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## Claims UB-04

2023 Annual IHCP Works Seminar

Presenter: Dalesia Denning, Provider  
Engagement Advisor

# Agenda

- MHS Overview
- Claim Submission Process
- MHS Claims Issue Resolution Process
- Additional Claims Assistance
- Portal Functionality
- Facility Billing
- Web Portal Claim Payment and Review
- Online Claim Reconsiderations on the MHS Secure Provider Portal
- Prior Authorization
- MHS Team
- Summary
- Questions

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# MHS Overview

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# Who is MHS?

- Managed Health Services (MHS) is a health insurance provider that has been proudly serving Indiana residents for more than twenty-five years through Hoosier Healthwise, the Healthy Indiana Plan (HIP) and Hoosier Care Connect.
- MHS is your choice for better healthcare.

# MHS Products



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# Claim Submission Process

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# Medical Claim Submission

- **Electronic Data Interchange Submission:**
  - Preferred method of claims submission
  - Faster and less expensive than paper submission
  - MHS Electronic Payor ID **68069**
- Online through the **MHS Secure Provider Portal** at <https://www.mhsindiana.com/providers.html>
- 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

# Behavioral Health Claim Submission

- **Electronic Submission:**

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

- Online through the **MHS Secure Provider Portal** at <https://www.mhsindiana.com/providers.html>

- 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  
PO Box 6800  
Farmington, MO 63640-3818



# Claim Billing with Ease

- The NPI, Tax ID, Zip +4 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 MHS Secure Provider Portal

# Claim Submission

- In-Network providers: 90 calendar days from the date of service or discharge date. Out-of-Network providers: 180 calendar days from the date of service or discharge date.

## Exceptions:

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

# Claim Submission

## Claim Acceptance and Adjudication

- System reviews claim for errors and critical fields (i.e., dates of service, billing/rendering provider, etc.) prior to acceptance.
- Regulatory requirements (federal and state) mandate certain information to be present in order to accept and pay a claim.
- National Provider Identifier (NPI) common rejection/denial; provider information on claim must match record at IHCP enrollment – a State requirement.

# Transportation Claims

- Managed Health Services (MHS) will process all Medicaid emergent and non-emergent ambulance claims, including air ambulance, which would have previously been processed by LCP Transportation.
- Claims for the following services should be sent to MHS:
  - 911 Transports
  - Medically necessary non-emergent hospital transports requiring an ambulance with advanced life support (ALS) or basic life support (BLS)
  - Air ambulance
- Only providers enrolled with the Indiana Health Coverage Programs (IHCP) are eligible for reimbursement. Claims must be filed within 180 days of the Date of Service (DOS) for non-contracted providers and within 90 days of DOS for contracted providers.
- Claims should be submitted to MHS via a CMS-1500 professional claim form. Claims may be submitted via EDI (preferred), MHS web portal or paper.

# Transportation Claims

- MHS will follow IHCP billing guidelines for coding and reimbursement.
- For more information on Medicaid ambulance billing guidelines, please visit Transportation Module: [transportation-services.pdf \(in.gov\)](#)
- **Claim Inquiries:**
  - Check status online via the MHS Secure Web Portal
  - Call Provider Services at 1-877-647-4848

# 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.
- Rejected claims need corrected and submitted as a new claim.
- Timely filing is not substantiated when a claim is rejected.

# Claims Rejections

- EDI rejections require the provider to contact their clearinghouse and obtain a payer rejection report.
- Paper to electronic mapping is available on:  
<https://www.mhsindiana.com/providers/resources/guides-and-manuals.html>
- MHS website tools :
  - Reject code listing
  - Refer to Top 10 Rejection Code Help Aid Document  
<https://www.mhsindiana.com/content/dam/center/mhsindiana/medicaid/pdfs/508-Top-10-Rejections-Edu-Doc.pdf>

# Reason for Claim Rejections

## Medical

- 07** Invalid Subscriber/Member ID
- 09** Member Invalid on Date of Service
- 01** Invalid Provider ID Billing Physician (Provider State Crosswalk File)
- 08** Invalid Member Date of Birth
- 76** Original claim number required
- 40** Diagnosis code is missing
- 90** Invalid or Missing Modifier
- B5** Missing/incomplete/Invalid CLIA
- 77** Invalid Claim Type
- A3** Claim exceeded the maximum 97 service line limit

## Behavioral Health

- 09** Member Invalid on Date of Service
- 07** Invalid Subscriber/Member ID
- 08** Invalid Member Date of Birth
- 01** Invalid Provider ID Billing Physician (Provider State Crosswalk File)
- 76** Original claim number required
- 40** Diagnosis code is missing
- 31** Invalid Service Procedure code
- A3** Claim exceeded the maximum 97 service line limit



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# MHS Provider Claims Issue Resolution Process

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# Provider Claims Issue Resolution

## PROCESS

- Level 1: Informal Claims Dispute Online or with Medical Claim Dispute/Appeal form

Level 2: Formal Claim Dispute –Administrative Claim Appeal Online or with Medical Claim Dispute/Appeal form

- 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 – Medical and Behavioral Health

## Medical Claims Address:

Managed Health Services  
 PO Box 3000  
 Attn: Appeals Department  
 Farmington, MO 63640-3800

## Behavioral Health Claims Address:

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

<https://www.mhsindiana.com/content/dam/cene/mhsindiana/medicaid/pdfs/508-MHS-Dispute-Appeal-form.pdf>



**DO NOT USE THIS FORM FOR MEDICAL NECESSITY APPEALS.**

### Medical Claim Dispute/Appeal Form

**This form is not required but available to assist in submitting an informal dispute/appeal.**

\_\_\_ 1<sup>st</sup> Level (Informal Dispute/Reconsideration)  
 \_\_\_ 2<sup>nd</sup> Level (Appeal) – if you are not satisfied with resolution of informal dispute

This form must be completed in its entirety. In order to consider your request, you must provide an explanation of your appeal and **submit supporting documentation for the dispute/appeal**. Without sufficient documentation, the request cannot be reviewed and the original determination will be upheld.

Provider Name	Provider Tax ID
Provider NPI	Date of last Explanation of Payment
MHS Claim Number *	Dates of Service *
Member Name *	Member ID *

\* Required fields

Where more than one of claim number, DOS, member name, or member ID applies for the same appeal reason, please include this information as an attachment.

#### Reason for the appeal:

- Claim was denied for no authorization, but authorization number \_\_\_\_\_ was obtained.
- Claim was denied for no authorization, but no authorization is required for this service.
- Claim was denied for no authorization, however authorization was not obtained due to member's eligibility or medical condition.
- Claim was denied for Member not eligible, but member was eligible on DOS (attach eligibility information).
- Claim was not paid per the terms of my contract with Managed Health Services (attach relevant reimbursement section).
- Claim denied as non-covered benefit (attach supporting documentation as proof the service is a covered benefit).
- Claim was denied "Past Timely Filing" (attach proof of timely filing).
  - o Note: if the past timely filing deadline falls on a weekend or a holiday, the provider may request a reconsideration ( see Reconsideration Request Form)
- Claim was paid the incorrect amount (include calculation of expected payment and supporting information).
- Claim denied based on Managed Health Services Payment policy (attach medical records to support services provided).
  - o Note: Payment policies can be found at <https://www.mhsindiana.com/providers/resources/clinical-payment-policies.html>
- Other. Please explain (and provide supporting documentation): \_\_\_\_\_

Please ensure sufficient detail is provided to assist us in the review of your appeal.

**Preferred submission via the Provider Portal: Informal disputes – currently available;  
 2<sup>nd</sup> level appeal – available online beginning in early 2021**

Paper copies of the completed form and all attachments can be sent to:

**Medical Claims:**  
 Managed Health Services  
 PO Box 3000  
 Farmington, MO 63640-3800

**Behavioral Health Claims**  
 Managed Health Services BH Appeals  
 PO Box 6000  
 Farmington, MO 63640-3809



1-877-647-4548 | TTY: 1-800-743-3333 | mhs@mhsc.com  
 Abate! from MHS | Abate! from MHS | Healthy Indiana Plan (HIP) | Hoosier Care Connect | Hoosier Healthwise

1220.05.P.LT 1/21



# Informal Claims Dispute or Objection Form

## Level 1:

- Submit all documentation supporting your objection.
  - Copies of 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).
- Must be submitted via the Secure Web Portal or in writing within **60 calendar days** of receipt of the MHS Explanation of Payment (EOP) by using the Medical Claim Dispute/Appeal form.
  - Requests received after day 60 will not be considered.

# Informal Claims Dispute or Objection Form

## Level 1:

- MHS will make all reasonable efforts to review your documentation and respond to you within **30 calendar days.**
- At that time (or upon receipt of our response if sooner), you will have up to **60 calendar days** from date of dispute response to initiate a formal claim appeal (Level 2).

# Informal Claims Dispute or Objection Form

## Level 1: Helpful Tips

- Disputing multiple claim denials:
  - Submit separate Informal Claims Dispute Forms for each member/patient experiencing the denial;
  - Provide additional information such as:
    - The MHS denial code and description found on the EOP/remit;
    - 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 & Web Portal Inquiries

- After the informal claims dispute (Level 1) has been submitted, for assistance or questions, the provider can access the Provider Service Phone line or Web Portal. The inquiries will be logged and assigned a ticket number. Please keep this ticket number for your reference.
- Phone: 1-877-647-4848; Provider Services 8 a.m. to 8 p.m.
- Provider Web Portal: <https://www.mhsindiana.com/providers/login.html>
- Use the Messaging Tool.

# Provider Services Phone Requests & Web Portal Inquiries

## Helpful Tips:

### Disputing multiple claim denials:

- Provide the provider services rep or web portal team member with one claim number as an example of the specific denial. Communication is key!
- Inform the rep 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 TIN).
- Provide the MHS denial code and description found on the EOP.
- Briefly describe why you are disputing this denial or seeking research.



# Formal Claim Dispute - Administrative Claim Appeal

## Level 2:

- 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 Secure Portal or in writing by using the Medical Claim Dispute/Appeal form with an explanation including any specific details which may justify reconsideration of the disputed claim. The appeal clearly marked on the form as Level 2.
- See the MHS Provider Manual Chapter 5 Claims Administrative Reviews and Appeals for more information.
- [MHS - Provider Manual 2023 \(mhsindiana.com\)](https://mhsindiana.com)

# Arbitration

## Level 3:

- Level 3 is 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 need to be mailed to:

MHS Arbitration

550 N. Meridian Street, Suite 101

Indianapolis, IN 46204

- See the MHS Provider Manual Chapter 5 Claims Administrative Reviews and Appeals for more information.

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

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# Additional Claim Assistance

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# Provider Relations Regional Mailboxes

- If all claim denials are upheld after following the dispute processes and the provider has not received resolution by calling Provider Services or utilizing the secure messaging on the portal, please contact the Provider Relations team through the claim issues mailbox assigned to your region.
- Issues will be logged by the internal Provider Relations team and providers will receive a response email with next steps and any assigned reference numbers.
- Please do not email your Provider Partnership Associate directly as this may delay the time in getting a response due to their travel.

# Provider Relations Regional Mailboxes

## Helpful Tips:

Please submit the following information to the provider relations regional mailbox (attach spreadsheet if multiple claims but below fields must be included)

- Issue Reference Number(s)
- TIN
- Group/Facility Name
- Practitioner Name and NPI
- Member Name and MID Number
- Product (Medicaid/Ambetter/Allwell)
- Claim Number(s)
- DOS or DOS Range if multiple denials
- Related Prior Authorization Numbers (this is key if issue involves claims denied for no authorization)
- Provider reason for dispute

# Provider Relations Regional Mailboxes

- Regional Mailboxes
  - Northeast Region: [MHS\\_ProviderRelations\\_NE@mhsindiana.com](mailto:MHS_ProviderRelations_NE@mhsindiana.com)
  - North Central Region: [MHS\\_ProviderRelations\\_NC@mhsindiana.com](mailto:MHS_ProviderRelations_NC@mhsindiana.com)
  - Central Region: [MHS\\_ProviderRelations\\_C@mhsindiana.com](mailto:MHS_ProviderRelations_C@mhsindiana.com)
  - Northwest Region: [MHS\\_ProviderRelations\\_NW@mhsindiana.com](mailto:MHS_ProviderRelations_NW@mhsindiana.com)
  - Southwest Region: [MHS\\_ProviderRelations\\_SW@mhsindiana.com](mailto:MHS_ProviderRelations_SW@mhsindiana.com)
  - Southeast Region: [MHS\\_ProviderRelations\\_SE@mhsindiana.com](mailto:MHS_ProviderRelations_SE@mhsindiana.com)
  - South Central Region: [MHS\\_ProviderRelations\\_SC@mhsindiana.com](mailto:MHS_ProviderRelations_SC@mhsindiana.com)
  - Tier 1 Providers: [IndyProvRelations@mhsindiana.com](mailto:IndyProvRelations@mhsindiana.com)

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# Portal Functionality

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# Secure Web Portal Login or Registration

The screenshot displays the MHS website's 'Portal Login' page for providers. At the top, the MHS logo is on the left, and navigation links (Home, Find a Provider, Portal Login, Events, Careers, Contact Us) and a search bar are on the right. A secondary navigation bar includes 'FOR MEMBERS', 'FOR PROVIDERS', and 'GET INSURED'. The main content area is titled 'FOR PROVIDERS' and features a sidebar with a 'Login' section and a list of links: Enrollment and Updates, Prior Authorization, Dental Providers, Pharmacy, Opioid Resources, Behavioral Health Providers, Provider Resources, QI Program, Provider News, Email Sign Up, and Coronavirus Information. The main content area is titled 'Portal Login' and includes a heading 'Create your own online account today!', a brief description of the portal's benefits, and a list of actions users can take by creating an account. A 'Secure Provider Portal Login/Register' button is highlighted with a red box. Below this is a 'Provider Email Sign Up' button. A section titled 'PORTAL TRAINING GUIDES' lists several PDF guides. At the bottom, there is a 'Registration Help' section and a 'Vision and Dental Providers' section with links to their respective portal logins.

Home Find a Provider Portal Login Events Careers Contact Us

Contrast On Off a language

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

**FOR PROVIDERS**

Login

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

## 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)
- Submit a Claim CMS 1500 (PDF)
- Submit a Claim CMS UB-04 (PDF)
- Update Portal Account Details (PDF)
- Utilize Member Management Forms (PDF)

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

### Registration Help

If you are having trouble with your registration, you may need to submit a non-par set-up form. Visit our [Become a Provider](#) page to get started. For further assistance, you can call Provider Services at 1-877-647-4848 or see our [Account Registration Guide \(PDF\)](#).

### Vision and Dental Providers

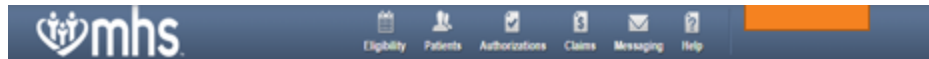
[Vision Provider Portal Login](#)

[Dental Provider Portal Login](#)

- Verify member eligibility
- View member benefits



# Homepage-MHS (Medicaid)



Eligibility Patients Authorizations Claims Messaging Help

Viewing Dashboard For: TIN [dropdown] Plan Type [Medicaid] [GO]

**Notification of Pregnancy (NOP)**  
NOP must be accessed through the IHCP Provider Healthcare Portal and electronically submitted. NOP option is only for Medicaid members. You must create a login and password in order to access the NOP form through the Provider Healthcare Portal.

**Please Note**  
Claims information is updated every 24 hours.

## Welcome, Kimberly!

Get summaries of claims data at a glance and easy access to the options you use most.

## Admin Settings

Add and manage user access and information.

[Add User](#) [Edit User Access](#) [Add a TIN](#)

## 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    
MM/DD/YYYY

Select Action Type \*

[SUBMIT](#)

## Authorization Overview

[Inpatient Authorizations](#) [View All](#)

[Outpatient Authorizations](#) [View All](#)

## Useful Links

[Reports](#)  
This repository contains reports that are uploaded and maintained by the health plan.

[Patient Analytics](#)  
This is a PHM tool that supports providers in the delivery of timely, efficient, and evidence-based care to our members.

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

# Claims

## Web Portal Claims Functionalities:

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

## Submit a New Claim:

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

The image displays two screenshots of the mhs web portal interface, illustrating the process of submitting a new claim.

**Top Screenshot:** Shows the main navigation bar with the mhs logo and menu items: Eligibility, Patients, Authorizations, Claims, Messaging (98), and Help. Below the navigation bar, there is a section for "Viewing Claims For:" with a dropdown menu set to "3" and "Medicaid", and a green "GO" button. To the right, there are buttons for "Upload EDI" and "Create Claim". Below this, a secondary navigation bar includes "Claims", "Individual", "Saved", "Submitted", "Batch", "Payment History", "My Downloads", "Claims Audit Tool", and a "Filter" button.

**Bottom Screenshot:** Shows the same interface but with the "Create Claim" process initiated. The "Viewing Claims For:" section is identical. To the right, there is a search area with "Member ID or Last Name" and "Birthdate" labels. The "Member ID or Last Name" field contains "123456789 or Smith" and the "Birthdate" field contains "mm/dd/yyyy". A red "Find" button is visible next to the search fields. The secondary navigation bar is also present at the bottom.

# Claim Submission

## Choose the Claim Type

- Professional or Institutional claim submission

The screenshot displays the mhs Claims Submission interface. At the top, the mhs logo is on the left, and navigation icons for Eligibility, Patients, Authorizations, Claims, Messaging, and Help are on the right. A dropdown menu for 'Provider Name' is also visible. Below the navigation bar, there is a section for 'Viewing Claims For:' with two dropdown menus: 'Tax ID Number' and 'Medicaid', followed by a green 'GO' button. To the right of this section are two buttons: 'Upload EDI' and 'Create Claim'. Below this is a large blue box with the text 'Choose Claim for :'. Underneath, the heading 'Choose a Claim Type' is displayed. Two large green buttons are shown: 'Professional Claim →' under the heading 'CMS 1500' and 'Institutional Claim →' under the heading 'CMS UB-04'. At the bottom of the main content area, an update notice reads: '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.'

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# Facility Billing

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# UB-04 Billing

- In the General Info section, populate the Patient's Control Number and other information related to the patient's condition by typing into the appropriate fields.
- Click Next.

The screenshot displays the mhs (Medical Health Services) interface for creating a claim. At the top, there is a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below this, a header indicates the user is viewing claims for a specific patient, with a dropdown menu set to 'Medicaid' and a green 'GO' button. To the right of the header are buttons for 'Upload EDI' and 'Create Claim'.

The main content area is titled 'Institutional Claim for [redacted]' and includes a 'Your Progress' indicator with a series of arrows, the first of which is highlighted in orange. Below this, the section is labeled 'THIS SECTION: General' with the instruction 'Enter Information for the Admission and Condition Codes'. A note indicates that the following fields are '\* Required field'.

The form contains several input fields, each with a corresponding label on the right side of the page:

- Patient Control #\***: A text input field with a mask of 'XXXXXXXXXX'. A large pink arrow points to this field.
- Medical Record #**: A text input field with a mask of 'XXXXXXXXXX'.
- Type Of Bill\***: A dropdown menu currently showing 'Select...'.
- Statement Dates\***: Two date input fields labeled 'From' and 'To', both with a mask of 'MM/DD/YYYY'.
- Prior Payments**: A text input field.
- Prior Authorization Number**: A text input field.

At the bottom left of the form area, the word 'Admission' is visible. A green 'Next →' button is located at the top right of the form area.

# UB-04 Billing

Add the provider information.  
Click **save** and click **next** to proceed.

Click **Add New Service Line**  
and enter the service lines  
information.

The screenshot shows the 'Provider Details' section of the mhs Institutional Claim form. A pink arrow points to the 'Next' button at the top right. Another pink arrow points to the 'Billing Provider' section, which contains a red-shaded area with an 'NP#' field and a 'Search' button. Below this are fields for 'Taxonomy', 'Pay-to Provider', and 'Attending Provider'.

The screenshot shows the 'Service Lines' section of the mhs Institutional Claim form. A pink arrow points to the 'Next' button at the top right. Below the 'Add New Service Line' header, there are several input fields: 'Revenue Code' (with a 'Lookup' button), 'HCPCS / Rate / HPPS Code', 'NDC', 'Modifiers' (with an 'Add' button), 'Service Date' (format MM/DD/YYYY), 'Service Units', and 'Charge Amount'. A 'Total: \$0.00' box is visible on the left side.

# UB-04 Billing

- Enter Additional Insurance (if applicable)

The screenshot shows the mhs web portal interface for an Institutional Claim. The top navigation bar includes links for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below the navigation bar, there are dropdown menus for 'Viewing Claims For' and 'Medicaid', along with 'Upload EDI' and 'Create Claim' buttons. The main content area is titled 'Institutional Claim for [redacted]' and features a progress bar with five steps. The current step is 'Additional Insurance', with the instruction 'Enter additional insurance details.' A yellow banner states: 'You may skip this section if there is no additional insurance.' with a 'Next >' button. Below this, the 'Primary Insurance' section is highlighted with a pink arrow. A notice reads: 'Notice: If the Member has more than one primary insurance (Medicaid would be the 3rd payer), the claim cannot be submitted through the Web.' The form fields include: Carrier Type (Select...), Policy Number (XXXXXXXX), Amount Allowed (XXXX.XX), Deductible (XXXX.XX), Copay (XXXX.XX), and Co-Insurance (XXXX.XX). A vertical sidebar on the right shows a progress indicator with a '50' and a '60'.

# Enter Diagnosis Codes (use Add button)

The screenshot shows the mhs web application interface for entering diagnosis codes. At the top, there is a navigation bar with the mhs logo and various menu items: Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below the navigation bar, there is a section for 'Viewing Claims For:' with a dropdown menu set to 'Medicaid' and a 'GO' button. To the right, there are buttons for 'Upload EDI' and 'Create Claim'.

The main content area is titled 'Institutional Claim for [redacted]' and includes a 'Your Progress' indicator with a series of arrows. Below this, the section is titled 'THIS SECTION: Diagnosis Codes' with the instruction 'Enter all relevant diagnosis codes.' A note states: 'Please note that for the claim statement dates entered, valid ICD-10 codes only are accepted.'

The form contains several fields for entering diagnosis codes:

- ICD Version Indicator\***: A radio button is selected for 'ICD 10'.
- Principal Diagnosis Code\***: A text input field with a placeholder 'XXXX e.g. V87', a 'POA Indicator' dropdown menu, and a 'Select...' button. A pink arrow points to this field.
- Admitting Diagnosis Code\***: A text input field with a placeholder 'XXXX e.g. V87'.
- Diagnosis Codes (S7A-Q)**: A text input field with a placeholder 'XXXX e.g. 140X', a 'POA Indicator' dropdown menu, an 'Add' button, and a 'Select...' button.
- Patient Reason for Visit**: A text input field with a placeholder 'XXXX e.g. V87' and an 'Add' button.
- External Cause of Injury Code (ECI)**: A text input field with a placeholder 'XXXX e.g. V87'.
- Prospective Payment Code**: A text input field.
- Condition Code**: A text input field with a placeholder 'V87' and an 'Add' button.

On the right side of the form, there are several tabs or indicators labeled '67.', '69.', '67 a-q', '70.', '72.', '71.', and '68,70'.



# Add Attachment(if applicable)

Viewing Claims For : [dropdown] Medicaid [dropdown] GO [Upload EDI] [Create Claim]

Institutional Claim for [redacted] Your Progress [progress bar]

THIS SECTION:  
**Attachments** Add attachments to the claim (5MB limit). Supported types are .jpg, .tif, .pdf and .tiff

← 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\* [input] Browse... Attachment Type\* [Select Type... dropdown] Attach

There are no attached files.

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

# Review Claim and Submit

The screenshot displays the mhs web portal interface. At the top, there is a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below this, a dropdown menu shows 'Viewing Claims For:' with 'Medicaid' selected. A 'GO' button and 'Upload EDI' button are visible. A progress bar indicates the current step is 'Review and Submit'.

**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:** [Redacted]

**General Info** [Edit](#)

Patient Control #: 111111111  
Medical Record #: 111111111  
Type Of Bill: 110  
Statement From Date: 09/01/2017  
Statement To Date: 09/05/2017  
Prior Payments:  
Prior Authorization Number:  
Admission Date: 09/01/2017  
Admission Hour: 10  
Admission Type: 9  
Admission Source: 7  
Discharge Status: 01  
Discharge Hour: 09

**Provider Details** [Edit](#)

Provider Type	NPI	Taxonomy	Name	Tax ID	Address (1)	Address (2)	City	State	Zip
Billing Provider	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]
PayTo Provider	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]

Provider Type	NPI	Taxonomy	First Name	Last Name	IRS/Tax ID Num	Organization
[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]

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# Web Portal Claim and Payment Review

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# Submitted Claims

The Submitted tab will only display claims created via the MHS portal:

- Paid is a green thumbs up.
- Denied is an orange thumbs down.
- Pending is a clock.
- RTEP 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		CMS-1500	S J	1	6	\$150.00	
👍	08/10/2017		C	CMS-1500	C	1		\$150.00	RTEP 👍
👍	08/02/2017	{	C	CMS-1500	S	1		\$150.00	RTEP 🚫
👍	07/24/2017	E	C	CMS-1500	S	1		\$150.00	RTEP 👍

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

# Individual Claims

On the Individual tab, submitted using paper, portal or clearinghouse:

- 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, a search bar shows 'Viewing Claims For:' with a dropdown menu set to 'Medicaid' and a 'GO' button. To the right are buttons for 'Upload EDI' and 'Create Claim'. The main content area features a 'Claims' header with a sub-menu where 'Individual' is selected and highlighted with a pink box. Below the header are tabs for 'Saved', 'Submitted', 'Batch', 'Payment History', 'My Downloads', and 'Claims Audit Tool', along with a 'Filter' button. The central part of the interface is a table with the following columns: CLAIM NO. ↑, CLAIM TYPE ↓, MEMBER NAME ↓, SERVICE DATE(S) ↓, BILLED/ PAID ↓, and CLAIM STATUS ↓. A pink arrow points to the CLAIM STATUS column. The table contains five rows of data, each representing a claim. The first four rows show claims with a green thumbs up icon, indicating they are paid. The fifth row shows a claim with an orange thumbs down icon, indicating it is denied. A pink box with a legend explains the icons: 'Paid is a green thumbs up, Denied is an orange thumbs down and a clock is Pending'.

CLAIM NO. ↑	CLAIM TYPE ↓	MEMBER NAME ↓	SERVICE DATE(S) ↓	BILLED/ PAID ↓	CLAIM STATUS ↓
Q 15	CMS-1500	K [REDACTED] R	07/24/2017 - 07/24/2017	\$65.00 / \$41.38	👍
G 31	CMS-1500	JE [REDACTED] EN	07/24/2017 - 07/24/2017	\$171.00 / \$106.34	👍
G 66	CMS-1500	E [REDACTED] R	07/24/2017 - 07/24/2017	\$253.00 / \$101.04	👍
G 1	CMS-1500	EI [REDACTED] R	07/24/2017 - 07/24/2017	\$2,783.00 / \$118.86	👍
G 2	CMS-1500	E [REDACTED] R	07/24/2017 - 07/24/2017	\$2,783.00 / \$0.00	👎

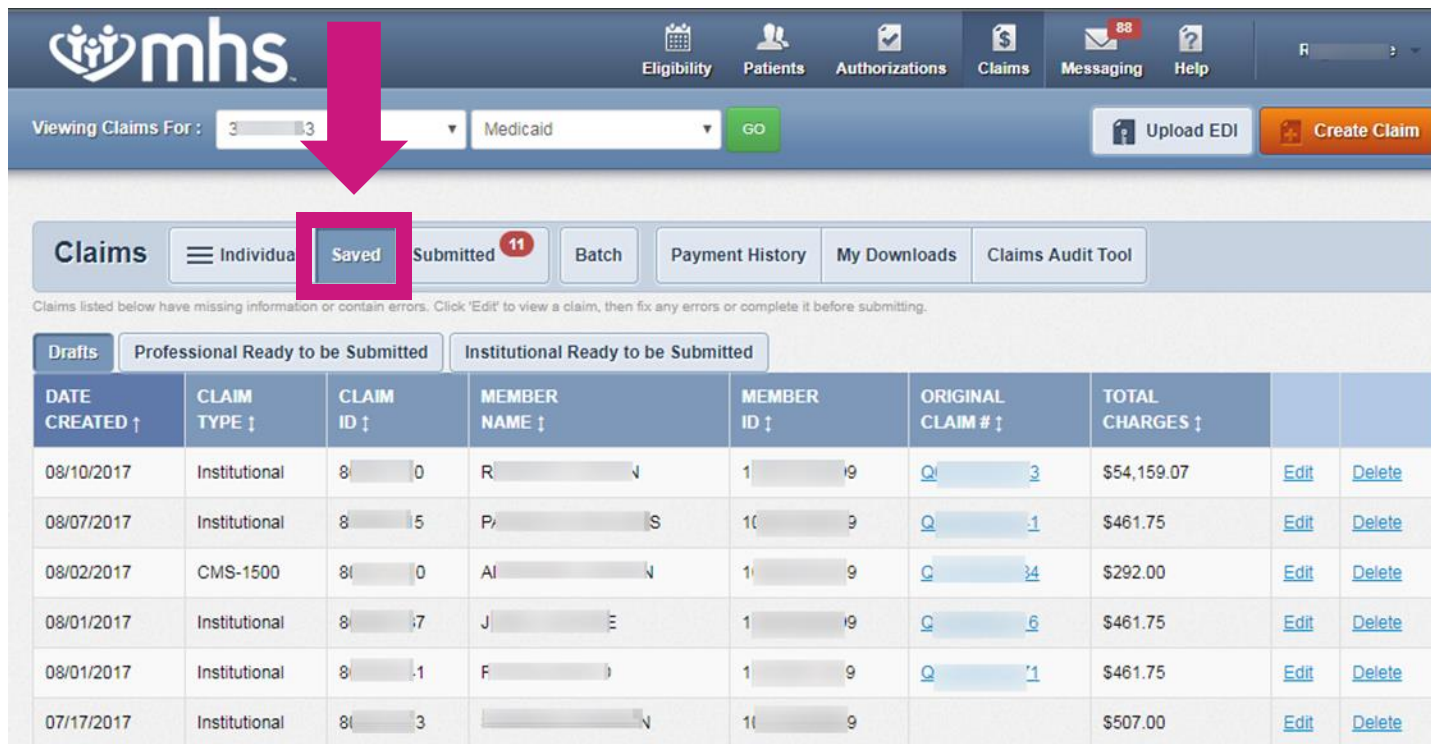
# Saved Claims

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

1. Click Delete to delete saved claim that is no longer necessary.
2. Click OK to confirm the deletion.



The screenshot shows the mhs Claims interface. At the top, there are navigation icons for Eligibility, Patients, Authorizations, Claims, Messaging (with 88 notifications), and Help. Below this is a search bar for 'Viewing Claims For:' with a date dropdown (3/13) and a 'Medicaid' dropdown, followed by a 'GO' button. To the right are 'Upload EDI' and 'Create Claim' buttons. The main navigation bar includes 'Claims', 'Individuals', 'Saved' (highlighted with a pink box and a pink arrow pointing to it), 'Submitted' (with 11 notifications), 'Batch', 'Payment History', 'My Downloads', and 'Claims Audit Tool'. Below the navigation bar, there is a warning: 'Claims listed below have missing information or contain errors. Click 'Edit' to view a claim, then fix any errors or complete it before submitting.' There are three tabs: 'Drafts', 'Professional Ready to be Submitted', and 'Institutional Ready to be Submitted'. The 'Drafts' tab is active, showing a table of claims.

DATE CREATED ↑	CLAIM TYPE ↑	CLAIM ID ↑	MEMBER NAME ↑	MEMBER ID ↑	ORIGINAL CLAIM # ↑	TOTAL CHARGES ↑		
08/10/2017	Institutional	8100	R...	1009	Q...3	\$54,159.07	<a href="#">Edit</a>	<a href="#">Delete</a>
08/07/2017	Institutional	8005	P...	1009	Q...1	\$461.75	<a href="#">Edit</a>	<a href="#">Delete</a>
08/02/2017	CMS-1500	8100	AI...	1009	C...14	\$292.00	<a href="#">Edit</a>	<a href="#">Delete</a>
08/01/2017	Institutional	8007	J...	1009	C...6	\$461.75	<a href="#">Edit</a>	<a href="#">Delete</a>
08/01/2017	Institutional	8001	F...	1009	Q...1	\$461.75	<a href="#">Edit</a>	<a href="#">Delete</a>
07/17/2017	Institutional	8003	...	1009		\$507.00	<a href="#">Edit</a>	<a href="#">Delete</a>



# 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

Viewing Claims For : TIN [ ] Plan Type Medicaid [ ] GO [ ] Upload EDI [ ] Create Claim [ ]

Claims [ ] Individual [ ] Saved [ ] Submitted [ ] Batch [ ] Recurring [ ] **Payment History** [ ] Claims Audit Tool [ ] Filter [ ]

### Transactions

All activity posted to your account between 06/20/2021 and 07/20/2021 .

**i** **Instructions:** Click on the Check Date to view the PDF of payment details from your payment provider. The PDF will open in a new window where you can save or print it. If there are any discrepancies on your payment details, please contact Provider Services.

CHECK DATE ↑	CHECK NUMBER ↑	CHECK CLEAR DATE ↓	MAILING ADDRESS ↑	PAYMENT AMOUNT ↓
<a href="#">06/24/2021</a> (PDF)	[REDACTED]	06/23/2021	[REDACTED]	\$100.64
<a href="#">06/24/2021</a> (PDF)	[REDACTED]	06/23/2021	[REDACTED]	\$145.73
<a href="#">06/24/2021</a> (PDF)	[REDACTED]	06/23/2021	[REDACTED]	\$72.01
<a href="#">06/24/2021</a> (PDF)	[REDACTED]	EFT	[REDACTED]	\$0.00
<a href="#">06/24/2021</a> (PDF)	[REDACTED]	EFT	[REDACTED]	\$208.65
<a href="#">06/24/2021</a> (PDF)	[REDACTED]	EFT	[REDACTED]	\$578.92

# Provider EOP

8754428027



Electronic Service Requested

606 0-7648 AV 0-366 5-DIGIT 30374

2400708113



RUN DATE: 07/09/20  
 CHECK #: [REDACTED]  
 PAYEE ID: [REDACTED]  
 IRS#: [REDACTED]

**STATEMENT TOTAL**

Beginning Negative Services Balance: .00  
 Beginning Prepayment Balance: .00  
 Total Beginning Balance: .00  
 Claims Paid This Run: [REDACTED]  
 Check Amount: [REDACTED]

**Remittance Advice and Explanation of Payment**

Insured Name: [REDACTED]	Member ID: [REDACTED]	Claim No: [REDACTED]
Patient Name: [REDACTED]	PCN: [REDACTED]	Carrier: DE
Service Provider: [REDACTED]	LNPI: [REDACTED]	Provider ID: [REDACTED]
		Group: [REDACTED]


Serv	Dates	Procedure	Modifiers	Days Ct/Qty	Charged	Allowed	Deduct/ Copay	Coinsur/ Discount	Interest	Med Allow/ Med Paid	TPP	Denied	Payment Codes	Payment
0100	[REDACTED]	[REDACTED]	G5	1.00	6388.16	263.75	.00	.00	.00	.00	.00	.00	A0 SR 30	258.47
0200	[REDACTED]	[REDACTED]	G5	1.00	6388.16	263.75	.00	5.28	.00	.00	.00	.00	A0 SR 30	258.47
0300	[REDACTED]	[REDACTED]	G5	1.00	6388.16	263.75	.00	5.28	.00	.00	.00	.00	A0 SR 30	258.47
0400	[REDACTED]	[REDACTED]	G5	1.00	6388.16	263.75	.00	5.28	.00	.00	.00	.00	A0 SR 30	258.47
0500	[REDACTED]	[REDACTED]	G5	1.00	6388.16	263.75	.00	5.28	.00	.00	.00	.00	A0 SR 30	258.47
0600	[REDACTED]	[REDACTED]	G5	1.00	6388.16	263.75	.00	5.28	.00	.00	.00	.00	A0 SR 30	258.47
0700	[REDACTED]	[REDACTED]	G5	1.00	6388.16	263.75	.00	5.28	.00	.00	.00	.00	A0 SR 30	258.47



# EFT and ERAs

## PaySpan Health

- Web based solution for:
  - Electronic Funds
  - Transfers (EFTs) and Electronic Remittance Advices (ERAs)
- One year retrieval of remittance advice.
- Provided at no cost to providers and allows online enrollment.
- Register at [Payspan | Healthcare Payment Reimbursement Solutions](#)
- For questions call 1-877-331-7154.

**PaySpan® Health** 

**FOLLOW THESE INSTRUCTIONS TO GET STARTED WITH PAYSAN® HEALTH, AN EFT AND ERA WEB BASED SOLUTION:**

- 1** Call 1-877-331-7154 for your unique registration code. Then, visit [payspanhealth.com](http://payspanhealth.com) and click **Register**.
- 2** Enter your registration code and click **Submit**.
- 3** Enter your PIN, TIN or EIN, and NPI. Then, click **Start Registration**.
- 4** Populate the requested Personal Information. Click **Next**.
- 5** Designate an account for fund transfers by completing the required fields. Click **Next**.
- 6** Verify your information and check the box to agree to the service agreement. Then, click **Confirm**.
- 7** Within a few business days, you will receive a deposit of less than \$1 from PaySpan. Then, follow these steps to complete registration:
  - ▶ Contact your financial institution to obtain the amount deposited by PaySpan.
  - ▶ Log into PaySpan, and click **Payments**.
  - ▶ Click the **Account Verification** link on the left side of the screen.
  - ▶ Enter the amount of the deposit in this format: 0.00.  
(The deposit does not need to be returned.)

For PaySpan registration assistance, call: **1-877-331-7154**  
Email: [providersupport@payspanhealth.com](mailto:providersupport@payspanhealth.com)

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# Tips to Remember

- Clicking on items (claim numbers, check numbers, dates) that are highlighted **blue** will reveal additional information.
- When filtering to find a claim or payment history, only a 30-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 Claims Reconsiderations on the MHS Secure Provider Portal

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# Summary Of Online Reconsiderations

## **Skip the phone call.**

- Providers can make their case directly on the 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.
- Providers may also view status online.

# Online Reconsiderations

Providers are able to:

- Submit informal disputes/reconsiderations on the secure portal.
- Upload/view supporting documents.
- View acknowledgement letters.
- Track real time updates.
- View denial code information.

# Online Reconsiderations


- 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.
- Providers may include a dispute form, but it is not required, as they may include comments directly into the portal.

# Level 1 Informal Claim Dispute and Level 2 Claim Appeals on the Secure Provider Portal

[Back to Claims](#) **Claim Details**

## Claim #T1234P1235: Denied

[COPY](#) [DISPUTE](#)



Claim Accepted — In Process — Denied

Participant	Provider	Claim	Most Recent Payment	
Participant Name [REDACTED]	Ref/Acct No. 1234567890	DOS Range 08/12/2020 - 08/15/2020	Payment Date ---	Paid Claim Amount \$0.00
Member ID ID123459	Servicing Provider [REDACTED]	Received Date 09/12/2020	Check/EFT No. ---	Total Check Amount ---
Member DOB [REDACTED]	Servicing NPI [REDACTED]	Billed Amount \$6,1234.12	Check Dated ---	

### Service Lines

Label	Label	Label	Label	Label	Label	Label
-------	-------	-------	-------	-------	-------	-------

# Level 1 Informal Claim Dispute and Level 2 Claim Appeals on the Secure Provider Portal

The screenshot displays the Secure Provider Portal interface. At the top, a dark blue navigation bar contains icons and labels for 'Eligibility', 'Patients', 'Authorizations', 'Claims', and 'Messaging', along with a 'User Name' dropdown menu. Below this, a light blue header bar features a 'Back to Claims' button and a text field containing a redacted ID followed by ': Claim #T1234P1235'. The main content area lists three options, each with a 'SELECT' button:

- Option 1: Correct the claim**  
Most providers use this option when there is a mistake on the submitted claim.
- Option 2: Informally dispute the claim**  
A dispute is a informal review performed by the Claims Department.
  - A response will be issued within **30 calendar days** of submission.
  - You will still have the opportunity to select **Option 3: 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.
- Option 3: 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.



# Claim Reconsiderations

Enter your explanation for reconsideration and check email updates.

### Reconsider Claim

Claim No:

**For reconsiderations only. Not for appeals/Claim disputes**  
Example: If an authorization was not obtained and/or you need to review for medical necessity, submit an appeal.  
**Any submission on this form will be treated as a reconsideration.**  
Please refer to your Provider Manual.

**Reconsideration Type**  
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 reconsideration.  
Please upload files less than 10MB each. Supported file formats are PDF, TIFF, TIF, JPEG, and JPG.

# Level 1 Informal Claim Dispute and Level 2 Claim Appeals on the Secure Provider Portal

Back to Claims
**Claim Details**

## Claim #T1234P1235: Denied

COPY
DISPUTE

U026IA1234566

### Dispute/Appeal Details

Created Date	Type	Current Status	Reference No.	Tools
1/26/2021	Dispute - Claim Paid at the Incorrect Amount	Resolved	U026IA1234566	

Member	Provider	Claim	Most Recent Payment
Participant Name <div style="background-color: #0056b3; height: 15px; width: 100%;"></div>	Ref/Acct No. 1234567890	DOS Range 08/12/2020 - 08/15/2020	Payment Date ---
Member ID ID123459	Servicing Provider <div style="background-color: #0056b3; height: 15px; width: 100%;"></div>	Received Date 09/12/2020	Check/EFT No. ---
Member DOB <div style="background-color: #0056b3; height: 15px; width: 100%;"></div>	Servicing NPI 1234567890	Billed Amount \$6,1234.12	Total Check Amount ---
			Check Dated ---

### Service Lines


Label	Label	Label	Label	Label	Label	Label	Label

# Level 1 Informal Claim Dispute and Level 2 Claim Appeals on the Secure Provider Portal


Back to Claims
**Claim Details**

## Claim #T1234P1235: Denied


COPY
DISPUTE




Claim Accepted




Claim Denied




Dispute Submitted



Claim Denied (Decision Upheld)



Appeal Submitted



Outcome TBD





**Dispute**

U026IA1234566

**Appeal**

ABCDE1234567

### Dispute/Appeal Details

Created Date	Type	Current Status	Reference No.	Tools
2/15/2021	Appeal - Claim Paid at the Incorrect Amount	In Progress	ABCDE1234567	 
1/26/2021	Dispute - Claim Paid at the Incorrect Amount	Resolved	U026IA1234566	 

Member	Provider	Claim	Most Recent Payment
Participant Name <div style="background-color: #0056b3; height: 15px; width: 100%;"></div>	Ref/Acct No. 1234567890	DOS Range 08/12/2020 - 08/15/2020	Payment Date ---
Member ID ID123459	Servicing Provider <div style="background-color: #0056b3; height: 15px; width: 100%;"></div>	Received Date 09/12/2020	Check/EFT No. ---
Member DOB <div style="background-color: #0056b3; height: 15px; width: 100%;"></div>	Servicing NPI 1234567890	Billed Amount \$6,1234.12	Total Check Amount ---
			Check Dated ---

### Service Lines

Label	Label	Label	Label	Label	Label	Label

# Coordination of Benefits

This screen shows if a member has other insurance.

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

Overview	Effective Date	Term Date	Policy Number	Group Number	Carrier Name	Coverage
Cost Sharing	06/01/2008	12/21/2013	V. [REDACTED]		AETNA	MEDICAL AND HOSPITAL
Assessments						
Health Record						
Care Plan						
Authorizations						
<b>Coordination of Benefits</b>						
Claims						

---

# Prior Authorization

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# Authorizations

View previously submitted or Create a New Authorization.

Back to Patient List
**Member Name**

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

### Authorizations

STATUS	AUTH NBR	FROM DATE	TO DATE	DIAGNOSIS	AUTH TYPE	SERVICE
APPROVE	<a href="#">C [redacted]</a>	02/06/2018	05/06/2018	M51.36	OUTPATIENT	Office Visit
APPROVE	<a href="#">C [redacted]</a>	03/14/2017	01/05/2018	G89.4	OUTPATIENT	Office Visit

[Create a New Authorization](#)

Click on **AUTH NBR** above

**Auth Status:** APPROVE  
**Auth Nbr:** C [redacted]  
**Service:** Office Visit  
**Provider of Service(s):** [redacted]  
**Diagnosis Code(s):** M51.36

**Explanation:** Pay  
**Auth Type:** OUTPATIENT  
**From Date:** 02/06/2018  
**To Date:** 05/06/2018  
**Procedure Code(s):** 99214  
**Notes & Attachments:** [View](#)

Line Item	Service type	Start Date	End Date	Units Req.	Units Apprd	Servicing Provider	Location	Status	Medical Necessity	Decision Date
1	Office Visit	02/06/2018	05/06/2018	3	3	[redacted]	Office	APPROVE	Met as requested	01/31/2018

# Authorization Considerations

- **Need to know what requires Authorization:**
  - Pre-Authorization tool  
<https://www.mhsindiana.com/providers/prior-authorization/medicaid-pre-auth.html>
- **How to obtain Authorization:**
  - Online: <https://www.mhsindiana.com/providers/prior-authorization.html>
  - Phone: 1-877-647-4848
  - Fax: 1-866-912-4245
- **Authorizations do not guarantee payment.**

# Prior Authorization

The screenshot shows the mhs website's Medicaid Pre-Auth tool. The top navigation bar includes links for Home, Find a Provider, Portal Login, Events, Careers, and Contact Us, along with a search bar and contrast settings. The main navigation menu has three tabs: FOR MEMBERS, FOR PROVIDERS (selected), and GET INSURED. On the left, a sidebar lists various services and resources, with 'Prior Authorization' expanded to show 'Medicaid Pre-Auth', 'Ambetter Pre-Auth', and 'Medicare Pre-Auth'. The main content area is titled 'Medicaid Pre-Auth' and features a disclaimer, verification requirements for various services, and a form to check for prior authorization. The form includes a question about emergency services, a table for service types, a code entry field, and a result box for code 58270.

**FOR PROVIDERS**

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

**FOR PROVIDERS**

## Medicaid Pre-Auth

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

Vision services need to be verified by [Envolve Vision](#).  
 Dental services need to be verified by [Envolve Dental](#).  
 Ambulance and Transportation services need to be verified by [LCP Transportation](#).  
 Musculoskeletal services need to be verified by [TurningPoint](#).  
 Complex imaging, MRA, MRI, PET, CT scans, PT, ST, and OT need to be verified by [NIA](#).

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

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

Yes  No

Types of Services	YES	NO
Is the member being admitted to an inpatient facility?	<input type="radio"/>	<input checked="" type="radio"/>
Are services other than lab, radiology, domiciliary visits DME, Orthotics, or Prosthetics being rendered in the home?	<input type="radio"/>	<input checked="" type="radio"/>
Are anesthesia services being rendered for pain management?	<input type="radio"/>	<input checked="" type="radio"/>
Are services for infertility?	<input type="radio"/>	<input checked="" type="radio"/>

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

58270

**Y**  
Yes

**58270** - VAG HYST UTRUS 250 GM/←REP ENTROCL  
 Pre-authorization required for all providers.

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



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# MHS Team

---

# MHS Team

## MHS Provider Network Territories

### Indiana

#### NORTHEAST REGION

For claims issues, email:  
 MHS\_ProviderRelations\_NE@mhsindiana.com  
 Chad Pratt, Provider Partnership Associate II  
 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 II  
 1-877-647-4848, ext. 20080

#### SOUTH CENTRAL REGION

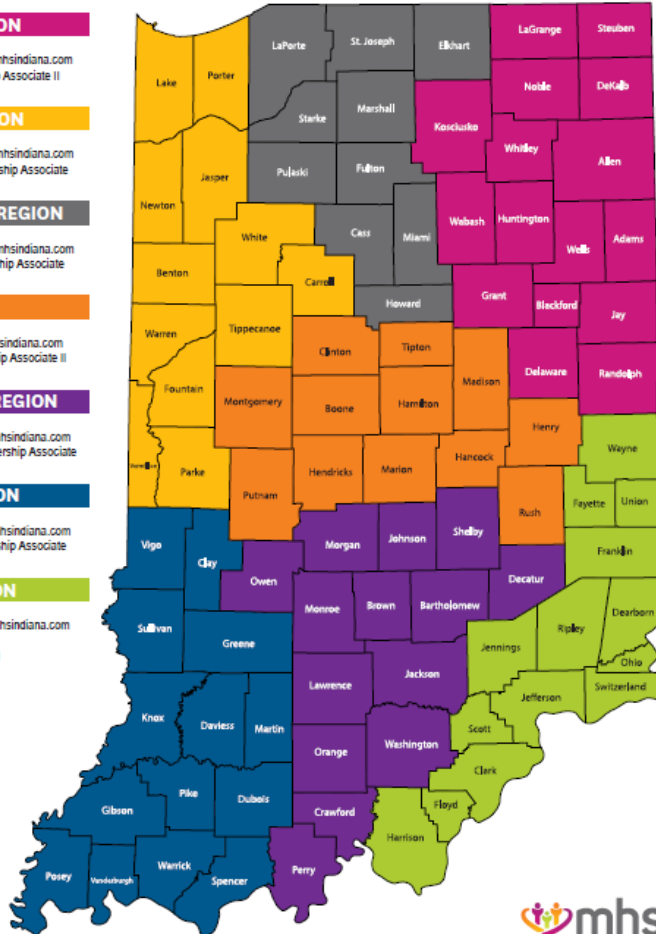
For claims issues, email:  
 MHS\_ProviderRelations\_SC@mhsindiana.com  
 Dalesia Denning, Provider Partnership Associate  
 1-877-647-4848, ext. 20026

#### 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 II  
 1-877-647-4848, ext. 20114



550 N. Meridian Street, Suite 101 - Indianapolis, IN 46204 - 1-877-647-4848 - mhsindiana.com  
 Allwell from MHS - Ambetter from MHS - Healthy Indiana Plan (HIP) - Hoosier Care Connect - Hoosier Healthwise

#### NORTHEAST REGION

For claims issues, email:  
 MHS\_ProviderRelations\_NE@mhsindiana.com  
 Chad Pratt, Provider Partnership Associate II  
 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 II  
 1-877-647-4848, ext. 20080

#### SOUTH CENTRAL REGION

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# MHS Team

## MHS Provider Network Territories

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#### PROVIDER GROUPS

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#### CAROLYN VALACHOVIC MONROE

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#### PROVIDER GROUPS

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Ascension Complete  
Franciscan Health

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#### PROVIDER GROUPS

Lutheran Medical Group  
Parkview Health System  
Beacon Medical Group  
Heart City Health Center



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Allwell from MHS - Ambetter from MHS - Healthy Indiana Plan (HIP) - Hoosier Care Connect - Hoosier Healthwise



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Thank you for being our partner in care.

Questions?

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