



Claims *CMS-1500*

**Updates and Insights:
Navigating Regulatory Changes
(Medicaid)**

Agenda

- MHS Overview
- Claim Submission Process
- MHS Provider Claims Issue Resolution Process
- Portal Functionality
- Professional Billing
- Web Portal Claim and Payment Review
- Online Claim Reconsiderations on the MHS Secure Provider Portal
- Coordination of Benefits
- Prior Authorization
- MHS Provider Engagement Team
- Questions

MHS Overview

Who Is MHS?

Managed Health Services (MHS) is a health insurance provider that has been proudly serving Indiana residents for 30 years through Hoosier Healthwise (HHW), the Healthy Indiana Plan (HIP), and Hoosier Care Connect (HCC).

MHS is your choice for better healthcare.

Claim Submission Process

Behavioral Health Claims Submission

- **Electronic Submission:**
 - Payor ID **68068**.
 - MHS accepts Third Party Liability (TPL) information via EDI.
 - It is the responsibility of the provider to review the error reports received from the Clearinghouse (Payor Reject Report).
- **Online Portal**
 - Provides immediate confirmation of received Claims and Acceptance:
 - Institutional and Professional.
 - Batch Claims.
 - Claim Adjustments/Corrections.
 - Claim Review/Adjustments Request.
- **Paper Claims:**

MHS Behavioral Health
P.O. Box 6800
Farmington, MO 63640-3818

Medical Claims Submission

- **Electronic Data Interchange (EDI) Submission:**
 - Preferred method of claims submission.
 - Faster and less expensive than paper submission.
 - MHS Electronic Payor ID **68069**.
- **Online Portal**
 - Provides immediate confirmation of received Claims and Acceptance:
 - Institutional and Professional.
 - Batch Claims.
 - Claim Adjustments/Corrections.
 - Claim Review/Adjustments Request.
- **Paper Claims:**

Managed Health Services
P.O. Box 3002
Farmington, MO 63640-3802

Claims Billing with Ease

- National Provider Identification (NPI), Taxonomy Code, Zip +4.
- This information is necessary for the system to make a one-to-one match based on the information provided on the claim and the information on file with Indiana Medicaid:
 - Member Information
 - Newborn's Member ID (MID) is required for payment
- Attachment Forms:
 - Required forms need to accompany the claim form.
- Secondary Claims TPL:
- Accepted electronically from vendors or via the [Online Secure Portal](#)

Timely Filing Limits

PROVIDER TYPE	TIMELY FILING LIMIT
In-Network Providers	90 calendar days from DOS or discharge date
Out-of-Network Providers	90 calendar days from DOS or discharge date

Exceptions to The Filing Limit

EXCEPTION TYPE	FILING LIMIT	ADDITIONAL REQUIREMENTS
Newborns (≤ 30 days)	365 calendar days from Date of Service (DOS)	Filed with newborn's MID
TPL - With EOP	365 calendar days from DOS	Include primary insurance Explanation of Payment (EOP)
TPL - Late EOP	60 calendar days from EOP receipt	Filed after 365-day window
TPL - No Response	90 calendar days	Include proof of filing with primary insurer

Paper Claim Corrections

- A corrected claim can be submitted following the Indiana Health Coverage Programs (IHCP) claim adjustment processes.
- A claim adjustment code is required on all claims, based on the type of Claim submitted.
 - Example: Frequency 7 entered in Box 22 of the *CMS-1500* form.
- The original claim number must also be listed on the corrected claim.
 - Box 22 on the *CMS-1500*.
 - Remember: A rejection must be submitted as a first-time claim, not as a corrected claim.
- Handwriting or stamping on a claim will not be accepted as submission of a corrected claim, and will be rejected with rejection code **RE**.

Paper Claim Corrections CMS-1500 Example

- If you must submit via paper – never handwrite “Corrected Claim” on the claim form.
- Complete box 22 (Resubmission Code) to include a 7 (the "Replace" billing code) to notify us of a corrected or replacement claim.

The image shows a CMS-1500 claim form with several fields filled in. Key annotations include:

- Box 22 (Resubmission Code):** Contains the number "7". A blue arrow points to this box with the text "Resubmission code is '7'".
- Box 18 (Original Ref. No.):** Contains a blacked-out number. An orange arrow points to this box with the text "Original claim number".
- Box 23 (Prior Authorization Number):** Contains the number "0".
- Box 24 (Date(s) of Service):** Shows a date range from MM/DD/YY to MM/DD/YY.
- Box 24 (Diagnosis/Procedure):** Shows a procedure code (ICD-9) and a modifier.
- Box 24 (Rendering Provider ID #):** Shows a provider ID number.
- Box 24 (Total Charge):** Shows a dollar amount.
- Box 24 (Amount Paid):** Shows a dollar amount.
- Box 24 (Signature of Physician or Supplier):** Shows a signature and date.
- Box 24 (Billing Provider Info):** Shows a name and address.

Claim Rejections

- A rejection is an unclean claim that contains invalid or missing data elements required for acceptance of the claim in the claim process system.
- Timely filing is not substantiated.
- Rejected claims must be corrected and submitted as a first-time new claim.
- EDI rejections require the provider to contact their clearinghouse and obtain a payer rejection report.

Common Claim Rejections

Medical

- **B5** Missing/incomplete/Invalid Clinical Laboratory (CLIA) Licensing and Certification.
- **01** Invalid Provider ID Billing Physician (Provider State Crosswalk File).
- **02** Invalid Provider ID-Rendering Physician (Provider State Crosswalk File).
- **07** Invalid Subscriber/Member ID.
- **08** Invalid Member Date of Birth.
- **09** Member Invalid on Date of Service.
- **40** Diagnosis code is missing
- **76** Original Claim Number required.
- **90** Invalid or Missing Modifier.

Behavioral Health

- **01** Invalid Provider ID Billing Physician (Provider State Crosswalk File).
- **02** Invalid Provider ID-Rendering Physician (Provider State Crosswalk File).
- **07** Invalid Subscriber/Member ID.
- **08** Invalid Member Date of Birth.
- **09** Member Invalid on Date of Service.
- **40** Diagnosis code is missing.
- **31** Invalid Service Procedure code.
- **76** Original claim number required.

MHS Provider Claims Issue Resolution Process

Provider Claims Issue Resolution

PROCESS

- Level 1: Informal Claims Dispute
- Level 2: Formal Claim Dispute – Administrative Claim Appeal
- Level 3: Arbitration.

Please note, this is different than an authorization appeal. A claim appeal cannot change a denied authorization status. To change authorization status, you must appeal the denied authorization.

Claim Dispute/Appeal Form Mailing Address

- Medical Claims Address:
Managed Health Services
Attn: Appeals Department
P.O. Box 3002
Farmington, MO 63640-3802
- Behavioral Health Claims Address:
Managed Health Services BH Appeals
Attn: Appeals Department
P.O. Box 6800
Farmington, MO 63640-3818

Informal Claims Dispute or Objection Form

Submit all documentation supporting your Dispute:

- Copies of original MHS EOP showing how the claims in question were processed.
- Any subsequent MHS EOPs or other determinations on the claim(s) in question.
- Documentation of any previous attempt you have made to resolve the issue with MHS.
- Other documentation that supports your request for reprocessing or reconsideration of the claim(s).
- Can be submitted via the Secure Web Portal within 60 calendar days of receipt of the MHS EOP.
- Requests received after the 60 calendar days will not be considered.

Informal Dispute or Objection Form

- Level 1 - Informal Dispute: Upon receipt of the informal claim dispute, MHS will review the claim and the additional information submitted and respond to the provider within 30 calendar days.
- At that time (or upon receipt of our response if sooner), providers will have up to 60 calendar days from date of dispute response to initiate a formal claim appeal, which is (Level 2).

Informal Claims Dispute Objection Form

Helpful Tips

- Disputing multiple claim denials:
 - Submit separate Informal Claims Disputes for each member/patient experiencing the denial.
 - Provide additional information such as:
 - The MHS denial code and description found on the EOP
 - Briefly describe why you are disputing this denial.
 - For multiple claims, please either list all claim numbers or in the “Reason for Dispute” section state that “member is experiencing denial reason ____ for all Claims DOS ____ to ____; Please review all associated claims.”

Save copies of all submitted Informal Claims Dispute Forms.

Provider Services Phone Requests and Web Portal Inquiries

After the Informal Claims Dispute (Level 1) has been submitted, the provider can access the Provider Service Phone Line or Web Portal for assistance or questions. The inquiries will be logged and assigned a ticket number. Please keep this ticket number for your reference.

- Phone:
 - 1-877-647-4848 - Provider Contact Center.
 - 8 a.m. to 8 p.m. EST.
- **Online Secure Portal**
 - Use the Messaging Tool.

Disputing Multiple Claims

Disputing multiple Claim Denials:

- Provide the Provider Services Representative or Web Portal Team member with one claim number as an example of the specific denial.
- Communication is key! Inform the Contact Center that you have a “Claims Research Request” to review all Claims for the specific denial reason.
- State if this denial is happening for one or multiple practitioners within your group or clinic; (if multiple, provide your Tax Id Number (TIN)).
- Provide the MHS denial code and description found on the EOP.
- Briefly describe why you are disputing this denial or seeking research.

Formal Claims Dispute - Administrative Claim Appeal

- Level 2 is a Formal Claim Dispute, Administrative Claim Appeal.
- In the event the provider is not satisfied with the Informal Claim Dispute, Objection Resolution, the provider may file an Administrative Claim Appeal. The appeal must be filed within 60 calendar days from receipt of the Informal Dispute Resolution Notice.
- An Administrative Claim Appeal must be submitted via the [Online Portal](#)
- or in writing by using your company letter head with an explanation including any specific details which may justify reconsideration of the disputed claim. The appeal should be clearly marked on the form as Level 2.

Arbitration

- Level 3 is arbitration, a part of the formal MHS Provider Claims Dispute process.
- In the event a provider is not satisfied with the outcome of the Administrative Claim Appeal Process (Level 2), the provider may request arbitration. Claims with similar issues from the same provider may be grouped together for the purpose of requesting arbitration.
- To initiate arbitration, the provider should submit a written request to MHS on company letterhead. The request must be postmarked no later than 60 calendar days after the date the provider received MHS' decision on the Administrative Claim Appeal.
- Arbitration Requests must be mailed to:

MHS Arbitration
429 N. Pennsylvania Street, Suite 109
Indianapolis, IN 46204

Portal Functionality

Secure Web Portal Login or Registration

For Providers

Provider Portal Login

Behavioral Health

Clinical & Payment Policies

Dental Providers

Education & Trainings

Email Sign Up

Enrollment and Updates

News

Pharmacy

Prior Authorization

Quality Improvement

Resources

Provider 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

Portal Training Guides



Secure Provider Portal

This login does not include Wellcare Complete.

Login/Register

Wellcare Complete Provider Portal

Wellcare Complete requires a distinct password and login.

Login/Register

Provider Email Sign Up

Sign Up

Get the best experience on our website.

Homepage - MHS (Medicaid)

After logging into the portal this homepage will appear that allows providers to access information

The screenshot shows the MHS (Medicaid) homepage. At the top, there is a navigation bar with the MHS logo and icons for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below the navigation bar, there is a "Viewing Dashboard For:" dropdown menu set to "TM" and a "Plan Type" dropdown menu set to "Medicaid" with a "GO" button. The main content area features a "Welcome, Michelle!" message and a link to "Get easy access to the features you use most." Below this is a "Quick Actions" section with a form for a quick eligibility check. The form includes fields for "Member ID or Last Name *", "Member Date of Birth" (with a calendar icon and "MM/DD/YYYY" format), and "Select Action Type *" (with a dropdown menu). A "SUBMIT" button is located to the right of the form. Below the "Quick Actions" section is an "Authorization Overview" section with two buttons: "Inpatient Authorizations" and "Outpatient Authorizations", each with a "View All" link. At the bottom is a "Useful Links" section with three links: "Reports", "Provider Analytics" (with an external link icon), and "Provider Complaints".

Quick Actions
Do a quick eligibility check, find patient benefits information, create a new claim or recurring claim or an authorization.

Member ID or Last Name * Member Date of Birth Select Action Type *

MM/DD/YYYY

Authorization Overview

Inpatient Authorizations **Outpatient Authorizations**

[View All](#) [View All](#)

Useful Links

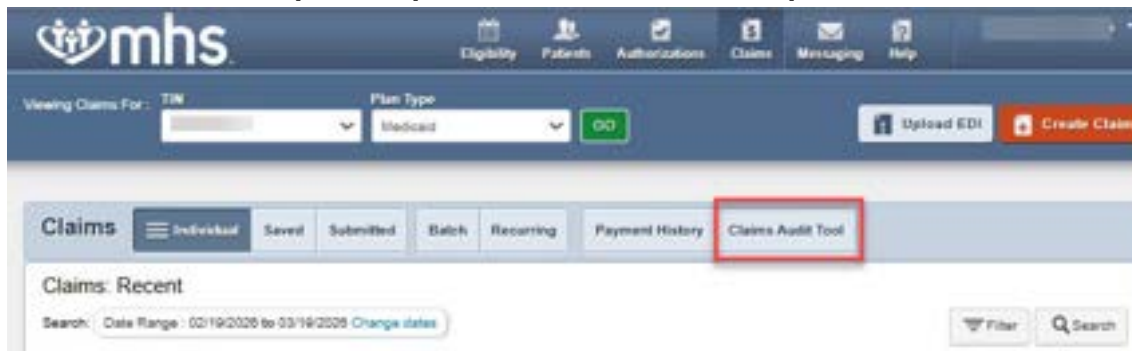
Reports
This repository contains reports that are uploaded and maintained by the health plan.

Provider Analytics
Used by PCP groups to access data/reports/dashboard that assist in providing better health outcomes and lower cost.

Provider Complaints
View submitted complaints to the provider.

Claims Audit Tool

- The Clear Claim Connection screen appears, allowing you to enter the Procedure Code, Modifiers, Quantity, Date and Place of Service, and Diagnosis for a Claim proactively before you submit or retroactively after you submit. This tool helps to prescreen claims prior to submitting.



The screenshot shows the McKesson 'Clear Claim Connection' form. The header includes 'McKesson Edit Development', 'Glossary', and 'About'. The main section is titled 'CLAIM ENTRY' and contains several input fields: 'Claim Type' (Professional), 'Gender' (Male), 'Date of Birth', 'ICD-Code Set' (ICD9), and 'Diagnosis Codes' (1, 2, 3, 4). There is a 'Clear' button and a 'Review Audit Results' button. Below the form, there is a table for entering procedure codes and modifiers. The table has columns for 'LINE', 'PROCEDURE CODE', 'MOD', 'MOD2', 'MOD3', 'MOD4', 'QTY', 'DATE OF SERVICE', 'PLACE OF SERVICE', 'PROVIDER', 'YTD', and 'LINE DATE TIME'. The table is currently empty.

LINE	PROCEDURE CODE	MOD	MOD2	MOD3	MOD4	QTY	DATE OF SERVICE	PLACE OF SERVICE	PROVIDER	YTD	LINE DATE TIME	LINE DATE TIME	LINE DATE TIME	LINE DATE TIME	LINE DATE TIME
1															
2															
3															
4															
5															

Claims

- **Web Portal Claims Functionalities:**
 - Submit new Claim.
 - Review Claims information on file for a patient.
 - View payment history
- **Submit a New Claim:**
 - Click **Create Claim** and enter **Member ID** and **Birthdate**.

The screenshot shows the top navigation bar of the mhs web portal. The navigation menu includes: Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below the navigation bar, there is a search area with a dropdown menu for 'Viewing Claims For:' set to 'Medicaid' and a green 'GO' button. To the right of this area are two buttons: 'Upload EDI' and 'Create Claim'. Below the search area is a secondary navigation bar with tabs for 'Claims', 'Individual', 'Saved', 'Submitted', 'Batch', 'Payment History', 'My Downloads', and 'Claims Audit Tool'. A 'Filter' button is located on the far right of this secondary navigation bar.

This screenshot shows the same mhs web portal interface as the previous one, but with the search fields filled out. The 'Viewing Claims For:' dropdown is still set to 'Medicaid'. The 'Member ID or Last Name' field contains the text '123456789 or Smith' and the 'Birthdate' field contains 'mm/dd/yyyy'. A red 'Find' button is positioned to the right of these fields. The rest of the interface, including the navigation bars and buttons, remains the same as in the previous screenshot.

Claims Submission

- Choose the **Claim Type**.
 - **Professional** or **Institutional** claim submission

Viewing Claims For: TIN Plan Type Medicaid

Choose Claim for

Choose a Claim Type

CMS 1500

CMS UB-04

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 Billing

Professional Claims Submission

- In the **General Info** section, populate the **Patient's Account Number** as assigned to your member account and other information related to the patient's condition by typing into the appropriate fields.
- Click **Next**.

* Required fields

Patient's Account Number*	<input type="text" value="XXXXXXXXXX"/>	26
Statement Dates*	From <input type="text" value="MM/DD/YYYY"/> To <input type="text" value="MM/DD/YYYY"/>	
Date of current illness, Injury, Pregnancy (LMP)	Select Type... <input type="text" value="MM/DD/YYYY"/>	14
Other Date	Select Type... <input type="text" value="MM/DD/YYYY"/>	15
Hospitalization	From <input type="text" value="MM/DD/YYYY"/> To <input type="text" value="MM/DD/YYYY"/>	18
Additional Claim Information:	<input type="text" value="XXXXXXXXXXXX"/>	19a
Outside Lab?	<input type="radio"/> Yes <input checked="" type="radio"/> No	20
Referral Number	<input type="text" value="XXXXXXXXXXXX"/>	
Prior Authorization Number	<input type="text" value="XXXXXXXXXXXX"/>	23a
CLIA Number	<input type="text" value="XXXXXXXXXXXX"/>	23b
Amount Paid	<input type="text" value="XXXX.XX"/>	29

Professional Claims Submission Cont.

- Add the **Diagnosis Codes** for the patient in Box 21. There are some situations that a specific diagnosis is required in position 1 and the claims will deny if it is not listed in primary location.
- Click the **Add** button to save.

The screenshot displays the 'Professional Claim for' interface. At the top, there is a 'Your Progress' indicator with four chevron arrows, the first of which is green. Below this, the section is titled 'THIS SECTION: Diagnosis Codes' with the subtitle 'Diagnosis Code and Additional Insurance Information'. The interface includes a 'Back' button on the left and a 'Next' button on the right. A '* Required field' label is present. The 'ICD Version Indicator*' is set to 'ICD 10'. A note states: 'Please note that for the claim statement dates entered, valid ICD-10 codes only are accepted.' The 'Diagnosis Codes*' field contains 'XXXX e.g. V07:' and an 'Add' button. A pink arrow points to the 'Add' button. Below this, a code 'V837 - PERS OUTSD INDUST VEH INJ NT ACC' is listed with a 'Remove X' button. An 'Add Coordination of Benefits' button is also visible. At the bottom, there are 'Back' and 'Next' buttons. A box number '21' is shown on the right side of the form.

Professional Claims Submission Cont.

Click **Add Coordination of Benefits (COB)** to include any payments made by another insurance carrier (if applicable).

Primary Insurance x Remove

Notice: If the Member has more than one primary insurance (Medicaid would be the 3rd payer), the claim cannot be submitted through the Web.

Carrier Type* C50M -- Commercial

Policy Number*

Professional Claims Submission Cont.

- **Add Service Lines**, and any applicable COB information at bottom of each line.

THIS SECTION
Service Lines
Enter maximum of 50 service lines.

← Back Next →

Total: \$53.00 * Required field Delete Save / Update

+ New Service Line

PROCEDURE / CHARGES

1: 88304 / \$53.00

Now Viewing Line 1: 88304 / \$53.00

Dates of Service* From: 04/27/2025 To: 04/27/2025 24 a

Place of Service* 11 - PROVIDERS OFFICE 24 b

Emergency Yes No 24 c EMG

Procedure Code* 88304 24 d

Modifiers XX Please enter the modifier and click the Add button.

26 Remove X

Diagnosis Code(s)*
 L720 - EPIDERMAL CYST 24 e
 L989 - DISORDER OF THE SKIN AND SUBCUTANEOUS TISSUE, UNSPECIFIED

Professional Claims Submission Cont.

- Enter **Referring, Rendering, and Billing Provider** information.
- **Service Facility Location.**
- Click **Next.**

* Required field

Referring Provider ←

NPI: XXXXXXXXXX Qualifier: Select... 17

Last Name or Organizational Name: Last Name First Name: First Name

Rendering Provider Only enter rendering provider information if not the same as Billing Provider information. 24 |

NPI: Tax ID:

Taxonomy #: 363LF0000X Last Name or Organizational Name: First Name:

Billing Provider ←

Tax ID: 33

Name*: CLINIC NPI: Taxonomy*: 193200000X

Address*: City*: State*: Indiana Zip*: 36

Service Facility Location ←

Professional Claims Submission Cont.

- In the Attachments section you can **Browse** and **Attach** any documents to the Claim as desired. (Note: If you have no attachments, skip this section.)
- Click **Next**.

Professional Claim for [Y]

Your Progress

THIS SECTION: **Attachments**
Add attachments to the claim (2MB limit)

supported types are .jpg, .tif, .pdf and .htm

← Back If there are no attachments, click Next. Next →

Attachments

*Do NOT send password protected files. You must click ATTACH for each file being submitted.

File* No file chosen Attachment Type* Select Type... Attach

There are no attached files

← Back If there are no attachments, click Next. Next →

Professional Claims Submission Cont.

Professional Claim for [redacted] Your Progress [Progress Bar]

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 [redacted]
Member Record Number: 210000018
Member Claim Amount Paid
Patient's Account Number: 810000018

General Info [Edit](#)
Statement From Date: 4/1/2017
Statement To Date: 4/30/2017
Date of Current Stress, Injury, Pregnancy (LMP):
Other Date:
Hospitalized From:
Hospitalized To:
Additional Claim Information:
Customs LMP: No
Customs Life Amount:
Proof Submission Number:
CJA Number:

Diagnosis Codes and Primary Insurance [Edit](#)
Diagnosis Codes:
8011 - CHRONIC MUSCULAR UNSPECIFIED

Service Lines [Edit](#)

Line	From	To	Place	Proc	Diagnosis	Amount	Units/Minutes/Days	Family Plan	CPWOT	MOI	Supplemental Info
1	03/16/2017	03/16/2017	22	8350	8011	850.00	1.0	No			

Providers [Edit](#)

Provider Type	Name	Tax ID	NPI	Secondary	Address
Referring Provider	<input type="text"/>		<input type="text"/>		
Rendering Provider	<input type="text"/>	<input type="text"/>	<input type="text"/>		
Billing Provider	<input type="text"/>				
Service Facility Location	<input type="text"/>				<input type="text"/>

Attachments

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

- In the **Review** section, you can see if the Claim is eligible for Real-Time Editing and Pricing (RTEP).

- Click **Validate** for RTEP claims and click **Submit** for regular processed Claims.

RTEP Claim Pricing View

The screenshot displays the RTEP Claim Pricing View interface. At the top, there is a navigation bar with the 'mhs' logo and icons for Eligibility, Patients, Authorizations, Claims, and Messaging. Below the navigation bar, there are input fields for 'Viewing Claims For:' and buttons for 'Upload EDI' and 'Create Claim'. The main content area features a 'COMPLETE!' message: 'You have successfully submitted your claim.' with a 'Print' button. Below this, there are fields for 'Web Reference No. 8' and 'Claim No.'. A summary section includes: 'RefAcct No: 1', 'DOS Range:', 'Member ID:', 'Billed Amount: \$90.00', 'Member Name:', 'Payment Amount: \$48.75', and 'Servicing Provider:', 'Status: APPROVED'. A table follows with columns: Line, DOS, Proc, Dx, Modifiers, Place of Service, Charged, Payment Amount, Status, and Status Description. The table contains two rows of data. At the bottom, a green message states: 'The system has provided a response back to the you indicating amount to be paid on the claim. Any post adjudication processes can change the amount paid.' and a 'Close' button.

Line	DOS	Proc	Dx	Modifiers	Place of Service	Charged	Payment Amount	Status	Status Description
1	09/21/2015 - 09/21/2015	99212	285.9		11	\$65.00	\$31.75	Approved	92: PAID ACCORDING TO CONTRACT STATE PROCESSING GUIDELINES
2	09/21/2015 - 09/21/2015	99050	285.9		11	\$25.00	\$15.00	Approved	92: PAID ACCORDING TO CONTRACT STATE PROCESSING GUIDELINES

RTEP Overview:

- On the final screen, each procedure code will receive a reimbursement estimate, pending Claim explanation, or Denial reason.
- Claims with a reimbursement estimate or pending explanation may be impacted by final adjudication, including a change to the reimbursement amount or a denial.
- Adjudication status may be affected by code editing or other payment rules.

Web Portal Claim and Payment Review

Individual Claims

On the **Individual** tab, Claims can be reviewed that had been submitted and accepted using paper, portal, or EDI clearinghouse methods.

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

The screenshot displays the mhs Claims portal interface. At the top, there is a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below this, there are search filters for TIN and Plan Type (Medicaid), a GO button, and buttons for Upload EDI and Create Claim. The main navigation area shows the 'Claims' section with the 'Individual' tab highlighted in a red box. Other tabs include Saved, Submitted, Batch, Recurring, Payment History, and Claims Audit Tool. Below the navigation, there is a 'Claims: Recent' section with a search bar for Date Range (01/01/2026 to 01/15/2026) and Filter/Search buttons. A table of claims is displayed below.

CLAIM NO.	CLAIM TYPE	MEMBER NAME	SERVICE DATE(S)	BILLED/PAID	CLAIM STATUS
	CMS-1500		01/01/2026 - 01/01/2026	\$191.59 / \$51.26	Paid
	CMS-1500		01/01/2026 - 01/04/2026	\$217.66 / \$94.43	Paid
	CMS-1500		01/01/2026 - 01/05/2026	\$85.80 / \$16.52	Paid
	CMS-1500		01/01/2026 - 01/06/2026	\$216.00 / \$0.00	Pending
	CMS-1500		01/01/2026 - 01/06/2026	\$368.85 / \$0.00	Denied

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 a saved Claim that is no longer necessary.
5. Click **OK** to confirm the deletion.

The screenshot shows the mhs Claims management interface. At the top, there are navigation tabs for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below this, there are filters for 'Viewing Claims For' (TIN) and 'Plan Type' (Medicaid), along with 'Upload EDI' and 'Create Claim' buttons. The 'Claims' section has several tabs: Individual, Saved (highlighted with a red box), Submitted, Batch, Recurring, Payment History, and Claims Audit Tool. Below the tabs, there is a warning message: 'Claims listed below have missing information or contain errors. Click 'Edit' to view a claim, then fix any errors or complete it before submitting.' The main content area shows a table of claims with columns for DATE CREATED, CLAIM TYPE, CLAIM ID, MEMBER NAME, MEMBER ID, ORIGINAL CLAIM #, and TOTAL CHARGES. There are also 'Edit' and 'Delete' buttons for each claim.

DATE CREATED	CLAIM TYPE	CLAIM ID	MEMBER NAME	MEMBER ID	ORIGINAL CLAIM #	TOTAL CHARGES		
03/09/2026	CMS-1500					\$1,894.09	Edit	Delete
03/03/2026	Institutional					\$593.45	Edit	Delete
02/26/2026	CMS-1500				Z	\$4,844.55	Edit	Delete
01/29/2026	Institutional				Y	\$8,700.00	Edit	Delete

Submitted Claims

- The **Submitted** tab will only display Claims created via the MHS portal:
 - **Accepted** is a **green** thumbs up.
 - **Denied** is an **orange** thumbs down.
 - **Pending** is a clock.
- **RTEP** indicators on the right claims also show if eligible (i.e., line 3 was submitted but was not eligible for RTEP).

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

SUBMITTED STATUS ↑	DATE SUBMITTED ↓	WEB #/ REF # ↓	CLAIM NUMBER ↓	CLAIM TYPE ↓	MEMBER NAME ↓	MEMBER ID ↓	ORIGINAL CLAIM # ↓	TOTAL CHARGES ↓	RTEP
👍	03/17/2026			CMS-1500				\$232.32	RTEP 🚫
👍	03/18/2026			CMS-1500				\$1,006.00	RTEP 🕒
👍	03/18/2026			CMS-1500				\$5,827.04	RTEP 👍

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.
 - Electronic Funds Transfer (EFT) register with [PaySpan](#)

The screenshot shows the mhs portal interface. At the top, there are navigation tabs for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below this, there are dropdown menus for 'Viewing Claims For: TIN' and 'Plan Type: Medicaid', with a 'GO' button. To the right are 'Upload EDI' and 'Create Claims' buttons. A secondary navigation bar includes 'Claims', 'Individual', 'Saved', 'Submitted', 'Batch', 'Recurring', 'Payment History' (which is selected), and 'Claims Audit Tool'. Below this is a search filter. The main content area is titled 'Transactions' and shows activity between 02/19/2026 and 03/19/2026. An information box provides instructions on clicking a 'Check Date' link to view payment details. The table below lists the transactions:

CHECK DATE ↑	CHECK NUMBER ↓	CHECK CLEAR DATE ↓	MAILING ADDRESS ↓	PAYMENT AMOUNT ↓
02/19/2026 (PDF)	[REDACTED]	EFT	[REDACTED]	\$565.94
02/19/2026 (PDF)	000000000	02/19/2026	[REDACTED]	\$0.00
02/19/2026 (PDF)	[REDACTED]	EFT	[REDACTED]	\$44,387.74
02/19/2026 (PDF)	000000000	02/19/2026	[REDACTED]	\$0.00

EFT and ERAs

Payspan Health

- Web-based solution for:
 - EFTs.
 - Electronic Remittance Advices (ERAs).
- One-year retrieval of remittance advice.
- Provided at no cost to providers and allows online enrollment.
- Register at: [Payspan](#)
- For questions call Payspan at: 1-877-331-7154
8:00am-8:00pm EST.

Tips to Remember

- Clicking on items (claim numbers, check numbers, or dates) that are highlighted in **blue** will reveal additional information.
- When **filtering** to find a Claim or payment history, only a **30-calendar-day** span within the same month can be used.
- Click on the **Saved Claims** tab to view Claims that have been created but not submitted. Claims in this queue can be edited for submission or deleted from this tab.
- In order to utilize the **Correct Claim** feature, the Claim needs to be in a **Paid** or **Denied** status.

Online Claim Reconsiderations on the MHS Secure Provider Portal

Online Reconsiderations

Providers can:

- Submit informal disputes/reconsiderations on the **Secure Provider Portal.**
- Submit corrected claims.
- Upload/view supporting documents.
- View acknowledgement letters.
- Track real-time updates.
- View denial code information.

Summary of Online Reconsiderations

Skip the phone call.

- Providers can make their case directly on the Provider Portal.

Make the case.

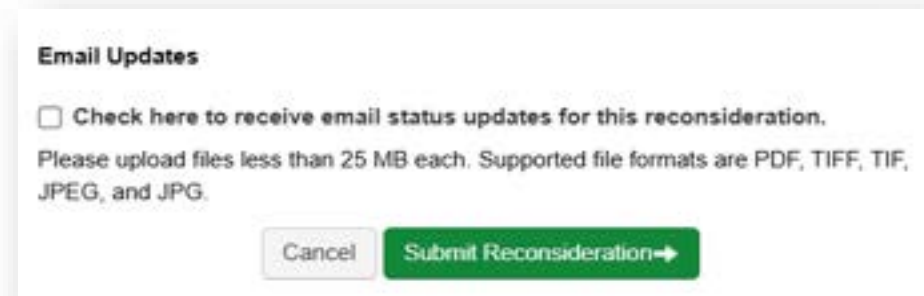
- Providers can submit informal Dispute/Reconsideration comments using expanded text fields.

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 when submitting online.
- Providers may also view status online.



Email Updates

Check here to receive email status updates for this reconsideration.

Please upload files less than 25 MB each. Supported file formats are PDF, TIFF, TIF, JPEG, and JPG.

Cancel Submit Reconsideration →

Online Reconsiderations Level 1

- It is important to note that all requests submitted via the online portal for Level 1 will be considered an **informal dispute**. Secure messages are not considered Reconsiderations/Appeals.
- Calling Provider Services **will not** pause the time frame for timely submissions for informal disputes.
- Providers **do not** need to call prior to submitting an online claim reconsideration/information dispute.

Claim Dispute on the Secure Provider Portal Options

SELECT

Option 1: Correct the claim

Most providers use this option when there is a mistake on the submitted claim.

SELECT

Option 2: Reconsiderations

Most providers use this option when there is a dispute in payment and/or additional documentation required.

SELECT

Option 3: Informally dispute the claim

A dispute is a informal review performed by the Claims Department.

- A response will be issued within **30 calendar day** of submission.
- You will still have the opportunity to select **Option 4: Appeal the claim**, if the decision is upheld.
- You should **NOT** use this option if an authorization is not obtained and/or need to review for medical necessity.
- Please refer to the [MHS Provider Manual](#) on filing a medical necessity appeal.

SELECT

Option 4: Appeal the claim

An appeal is a formal review of your claim.

- Appeal responses will be issued in writing within **45 calendar days** of submission, in accordance with 405 IAC 1-1.6.
- Your appeal will be reviewed by a panel of one or more individuals who are **knowledgeable** in the policy, legal, and/or clinical issues in the matter subject to the appeal.
- The panel was **not involved in any previous consideration** of the matter of the appeal.
- Please refer to the [MHS Provider Manual](#) for more information.

[Terms and Conditions](#) ↗(new tab)

[Privacy Policy](#) ↗(new tab)

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Level 1 Informal Claim on the Secure Provider Portal

Back to Claims

Claim Details

✘ Claim # Denied

+ Copy Claim
⌛ Void/Recoup Claim
Dispute Claim



Claim Accepted
In Process
Claim Denied

Member

Member Name:

Member ID:

Member DOB:

Provider

Ref/Accl No.:

Servicing Provider:

Servicing NPI:

Claim

DOS Range: 08/04/2025 - 08/04/2025

Received Date: 08/06/2025

Billed Amount:

Most Recent Payment

Payment Date: 08/14/2025 Paid Claim Amount: \$0.00

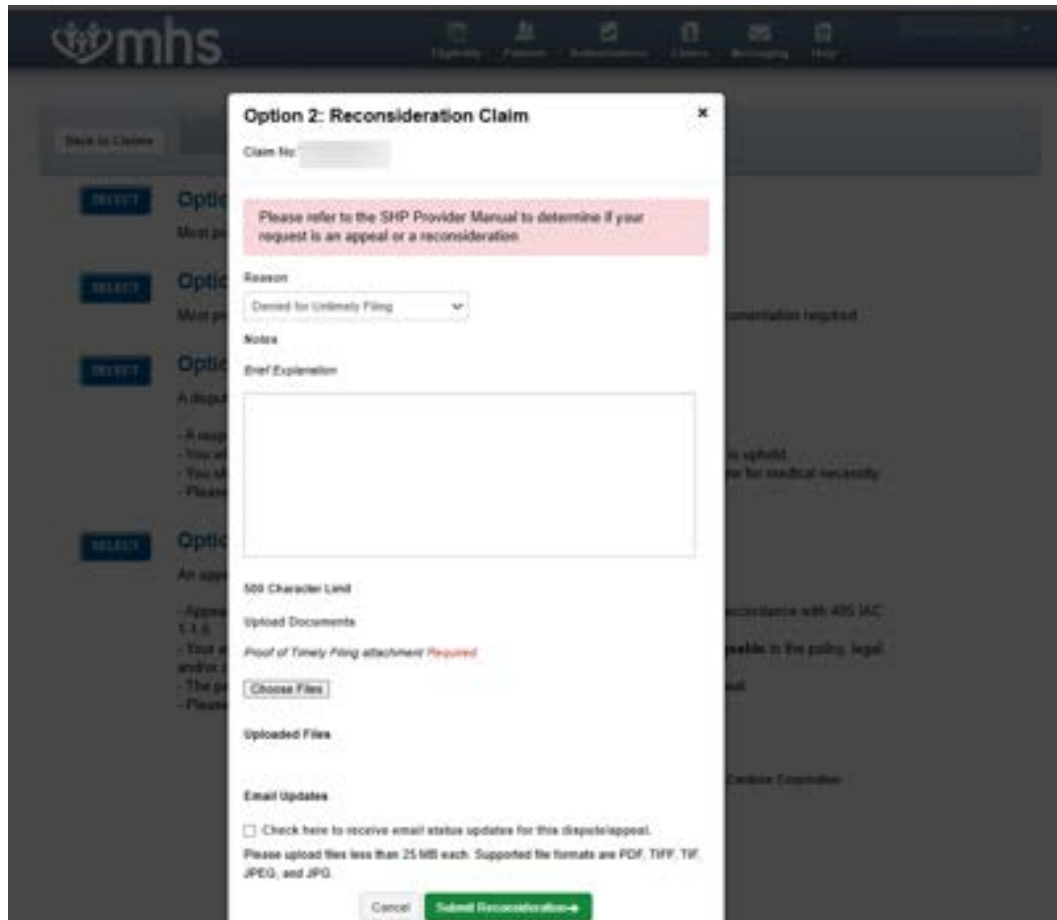
Check Dated: 08/13/2025

Service Lines

Line	DOS	Proc	Dx	Modifiers	Place of Service	Charged	Paid Amount	Payment Date	Status	Payment Codes

Claim Reconsideration

- Enter your explanation for reconsideration and check email updates.



The screenshot displays the 'Option 2: Reconsideration Claim' form within the mhs web portal. The form includes a 'Claim No.' field, a pink informational banner, a 'Reason' dropdown menu (set to 'Denied for Untimely Filing'), a 'Notes' section with a 'Brief Explanation' text area, an 'Upload Documents' section with a 'Choose Files' button, and an 'Email Updates' section with a checkbox for receiving status updates. The form also features a 'Cancel' button and a green 'Submit Reconsideration' button.

Option 2: Reconsideration Claim

Claim No:

Please refer to the SHP Provider Manual to determine if your request is an appeal or a reconsideration.

Reason
Denied for Untimely Filing

Notes
Brief Explanation

500 Character Limit

Upload Documents
Proof of Timely Filing attachment **Required**

Uploaded Files

Email Updates
 Check here to receive email status updates for this dispute/appeal.
Please upload files less than 25 MB each. Supported file formats are PDF, TIFF, TIF, JPEG, and JPG.

Level 2 Claim Appeals on the Secure Provider Portal

Claim #: [Redacted]: Denied

+ Copy Claim / Correct Claim

✓ Your Reconsideration request # [Redacted] has been submitted successfully.

RECONSIDERATION

Claim Accepted → In Process → Denied → In Process → OUTCOME TBD

Reconsideration Details

Created Date	Type	Current Status	Reference Number	Tools
06/11/2019	Denial Related to an Authorization	OPEN	[Redacted]	[Tools]

Member: [Redacted] Provider: [Redacted] Claim: [Redacted] Most Recent Payment: [Redacted]

Member Name: [Redacted] Ref/Acct No.: [Redacted] DOS Range: [Redacted] Payment Date: [Redacted] Granted Claim Amount: [Redacted]

Member ID: [Redacted] Servicing Provider: [Redacted] Received Date: [Redacted] Check Number: [Redacted] Total Check Amount: [Redacted]

Member DOB: [Redacted] Servicing NPI: [Redacted] Billed Amount: [Redacted] Check Date: [Redacted]

Service Lines

Line	DOS	Proc	Dx	Modifiers	Place of Service	Charged	Total Check Amount	Payment Date	Check Number	Status	Payment Codes
1	05/13/2019		Q059, N319, R32, K592		12	\$381.92	\$0.00	06/11/2019		⊘ DENY	L6,Ku

Denial Reason

Denial Code	Description
L6	DENY: BILL PRIMARY INSURER 1ST RESUBMIT WITH EOB
Ku	INFORMATIONAL:RE-ADJUDICATION PROCESS EX CODE

- The **Reconsideration Details** section is viewable to provide status and details.
- **Tools** section allows easy View of included attachments or correspondence letters and the option to add additional attachments to an open reconsideration case still in process.
- The **Most Recent Payment** will display the details of the last check or EFT that was made on the claim.

Coordination of Benefits

Coordination of Benefits

- This screen is available if a member has other insurance; it is found under the Patient Overview tab.

The screenshot displays the mhs website interface. At the top, there is a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below this, a search area allows users to filter by TIN and Plan Type (currently set to Medicaid). A 'GO' button is present. A 'Back to Eligibility Check' button is also visible. The main content area is titled 'Coordination of Benefits' and features a table with the following data:

Effective Date	Term Date	Policy Number	Group Number	Carrier Name	Coverage
12/01/2024	12/31/2025	ESYH771399328298	788992	EMPLOYERS NATIONAL	INDIANA MEDICAL AND HOSPITAL

A sidebar on the left contains a list of navigation options: Overview, Cost Sharing, Assessments, Health Record, ADT, Care Plan, Authorizations, Referrals, Coordination of Benefits (highlighted with a red border), Claims, Power Account Service Estimate, Document Resource Center, and Notes. A link for 'Print Coordination of Benefits' is located in the top right corner of the table area.

Prior Authorization

Prior Authorization Considerations

Learn More About Medicaid Prior Authorization


- [Pre-Authorization Tool.](#)

How to Obtain Authorization

- [Online](#): MHS Secure Provider Portal.
- Fax: 1-866-912-4245.

Authorizations do not guarantee payment.

Prior Authorization


For Members -
For Providers -
Get Insured

For Providers

- Provider Portal Login
- Behavioral Health
- Clinical & Payment Policies
- Dental Providers
- Education & Trainings
- Email Sign Up
- Enrollment and Updates
- News
- Pharmacy
- Prior Authorization**
- Medicaid Pre-Auth
- Medicare Pre-Auth
- Ambetter Pre-Auth
- Quality Improvement
- Resources

Medicaid Pre-Auth

DISCLAIMER

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

Vision services need to be verified by [Centene Vision Services](#)

Dental services need to be verified by [Centene Dental Services](#)

Musculoskeletal services need to be verified by [Evolut](#)

Complex imaging, MRA, MRI, PET, CT scans, PT, ST, OT and Pain Management need to be verified by [Evolut](#)

Medication under the pharmacy benefit needs to be verified by [Aetna United PDL](#)

NOTE: Services identified as administered by a Vendor may be specific to certain provider specialties, locations, procedure and diagnosis codes. For example, Physical Therapy services rendered by Chiropractic specialty providers or via Telehealth locations are NOT managed by Evolut. Any service rejected by the Vendor as outside of their scope of managed services, please enter a request to establish Health Plan authorization requirements.

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

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

Yes
 No

Types of Services	YES	NO
Are services being provided by a non-participating provider?	<input type="radio"/>	<input checked="" type="radio"/>
Is the member being admitted to an inpatient facility?	<input type="radio"/>	<input checked="" type="radio"/>
Are anesthesia services being rendered for pain management?	<input type="radio"/>	<input checked="" type="radio"/>
Are services for infertility?	<input type="radio"/>	<input checked="" type="radio"/>

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

CHECK FOR PRE-AUTH

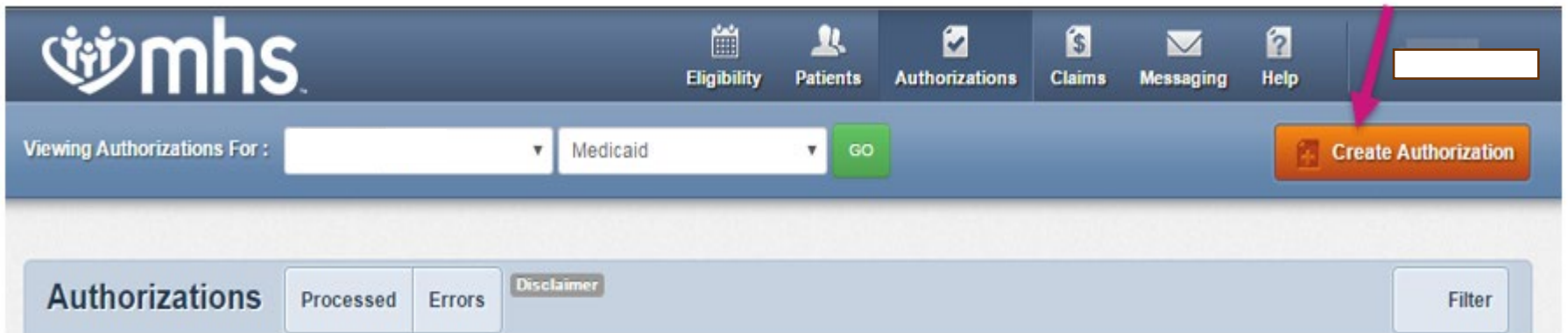
C

88270 - VAG HYET ULTRUS 250 GAIN-REP ENTROCL

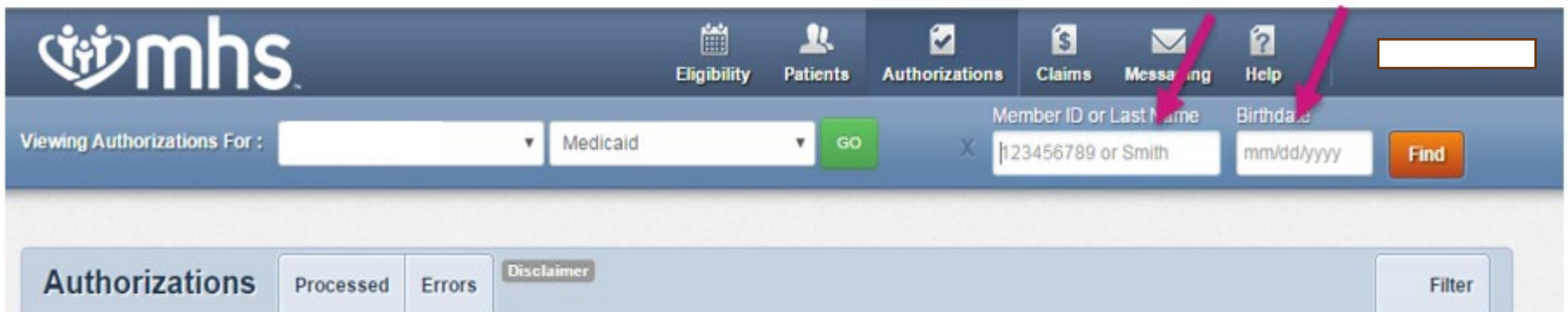
Pre-authorization is required if billed with a Gender Dysphoria diagnosis. If billed with any other diagnosis, pre-authorization is required for non-participating providers only.

Creating a New Authorization

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



The screenshot shows the top navigation bar of the mhs portal with icons for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below the navigation bar, there are two dropdown menus for 'Viewing Authorizations For:' with 'Medicaid' selected in the second one, and a green 'GO' button. On the right side, there is a search box and a prominent orange button labeled 'Create Authorization' with a plus icon, which is pointed to by a pink arrow.



This screenshot shows the same mhs portal interface but with the search section expanded. The search area includes a dropdown menu for 'Viewing Authorizations For:' with 'Medicaid' selected and a green 'GO' button. To the right, there are two input fields: 'Member ID or Last Name' containing the text '|23456789 or Smith' and 'Birthdate' with the placeholder 'mm/dd/yyyy'. A pink 'Find' button is located to the right of these fields. Two pink arrows point to the search input areas. Below the search section, there are buttons for 'Authorizations', 'Processed', 'Errors', 'Disclaimer', and 'Filter'.

Creating a New Authorization

- Select an Authorization Type.

The screenshot displays a web form for creating a new authorization, divided into two main sections: 'Authorization For' and 'Enter Authorization'.

Authorization For

DOB () MEDICAID NBR: 1

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 Nurse/Wise line at 877-647-4848 for after-hours urgent admission, inpatient notifications or requests. ✕

Enter Authorization

1. PROVIDER REQUEST

Urgent Request

Select an Authorization Type ▼

Select an Authorization Type

Inpatient Medical

Outpatient Medical

3. FINISH UP

Creating a New Authorization –Service Types

Inpatient Medical Auth Type Selected

Choose Service Type

Enter Authorization

1. PROVIDER REQUEST

Urgent Request

Inpatient Medical

Surgical?

Yes

No

Choose Service Type

- Choose Service Type
- C-Section Delivery
- Medical
- Neonate
- Premature/False Labor
- Rehab Inpatient
- Skilled Nursing
- Surgical Inpatient
- Transplant
- Vaginal Delivery

Outpatient Medical Auth Type Selected

Choose Service Type

Enter Authorization

1. PROVIDER REQUEST

Urgent Request

Outpatient Medical

Lab Testing?

Yes

No

Requesting Provider

Requesting Provider NPI or Last Name

NEXT >

3. FINISH UP

Creating a New Authorization

Select Provider NPI.

Add Primary Diagnosis.

Enter Authorization

1. PROVIDER REQUEST

Urgent Request

Outpatient Medical

Lab Testing?

Yes

No

Requesting Provider

Requesting Provider NPI or Last Name

NEXT →

Enter Authorization

1. PROVIDER REQUEST

Outpatient Medical

Lab Testing?

Yes

No

Requesting Provider

NPI:

TIN:

Name:

Primary Diagnosis

Diagnosis Code

CODE LOOKUP: [ICD-10](#)

+ Add Additional Diagnosis


Creating a New Authorization - Procedures

Add Additional Procedures (if applicable).

Authorization For

DOB: [REDACTED] | MEDICAID NBR: [REDACTED]

PROVIDER REQUEST

 Service Type: Outpatient Outpatient Services
SMITH
GENERAL SURGERY
Primary Diagnosis: 5430: HYPERPLASIA OF APPENDIX
Additional Diagnosis: 5379: UNSPEC DISORDER STOMACH&DUODENUM
NPI:
TIN:
Phone:

Enter Authorization

1. PROVIDER REQUEST [EDIT](#)

2. SERVICE LINE


TIN: [REDACTED]
Name: SMITH [REDACTED]
07/14/2015 - 07/24/2015
1
Primary Procedure
44970
LAPAROSCOPY RUSGICAL
APPENEDECTOMY
[CODE LOOKUP](#)

+ Add Additional Procedures

Select a Place Of Service
Ambulatory Surgical Center
Outpatient Hospital
Unspecified

+ Add New Service Line

NEXT >



Creating a New Authorization – Service Lines

Service Line Details:

Enter Authorization

1. PROVIDER REQUEST [EDIT](#)

2. SERVICE LINE

Now adding new service line


Servicing Provider

Same as Requesting Provider

NPI or Last Name

Start Date – End Date

Units/Visits/Days

Select a Place Of Service 

Primary Procedure

Procedure Code

- Provider request will appear on the left side of the screen.
- Update Servicing Provider. Check box if same as Requesting Provider.
- Update Servicing Provider if not the same.
- Update Start Date and End Date.
- Update Total Units, Visits, or Days.
- Update Primary Procedure.
- Add any additional procedures.
- Add additional Service Line if applicable: All Service Lines added will appear on the left side of the screen.

Creating a New Authorization - Submission

- Submit a new Authorization:
 - **Confirmation number**

The screenshot shows the '3. FINISH UP' step of the authorization submission process. It includes a 'SUBMIT' button at the bottom, which is highlighted with a red arrow. The form contains fields for phone numbers, fax, and email, along with an attachment section for uploading documents.

1. PROVIDER REQUEST **EDIT**

2. SERVICE LINE **EDIT**

3. FINISH UP

(123) 456-7890

Fax

(098) 765-4321

Email

jmuliner@centene.com

Questionnaire

Attachment:

Upload any relevant attachments. (5Mb limit)

Browse

Attach

Smart Sheet for Testing.pdf Remove

SUBMIT

The screenshot shows a 'Success!' dialog box with a list of information items. A red arrow points to the 'Your confirmation number' item. The background shows the 'Enter Authorization' step of the process.

Authorization For

DOB: MEDICAID NBR:

1. PROVIDER REQUEST

2. SERVICE LINE

Success!

- Your confirmation number
- Member's Name
- Date of Birth
- Medicaid Number

PROVIDER REQUEST

Service Type

SMIT

GENERAL

Primary Doctor

Additional

NPI: 147

TIN:

Phone:

SERVICE LINES

Medical Prior Authorization

- MHS has up to 48 hours to render standard PA decisions and 24 hours to render urgent PA decisions.
- Reasons for a delayed decision may include:
 - Lack of information or incomplete request.
 - Request requiring Medical Director review.
- Medical Management does not verify eligibility or benefit limitations:
 - Provider is responsible for eligibility and benefit verification.

MHS Provider Engagement



MHS Resources

- For additional information, please contact your MHS Provider Engagement Account Manager to schedule an appointment today
- Additional resources available at on the **MHS Website**
- Register online for additional **Monthly Web Sessions**

PEAM Contact Information

NORTHEAST REGION

For claims issues, email:
MHS_ProviderRelations_NE@mhsindiana.com
joy.k.diarra@mhsindiana.com
Joy Diarra, Provider Engagement Account Manager
1-317-864-2378

NORTHWEST REGION

For claims issues, email:
MHS_ProviderRelations_NW@mhsindiana.com
Candace.V.Ervin@mhsindiana.com
Candace Ervin, Provider Engagement Account Manager
1-317-364-7635

NORTH CENTRAL REGION

For claims issues, email:
MHS_ProviderRelations_NC@mhsindiana.com
Natalie.Smith@mhsindiana.com
Natalie Smith, Provider Engagement Account Manager
1-317-379-9035

CENTRAL REGION

For claims issues, email:
MHS_ProviderRelations_C@mhsindiana.com
ldavis@mhsindiana.com
Latisha Davis, Provider Engagement Account Manager
1-317-601-5999

SOUTH CENTRAL REGION

For claims issues, email:
MHS_ProviderRelations_SC@mhsindiana.com
DDENNING@mhsindiana.com
Dalesia Denning, Provider Engagement Account Manager
1-317-951-3800

SOUTHWEST REGION

For claims issues, email:
MHS_ProviderRelations_SW@mhsindiana.com
Dawnalee.A.McCarty@mhsindiana.com
Dawn McCarty, Provider Engagement Account Manager
1-317-556-6171

SOUTHEAST REGION

For claims issues, email:
MHS_ProviderRelations_SE@mhsindiana.com
tiffany.calloway@centene.com
Tiffany Calloway,
Provider Engagement Account Manager
1-812-697-8126

Large Provider Groups - Carolyn

**CAROLYN
VALACHOVIC
MONROE**

Provider Engagement Account Manager
1-317-443-8243
CMONROE@mhsindiana.com

PROVIDER GROUPS

Eskenazi/The Health and Hospital
Corp.
Baptist Health
Lifespring
Wellcare
Deaconess (including Little Company
of Mary)
Good Samaritan
Norton (including King's Daughters,
Clark & Scott Memorial)
Indiana University Health
Reid Hospital
St. Elizabeth Hospital
Community Health

Large Provider Groups - Mona

MONA GREEN

Provider Engagement Account Manager
1-812-614-1003
mona.green@mhsindiana.com

PROVIDER GROUPS

St. Vincent/Ascension
Wellcare Complete
Lutheran Medical Group
Parkview Health System
Beacon Medical Group
American Senior Care
CarDon & Associates
OrthoIndy
Heart City Health
ONE
Franciscan Health

Behavioral Health Provider Contact

ANGEL JOHNSON

Provider Engagement Account Manager

1-317-468-5184

angel.johnson3@centene.com

PROVIDER GROUPS

Park Center

Otis Bowen

Centerstone

Valley Oaks Health

Grant-Blackford

Four County

Hamilton Center

Community Mental Health
Center (Lawrenceburg)

Oaklawn

Northeastern Center

Edgewater Health

Regional Mental Health

Swanson Center

Porter-Starke Services

Southwestern Behavioral
Community Mental Health
Center (Vevay/Batesville)

Additional Contact Information

MHS Provider Network

NETWORK LEADERSHIP

JILL CLAYPOOL Senior Vice President, Network Development & Contracting 1-877-647-4848 Jill.E.Claypool@mhsindiana.com	MARK VONDERHEIT Senior Director, Provider Network 1-877-647-4848 MVONDERHEIT@mhsindiana.com
--	---

JENNIFER GARNER
Manager, Provider Relations
1-317-771-5537
jgarner@mhsindiana.com

NETWORK OPERATIONS

KELVIN ORR
Director, Network Operations
1-877-647-4848
Kelvin.D.Orr@mhsindiana.Com

NEW PROVIDER CONTRACTING

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

MICHAEL FUNK
Manager, Network Development & Contracting
1-877-647-4848
Michael.J.Funk@mhsindiana.com

CENTENE VISION

SIERRA HICKS
sierra.hicks@centene.com
Vision Provider Services: 1-844-820-6523

CENTENE DENTAL

THOMAS "TONY" SMITH
thomas.smith3@centene.com
Dental Provider Services: 1-855-609-5157

Questions?

Thank you for being our partner in care.
