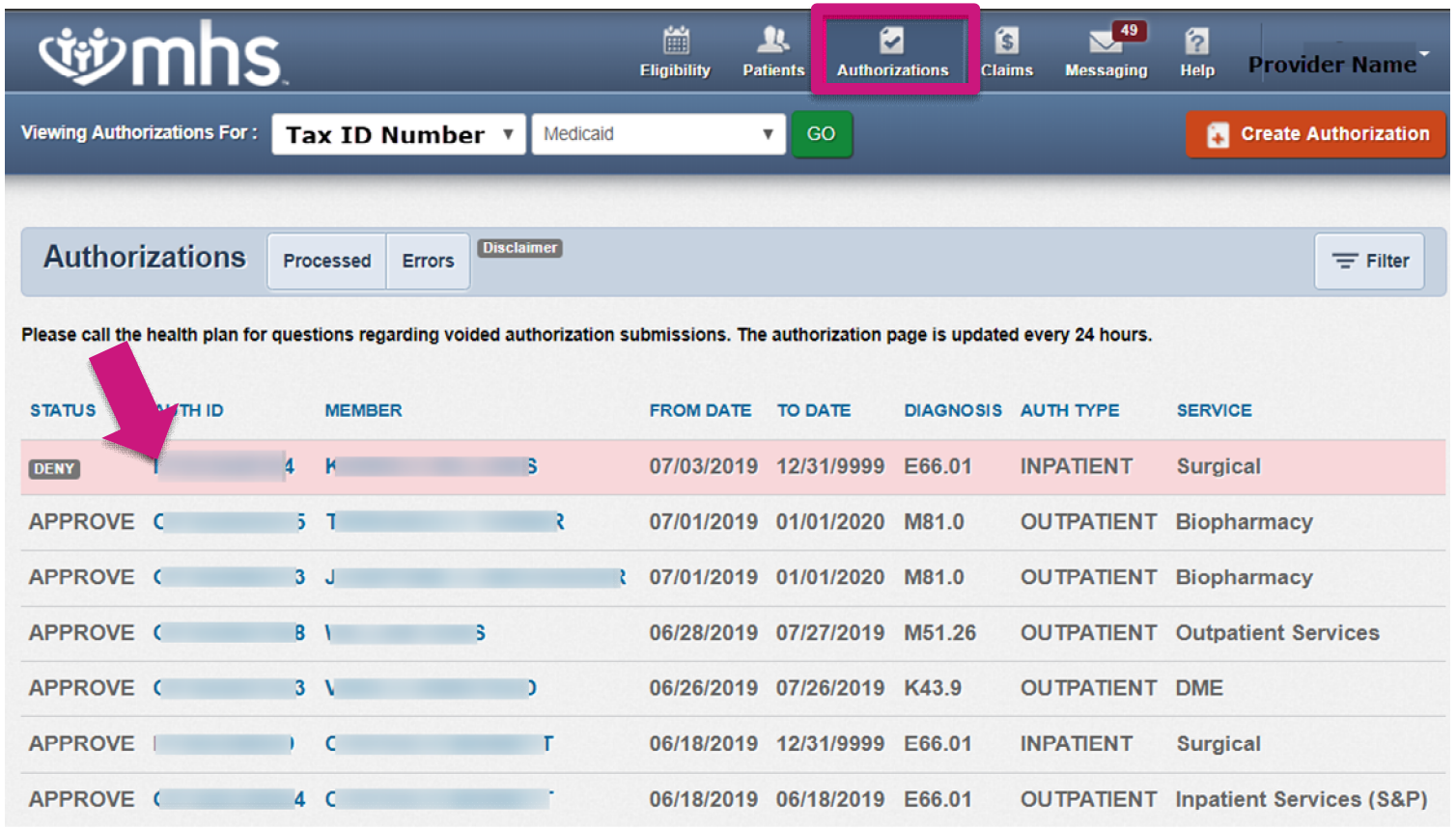
- Click **Patients** tab at the top of the screen.
- The patient list appears displaying **Eligibility Status**, **Preferred Language**, **Member Name**, **Medicaid ID**, **DOB**, **Phone Number**, **Alerts** and **Right Choice Program.**
- To download the patient list to Excel, click **Download**. This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



Authorizations

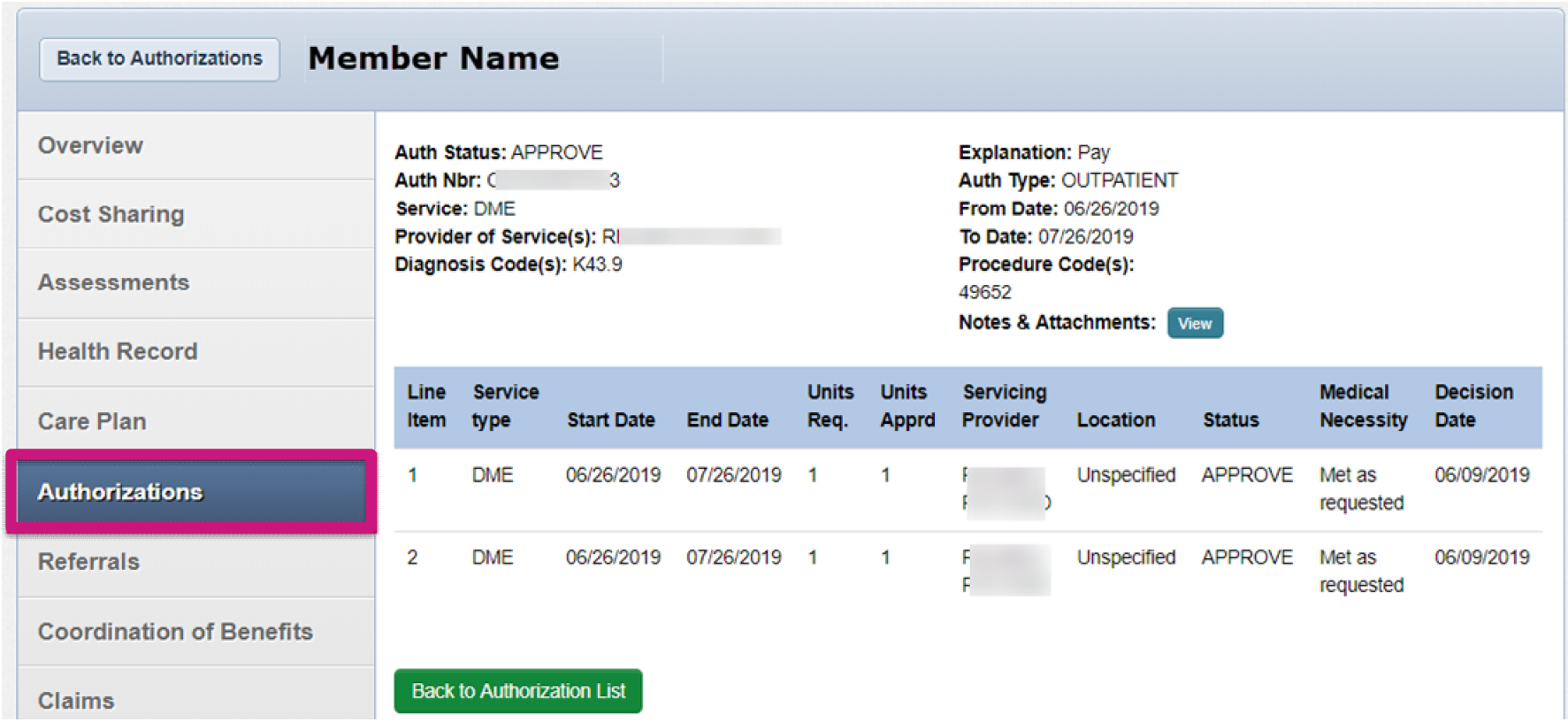
Authorizations

- View, create and filter group authorizations.
  - Click on the **AUTH ID** to see additional information.



Authorization Details

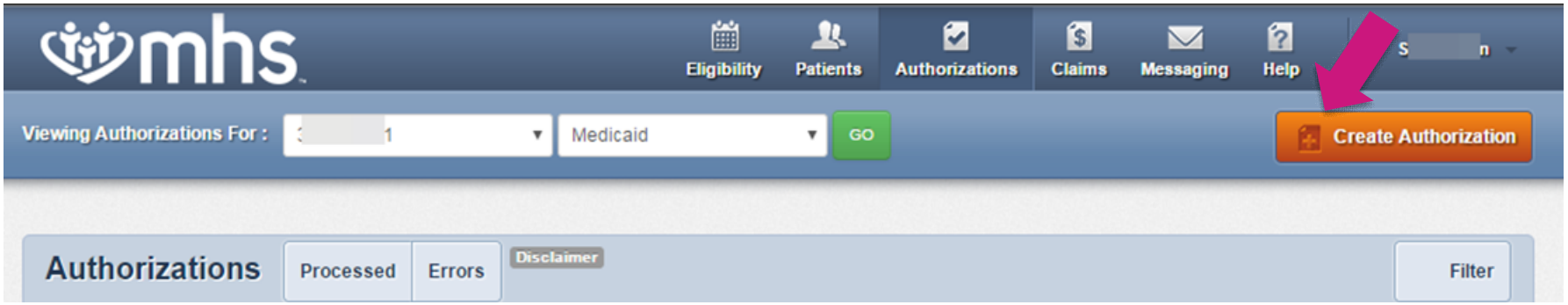
- View Auth Status, Auth Number, Service, Provider of Service(s), Diagnosis Code(s), Explanation, Auth Type, From Date, To Date, Procedure Code and Notes & Attachments.

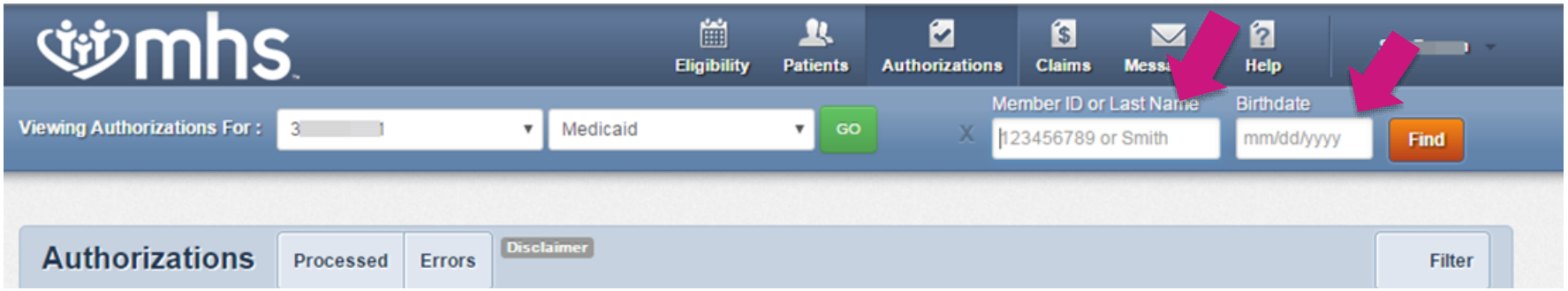


Create a New Authorization

New Authorization

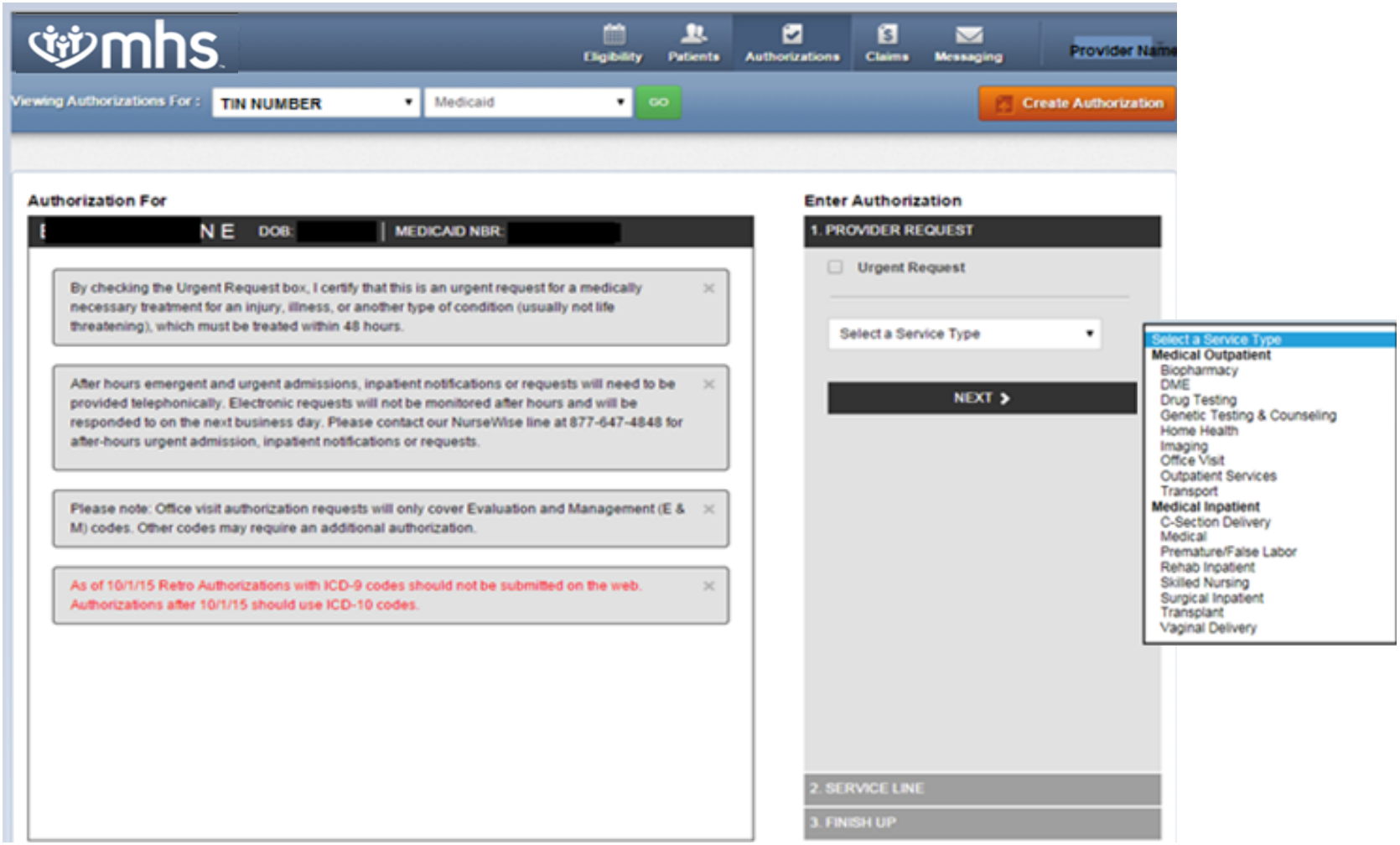
- Click **Create Authorization.**
- Enter **Member ID** or **Last Name** and **Birthdate.**





Creating a New Authorization

- Select a **Service Type.**



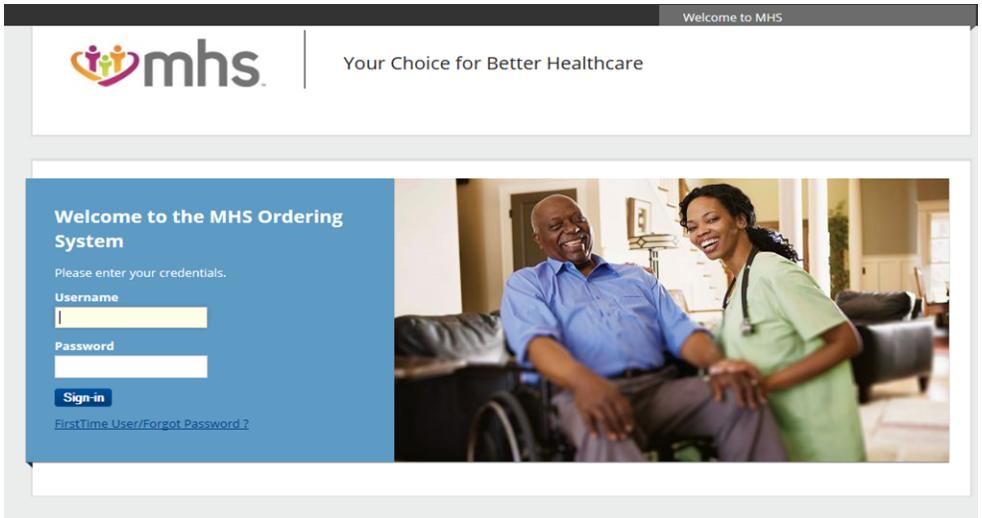
Inpatient Prior Authorization

- 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.

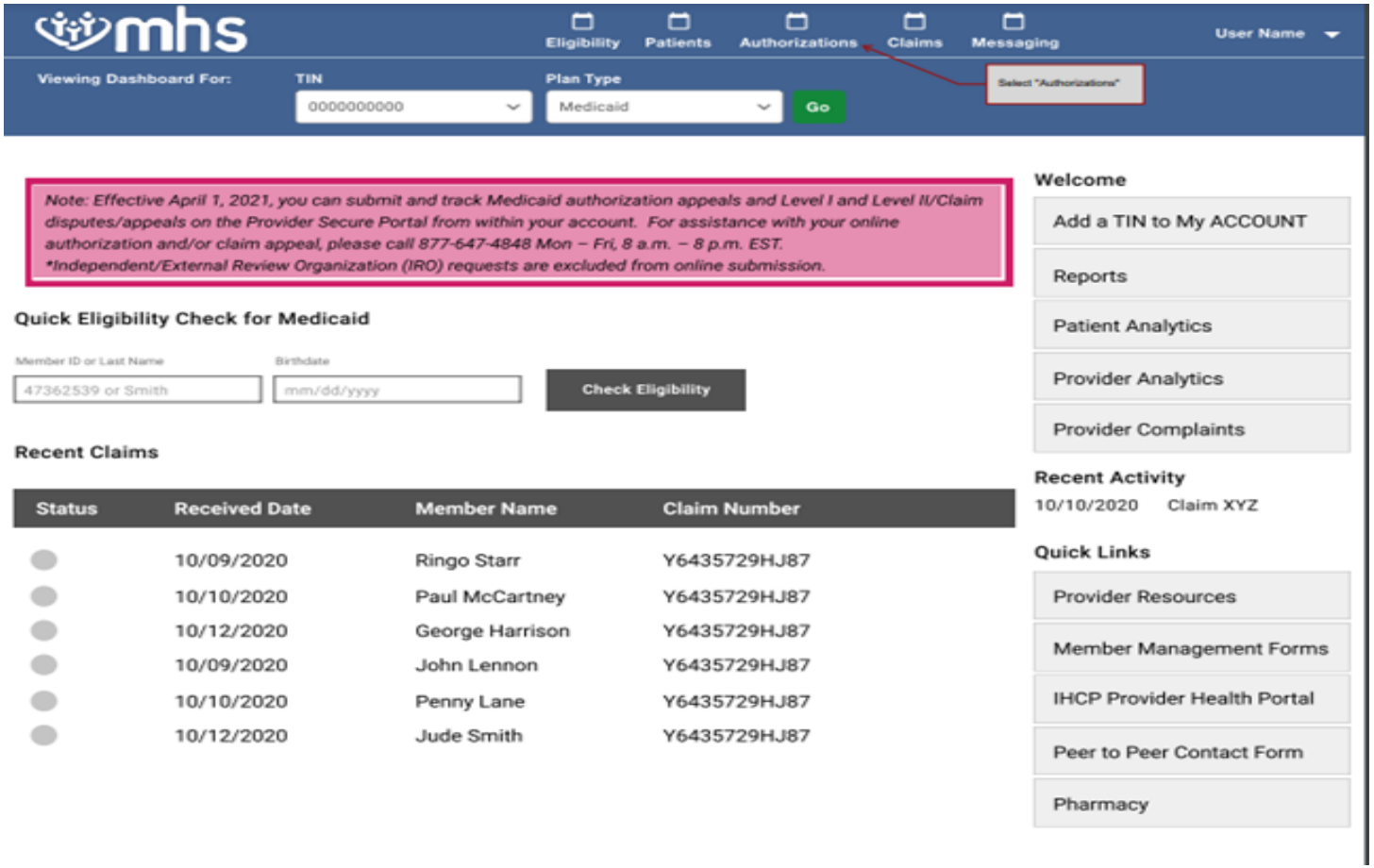
Authorization for Durable & Home Medical Equipment

- 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.

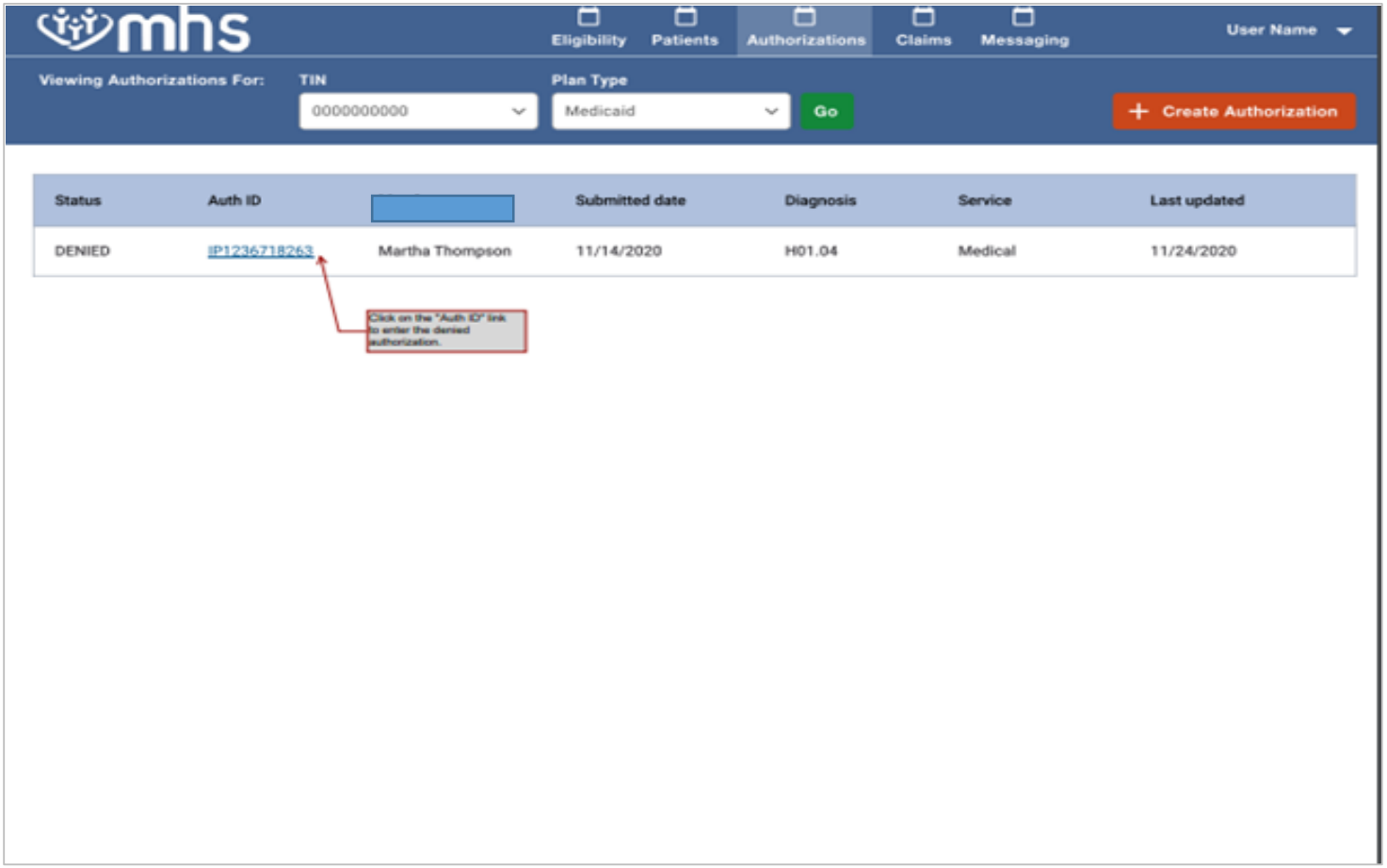


Prior Authorization/Medical Necessity Appeals

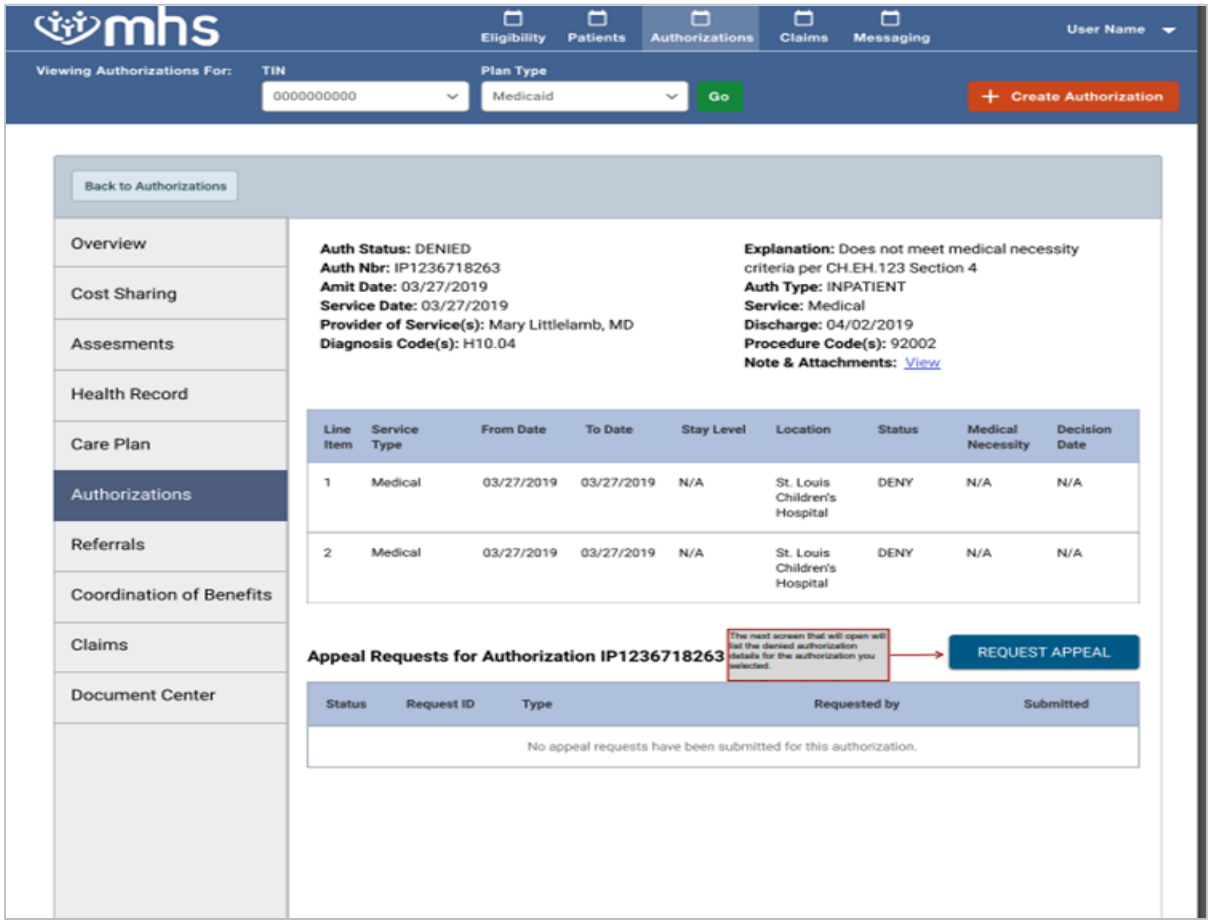
Prior Authorization/Medical Necessity Appeals



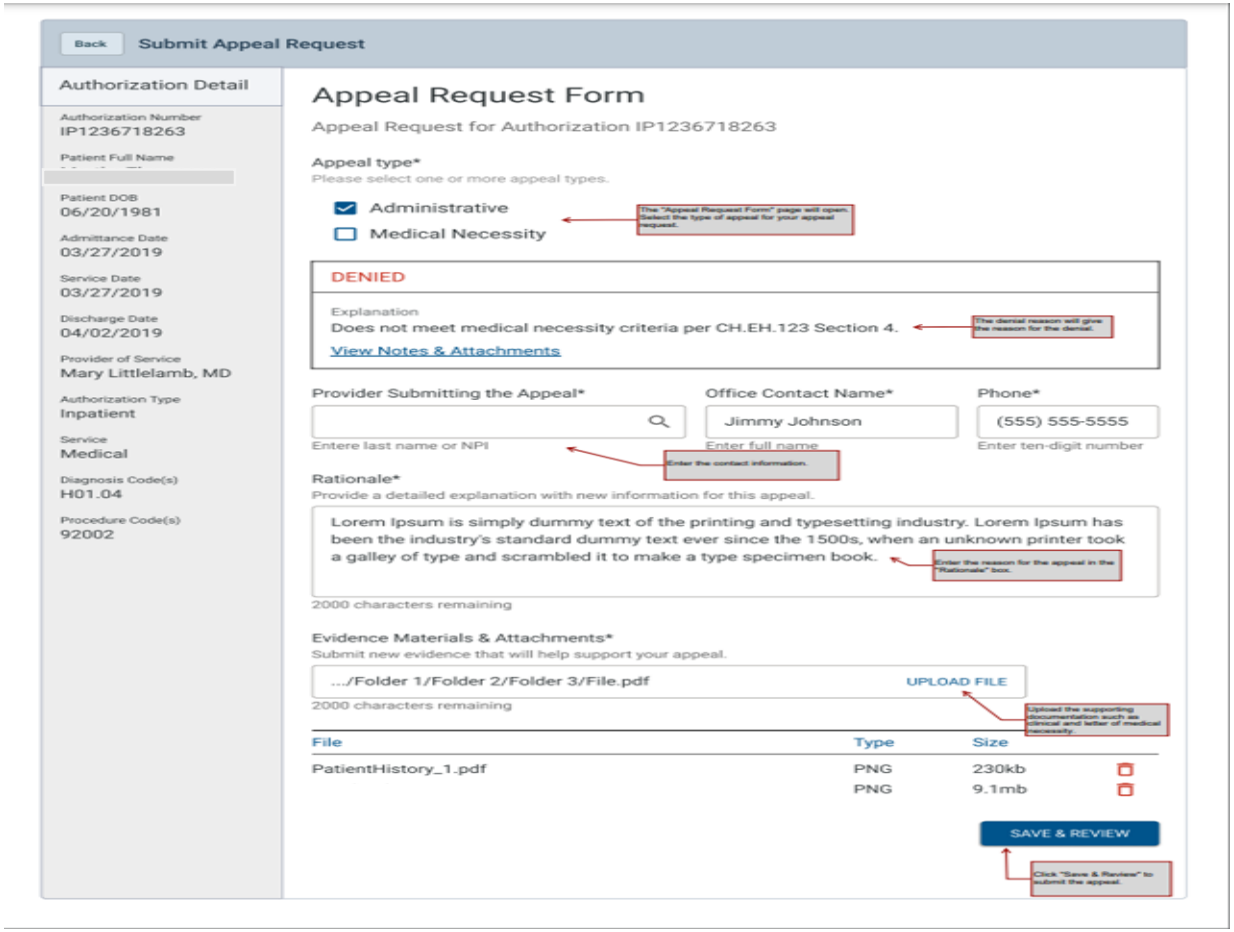
Prior Authorization/Medical Necessity Appeals



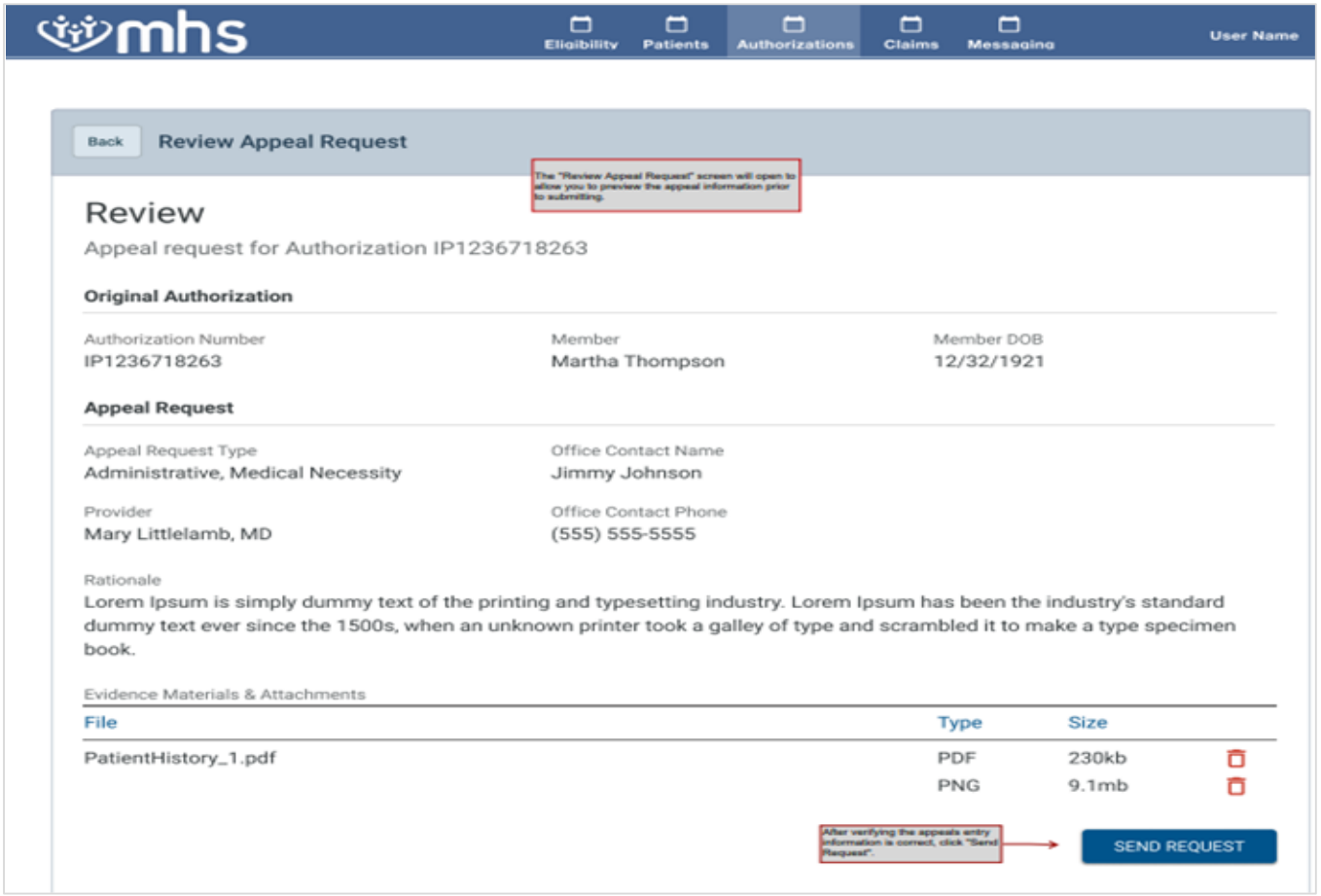
Prior Authorization/Medical Necessity Appeals



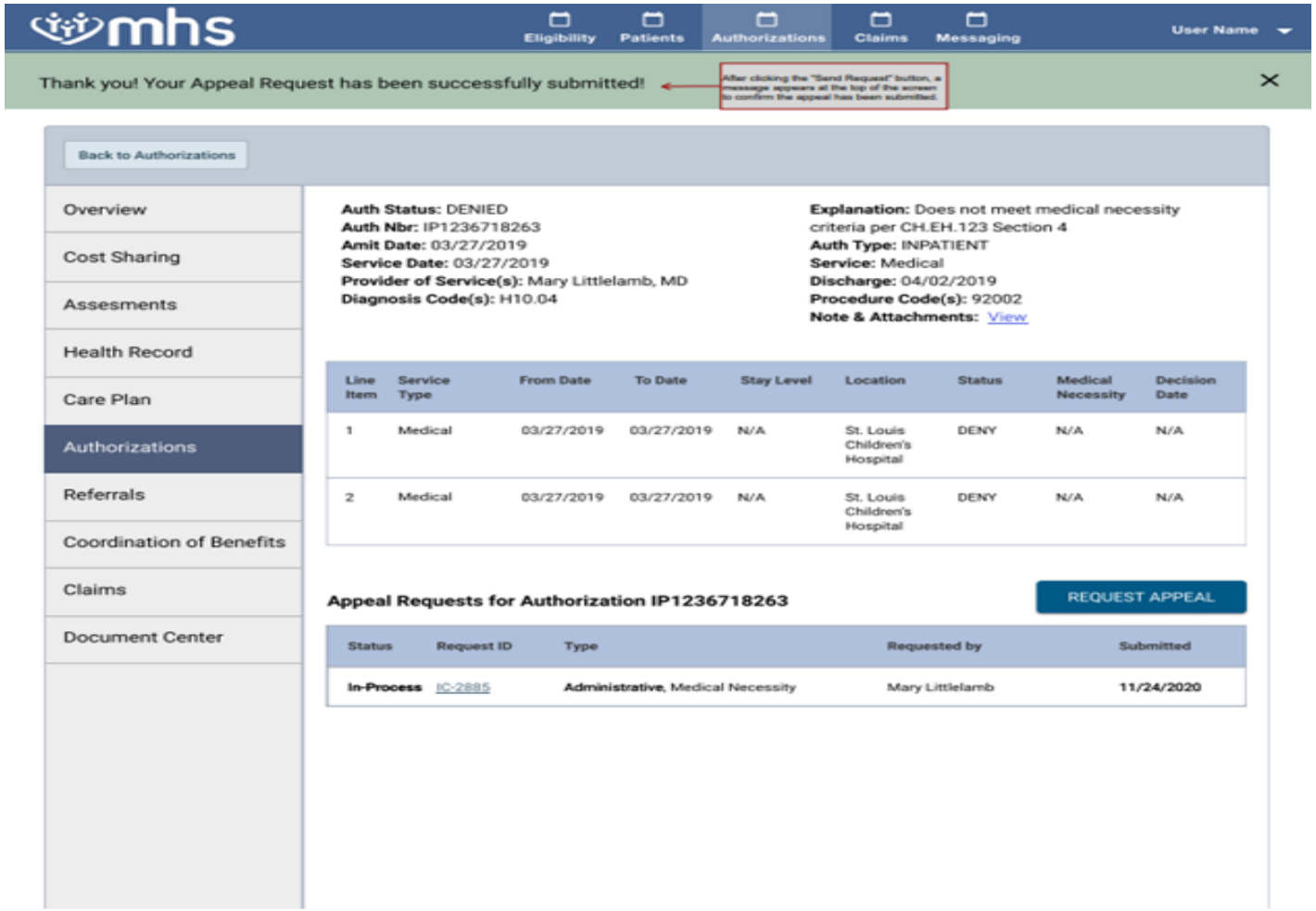
Prior Authorization/Medical Necessity Appeals on the Provider Secure Portal



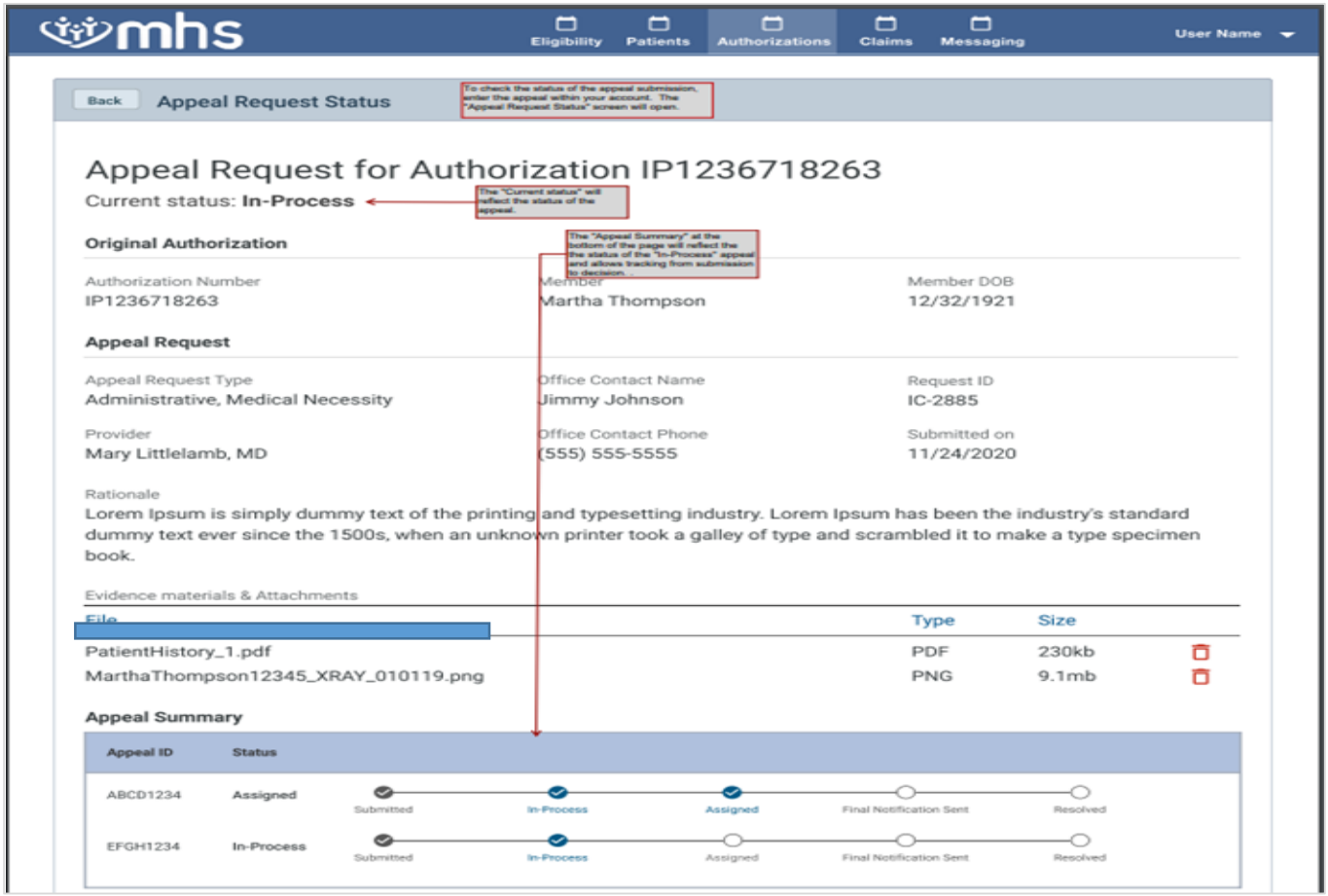
Prior Authorization/Medical Necessity Appeals



Prior Authorization/Medical Necessity Appeals



Prior Authorization/Medical Necessity Appeals



Claims

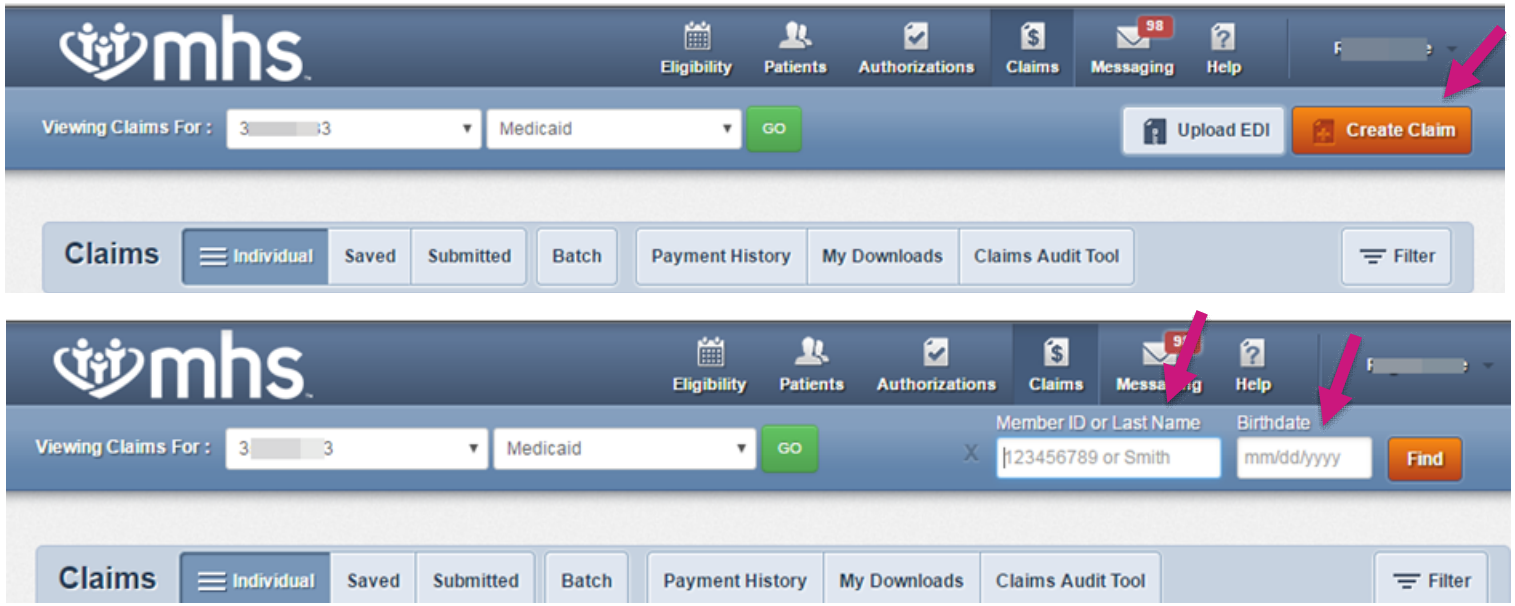
Claims

Claims Features:

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

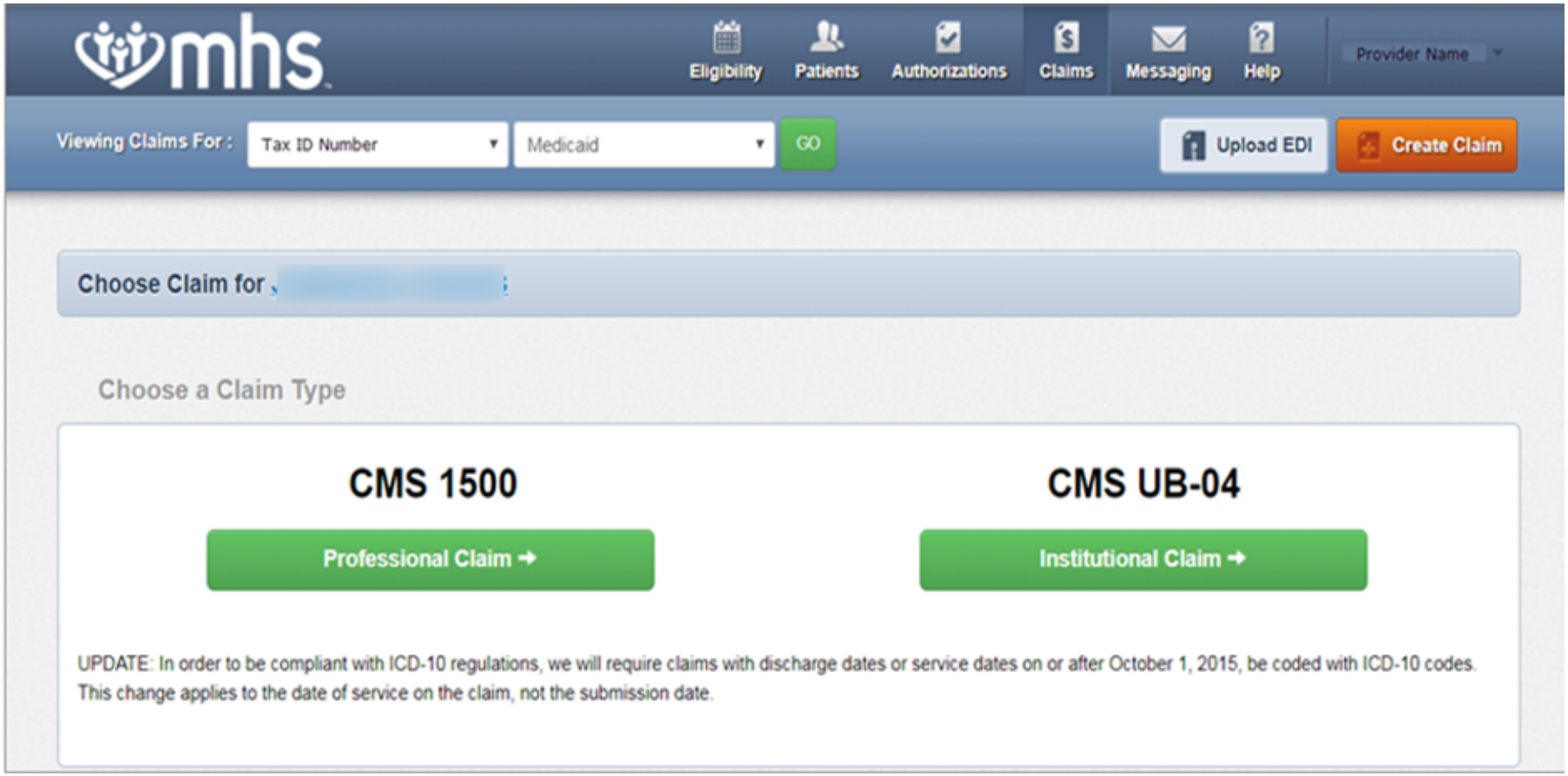
Submit a New Claim:

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



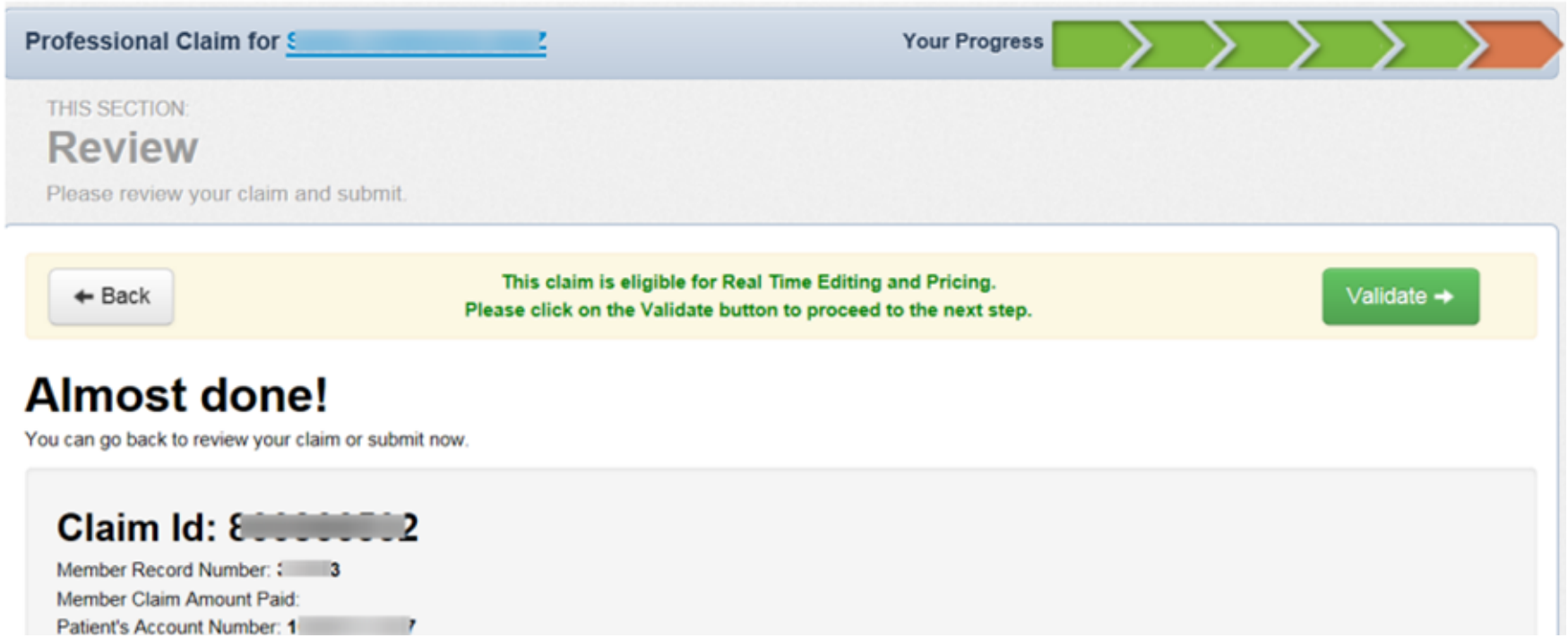
Claim Submission

- Choose the **Claim Type.**



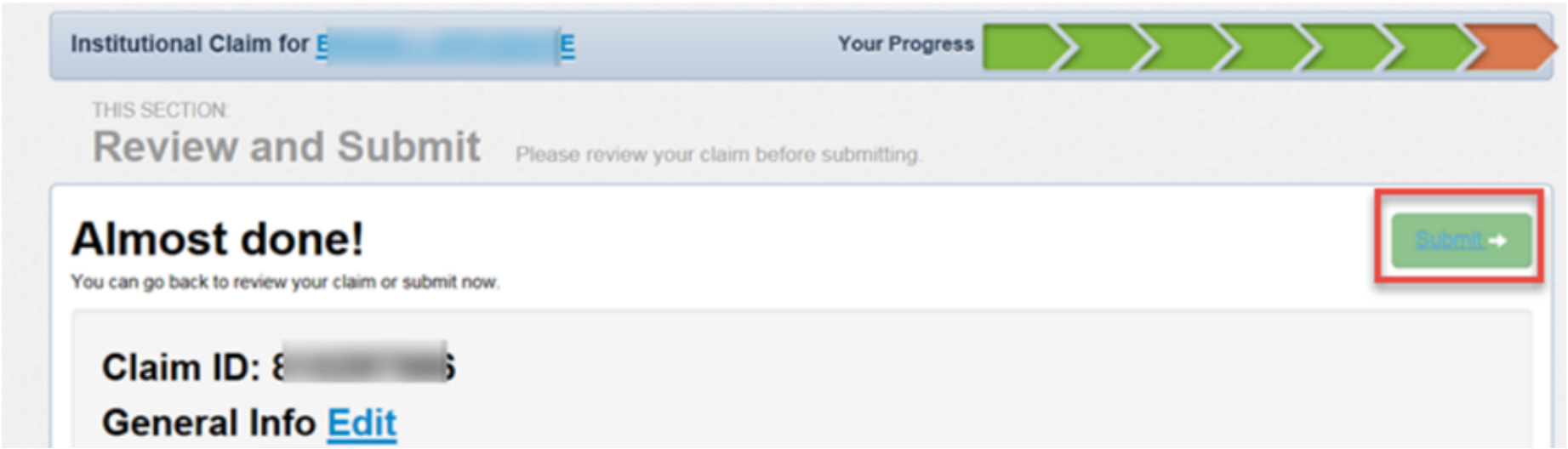
Professional Claim Submission

Follow **Your Progress** to see Professional Claim steps and submission.



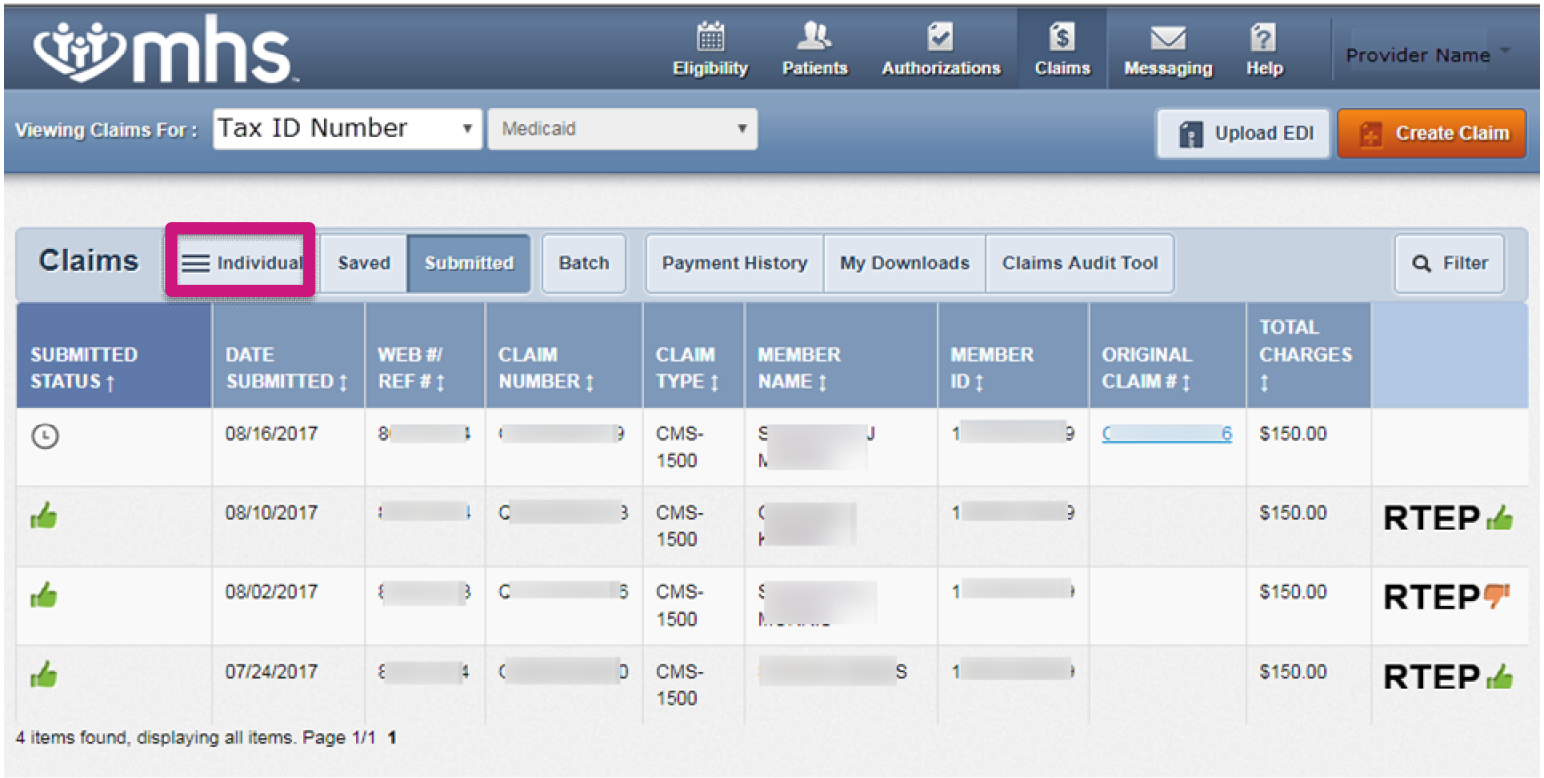
Institutional Claim Submission

- Follow **Your Progress** to see Institutional Claim steps and submission.



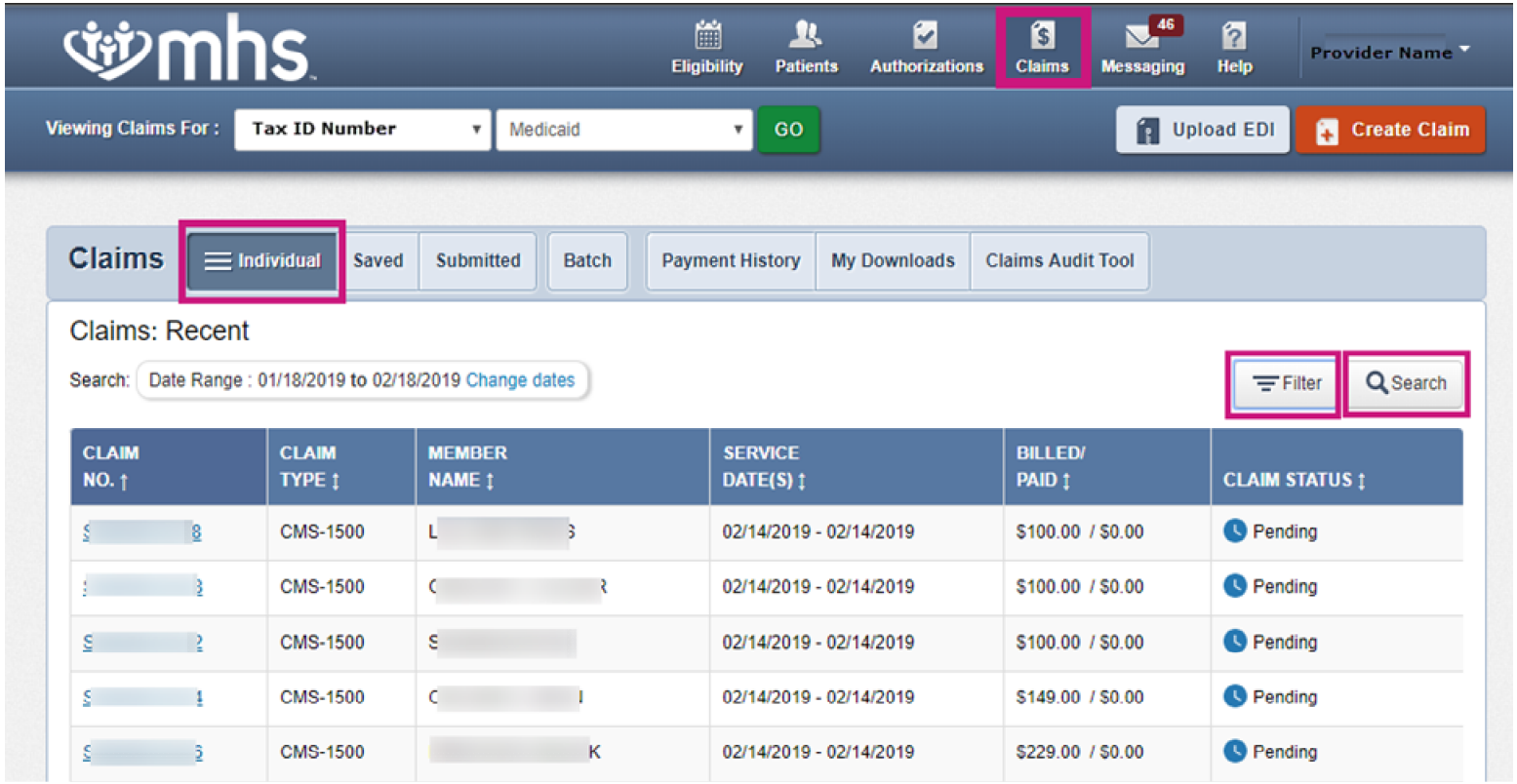
Submitted Claims

- 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.)



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.



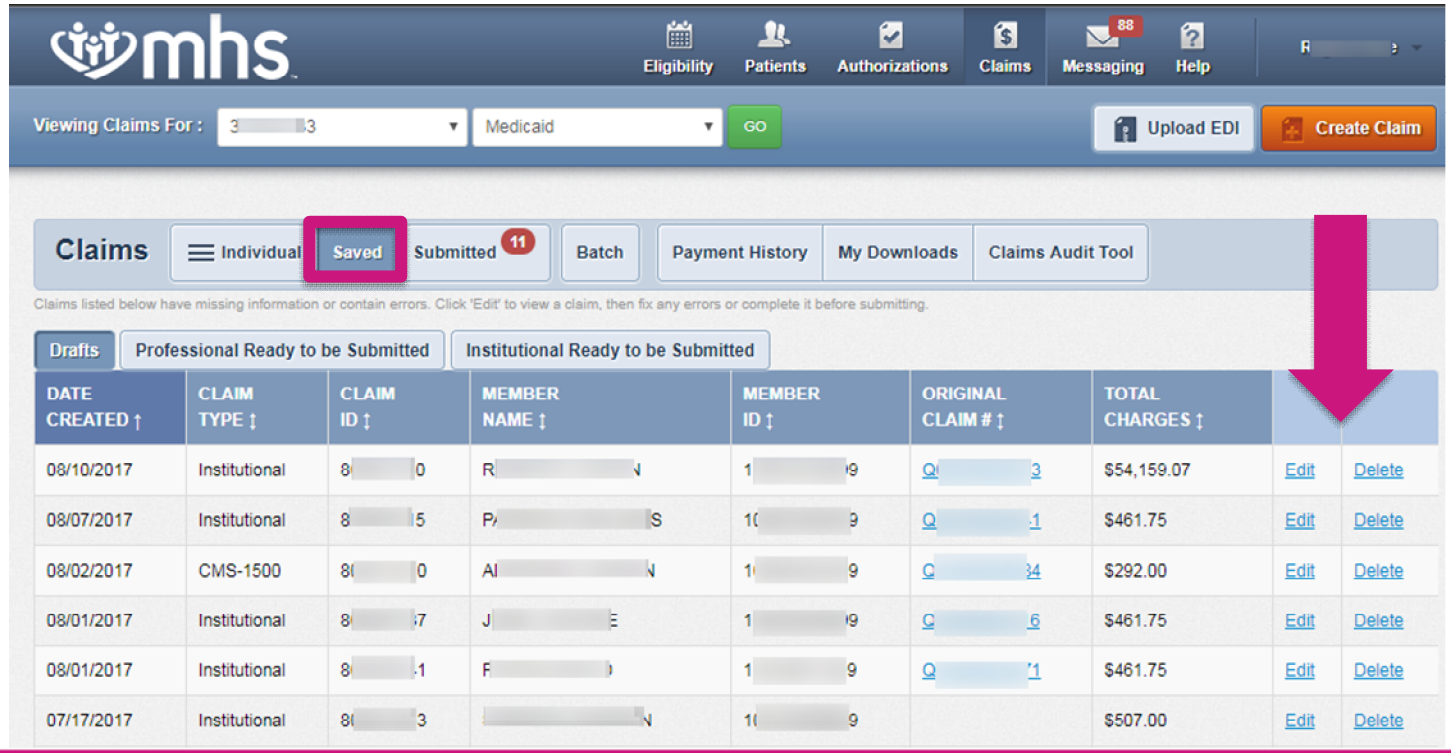
Saved Claims

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

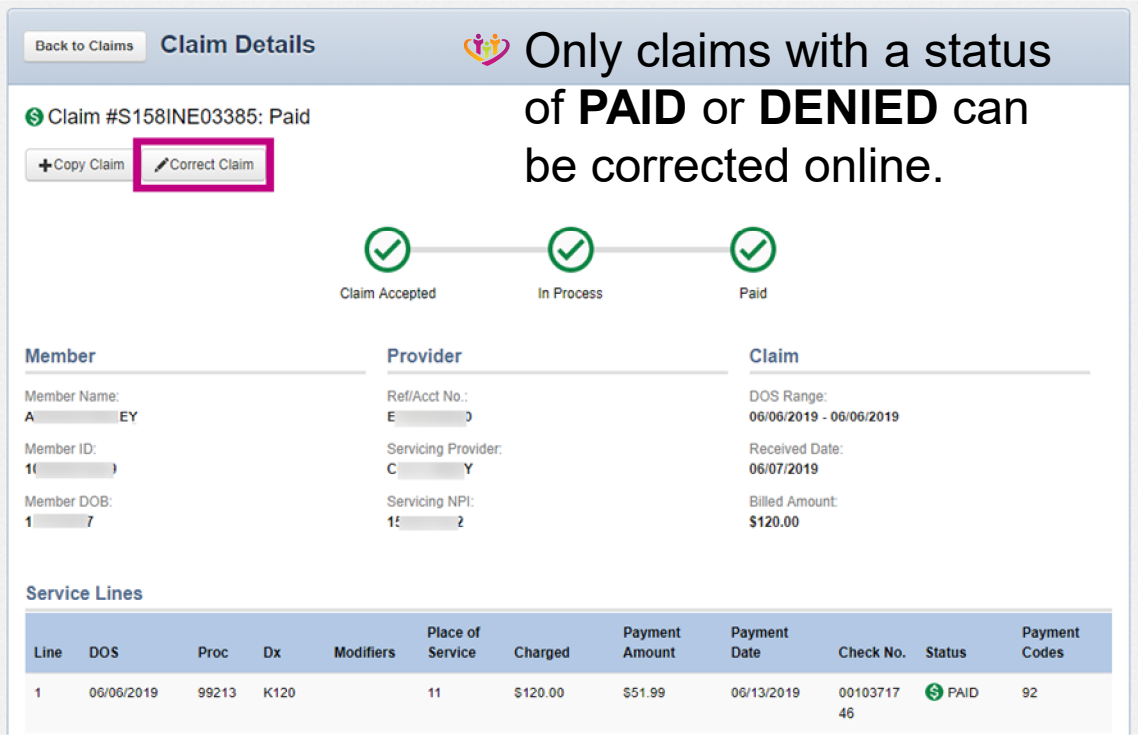
4. Click **Delete** to delete saved claim that is no longer necessary.
5. Click **OK** to confirm.



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.**

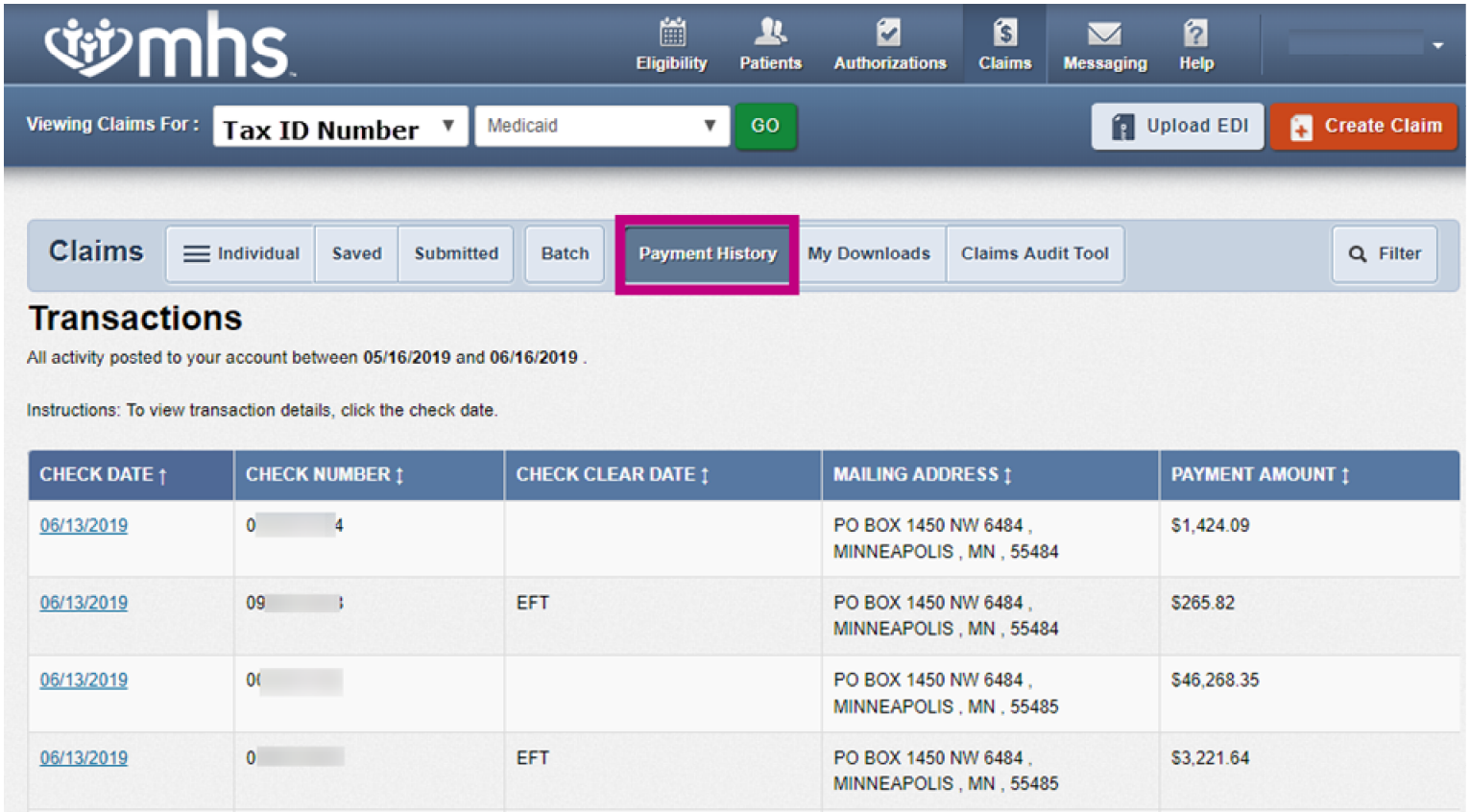


- Only claims with a status of **PAID** or **DENIED** can be corrected online.

- Submit a Correct Claim Guide

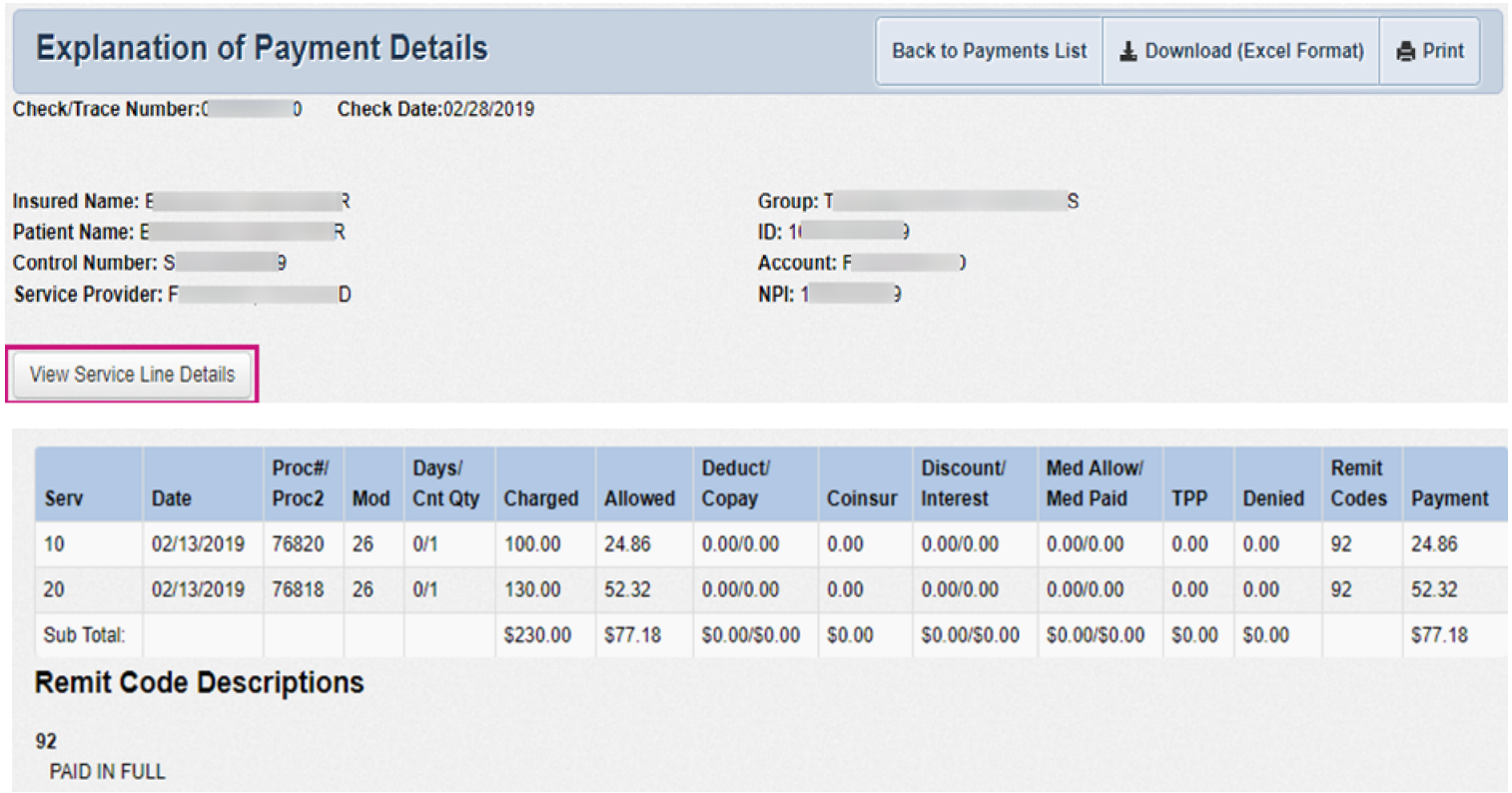
Payment History

- 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.



Payment History

Click on **View Service Line Details.**



Explanation of Payment Details

Back to Payments List | Download (Excel Format) | Print

Check/Trace Number:C 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 9
Account: F)
NPI: 1 9

View Service Line Details

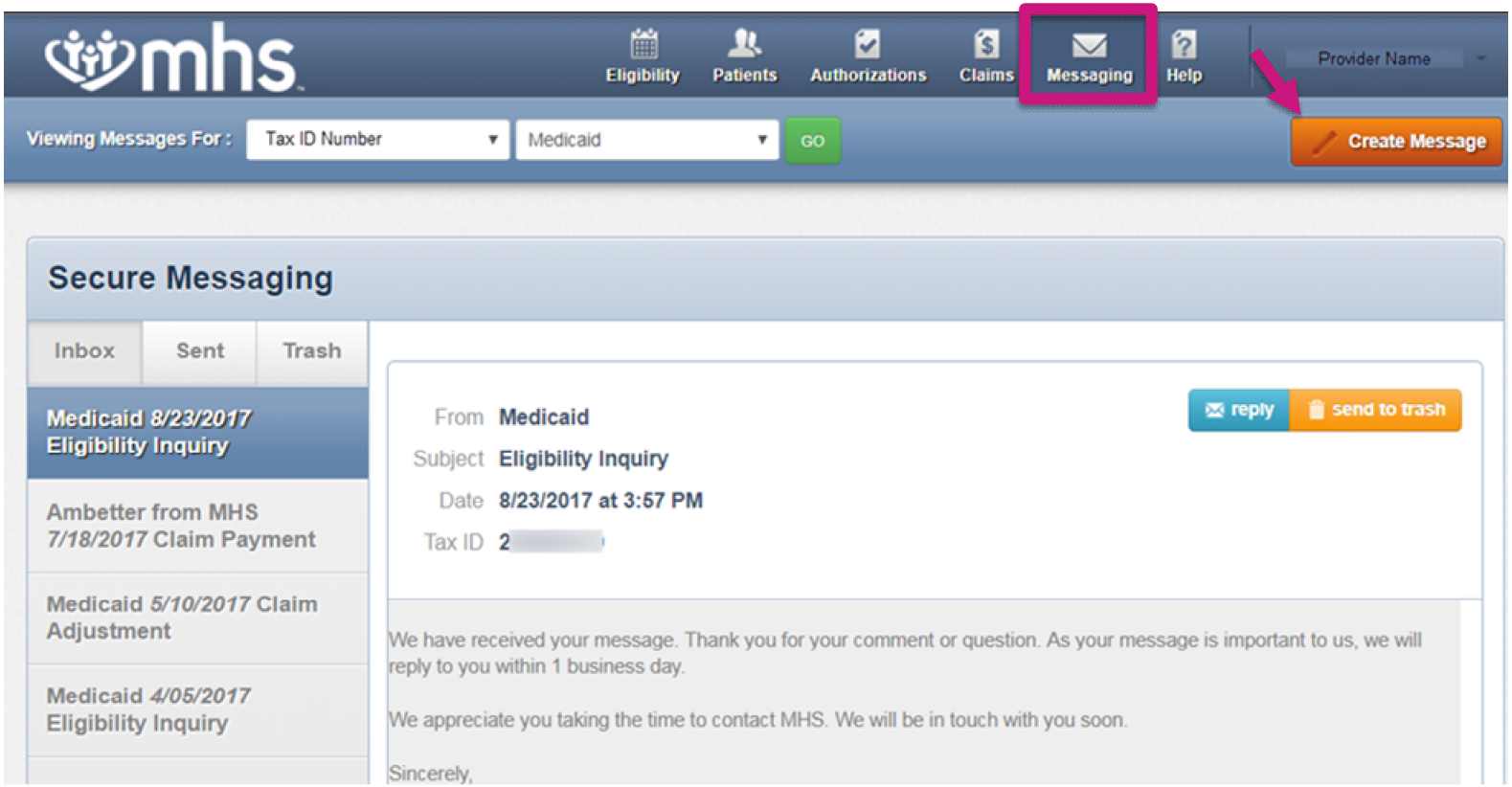
Serv	Date	Proc#/ Proc2	Mod	Days/ Cnt Qty	Charged	Allowed	Deduct/ Copay	Coinsur	Discount/ Interest	Med Allow/ Med Paid	TPP	Denied	Remit Codes	Payment
10	02/13/2019	76820	26	0/1	100.00	24.86	0.00/0.00	0.00	0.00/0.00	0.00/0.00	0.00	0.00	92	24.86
20	02/13/2019	76818	26	0/1	130.00	52.32	0.00/0.00	0.00	0.00/0.00	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.**



Online Claim Reconsiderations

Summary Of Online Reconsiderations

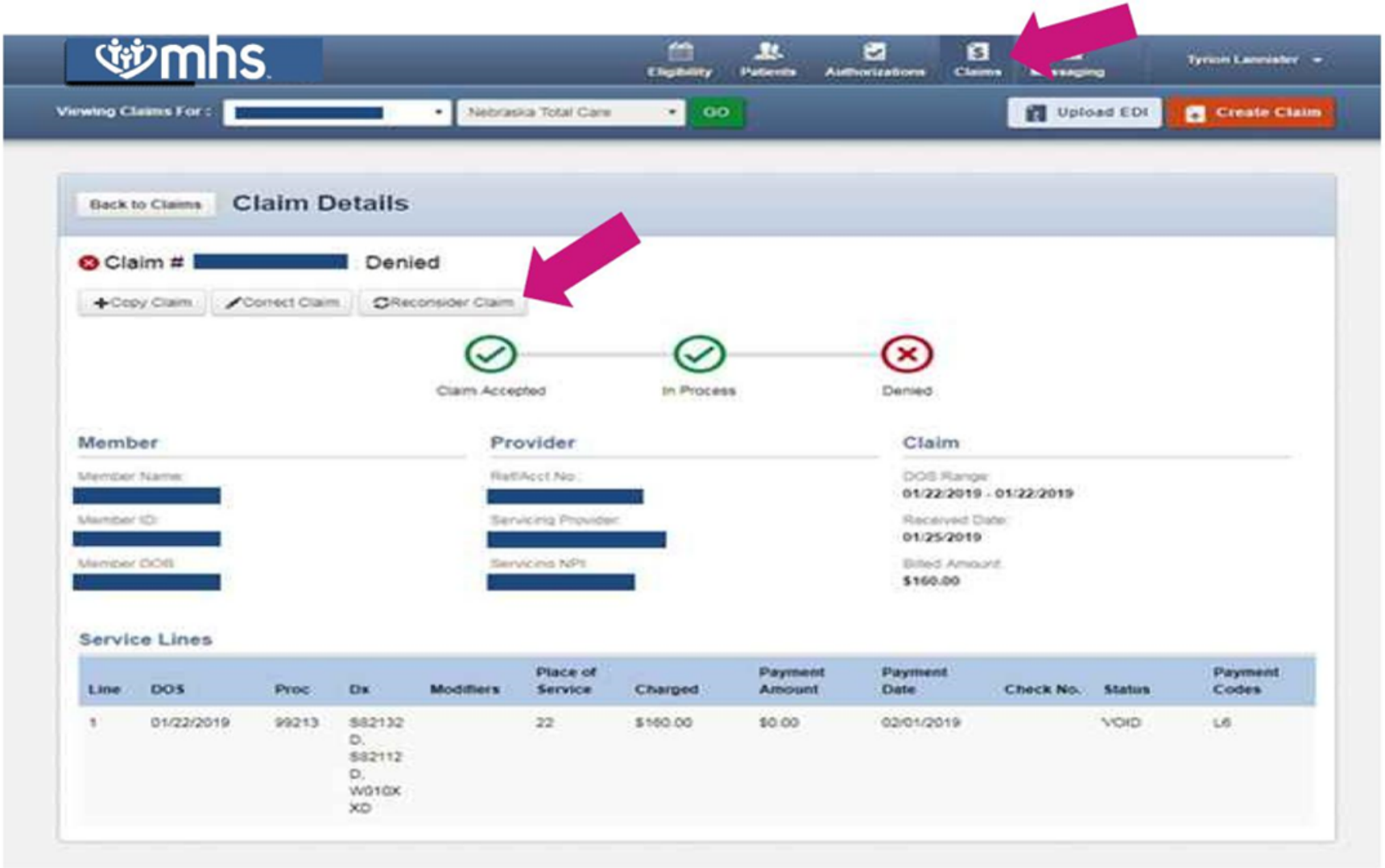
- **Skip the phone call.**
  - Providers make their case directly on the portal.
- **Make the case.**
  - Providers submit informal dispute/reconsideration comments using expanded text fields.
- **Add context.**
  - Providers can easily attach supporting documentation when filing an informal dispute/reconsideration.
- **Stay current.**
  - Providers may opt in/out for informal dispute/reconsideration status change emails.
  - Providers may also view status online.

Submit Reconsideration

- **Step1:** 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.

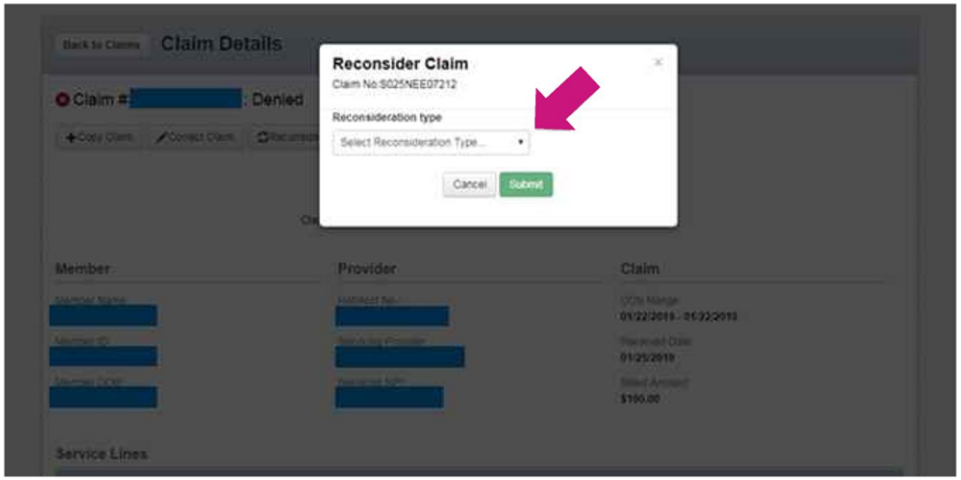
- Note: This option is only available to those claims that do not already have a web-initiated reconsideration already in progress.

Submit Reconsideration



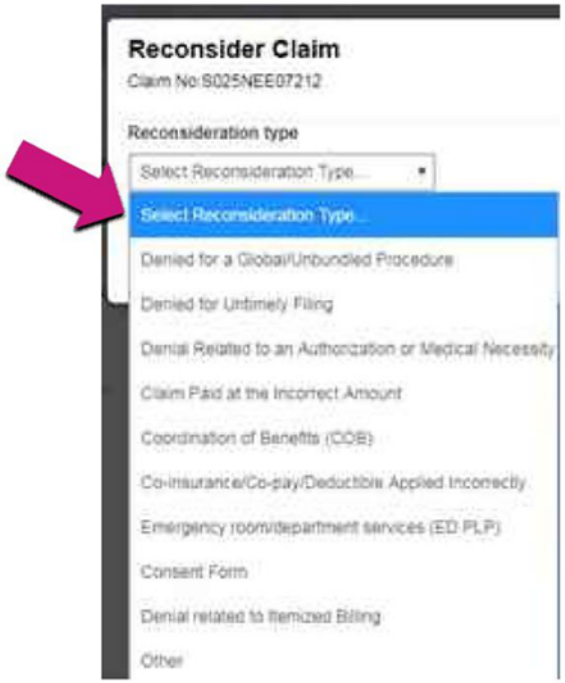
Submit Reconsideration – Pop-Up Window

- 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.

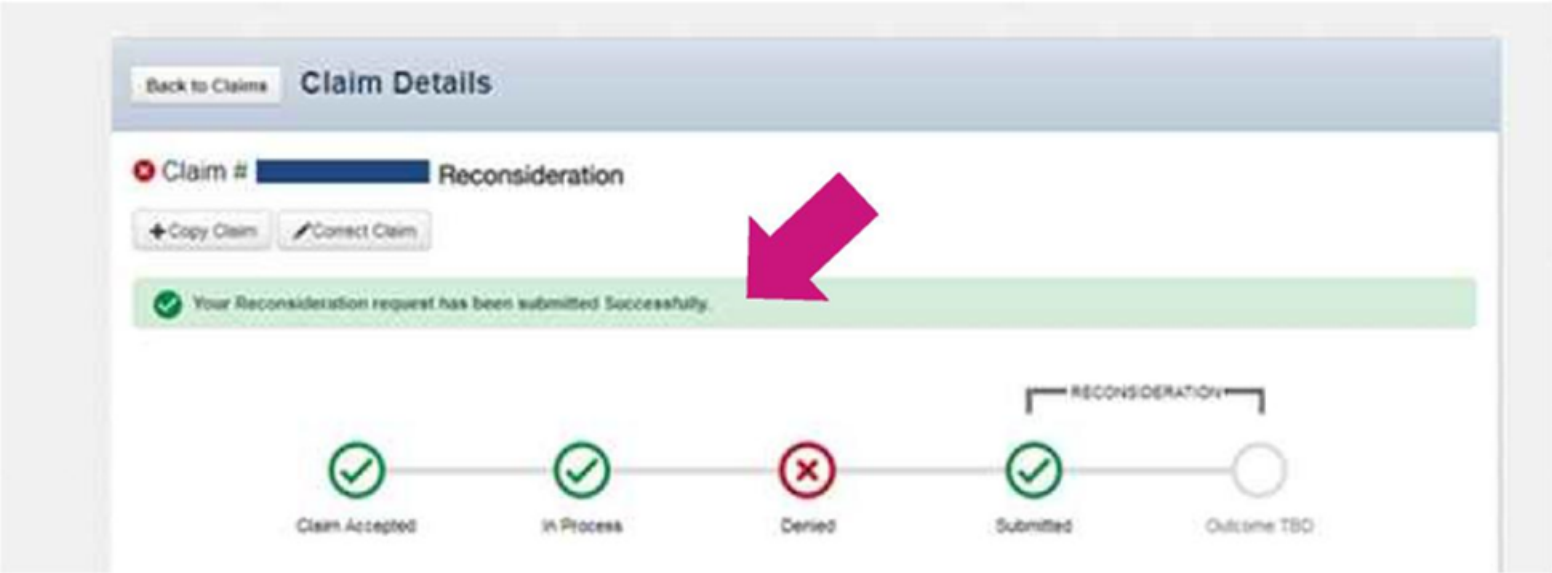


Submit Reconsideration – Enter Information

- 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

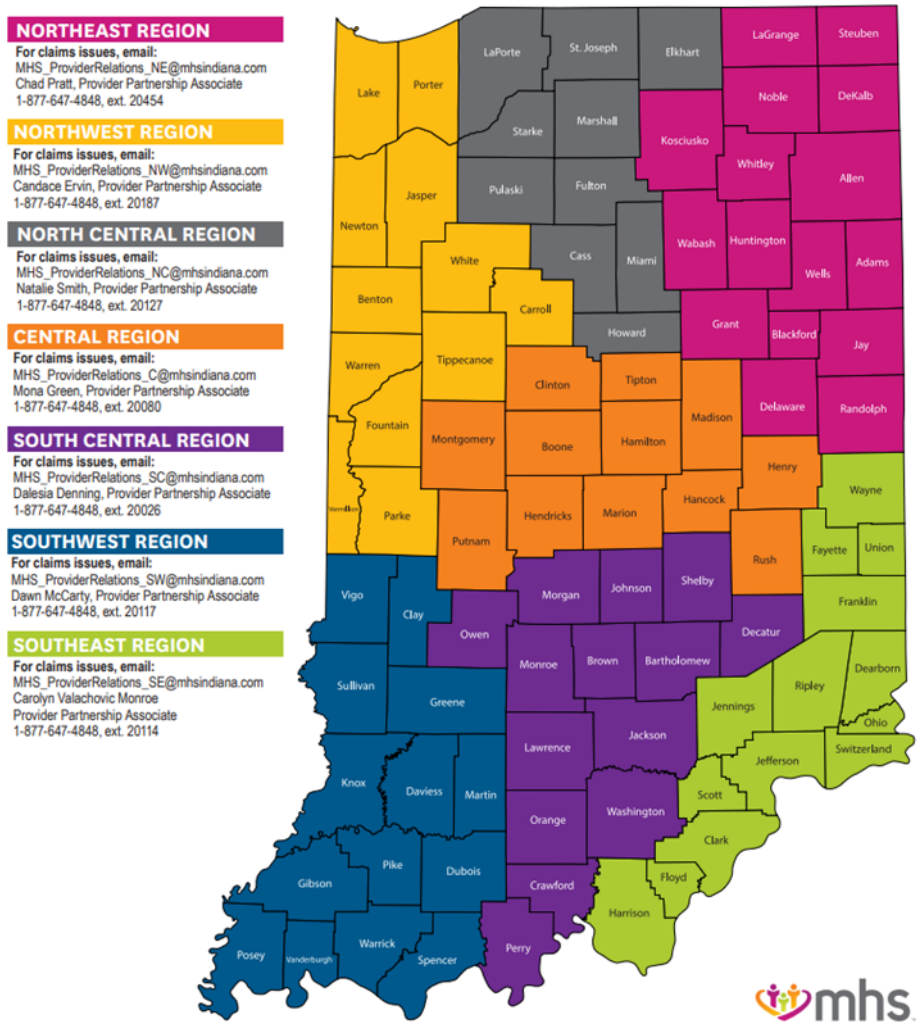
- Upon submission, a success banner will be displayed.



Submit Reconsideration – Updated

- Reconsideration is tracked as in progress.

Provider Relations Team



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

NORTHEAST REGION
For claims issues, email:
MHS_ProviderRelations_NE@mhsindiana.com
Chad Pratt, Provider Partnership Associate
1-877-647-4848, ext. 20454

NORTHWEST REGION
For claims issues, email:
MHS_ProviderRelations_NW@mhsindiana.com
Candace Ervin, Provider Partnership Associate
1-877-647-4848, ext. 20187

NORTH CENTRAL REGION
For claims issues, email:
MHS_ProviderRelations_NC@mhsindiana.com
Natalie Smith, Provider Partnership Associate
1-877-647-4848, ext. 20127

CENTRAL REGION
For claims issues, email:
MHS_ProviderRelations_C@mhsindiana.com
Mona Green, Provider Partnership Associate
1-877-647-4848, ext. 20080

SOUTH CENTRAL REGION
For claims issues, email:
MHS_ProviderRelations_SC@mhsindiana.com
Dalesia Denning, Provider Partnership Associate
1-877-647-4848, ext. 20026

SOUTHWEST REGION
For claims issues, email:
MHS_ProviderRelations_SW@mhsindiana.com
Dawn McCarty, Provider Partnership Associate
1-877-647-4848, ext. 20117

SOUTHEAST REGION
For claims issues, email:
MHS_ProviderRelations_SE@mhsindiana.com
Carolyn Valachovic Monroe
Provider Partnership Associate
1-877-647-4848, ext. 20114

mhs

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

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
Program Manager,
Provider Engagement
1-877-647-4848 ext. 20149
jgarner@mhsindiana.com

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

Back of Map

NETWORK LEADERSHIP

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

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

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

NEW PROVIDER CONTRACTING

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

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

NETWORK OPERATIONS

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

ENVOLVE DENTAL, INC.

ANTWAN PEREZ-ALVAREZ
Antwan.Perez-Alvarez@EnvolveHealth.com
Tyneshia James
Tyneshia.James@EnvolveHealth.com
Dental Provider Services: 1-855-609-5157
Questions: ProviderRelations@EnvolveHealth.com

ENVOLVE VISION, INC.

CHANTEL MCKINNEY
Chantel.McKinney@EnvolveHealth.com
Yojani Benitez
Yojani.Benitez@EnvolveHealth.com
Vision Provider Services: 1-844-820-6523
Questions: Envolve_AdvancedCaseUnit@EnvolveHealth.com

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

Thank you for being our partner in care.