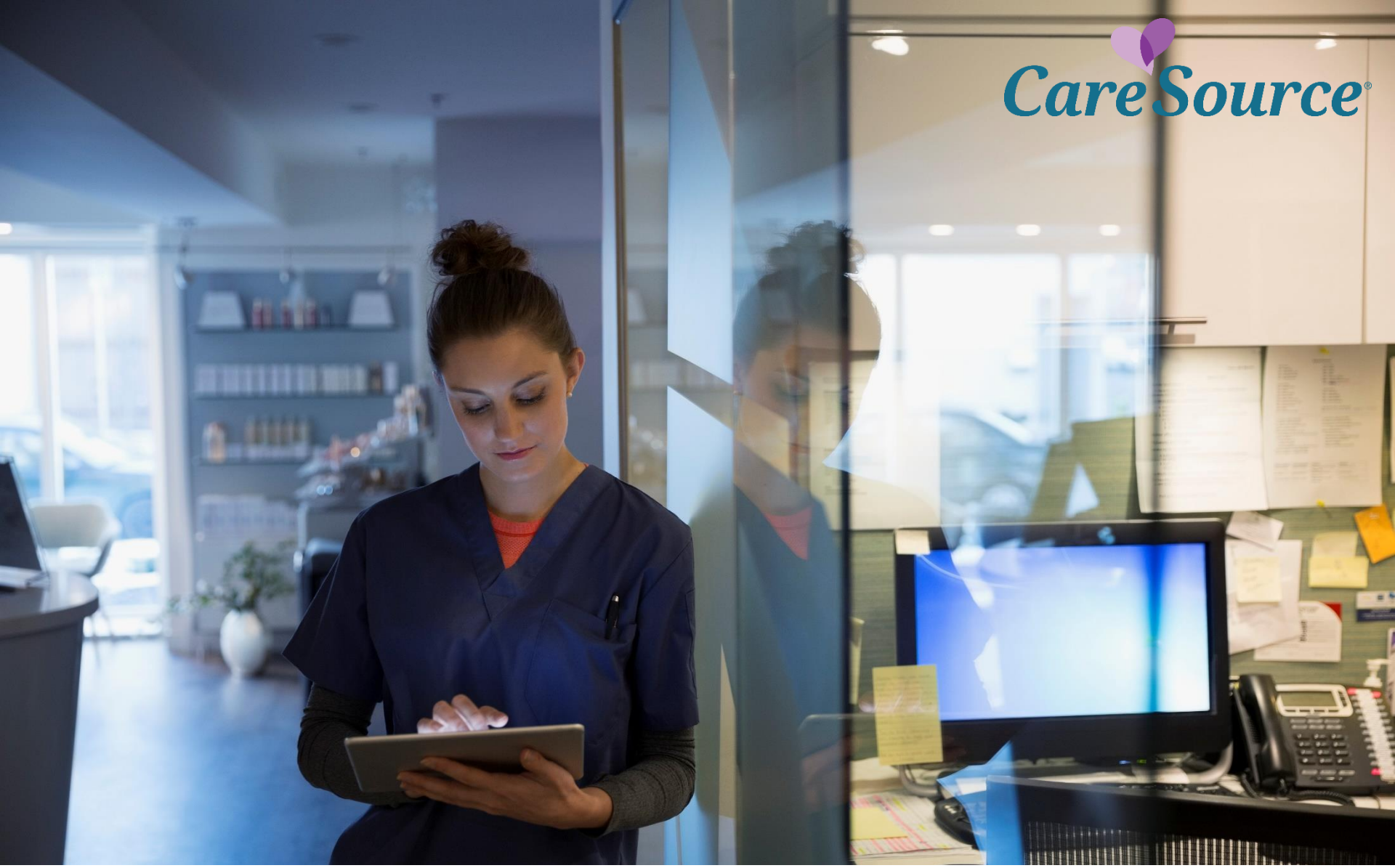


CareSource

Behavioral Health

2020 IHCP Works
Annual Seminar

Agenda

- SUD updates: Facility, E/M Visits (outside of per diem), Network Notifications
- Therapy Updates: Limits, Billing Updates
- IOP/IOT Updates: Network Notifications
- COVID-19 Updates: Network Notifications
- BH Prior Authorizations
- Provider Portal Highlights
- Claims
- BH Quality Initiatives
- Q&A

CareSource™

Updates/Reminders

BEHAVIORAL HEALTH

CareSource™

Behavioral Health Updates

SUD Residential Addiction Treatment Facilities

- IHCP established provider type 35-Addiction Services and Provider Specialty 836, Substance Use Disorder (SUD) Residential Addiction Treatment Facility
- Reimbursement for SUD residential treatment
- H2034 U1 or U2 and/or H0010 U1 or U2
- Box 24J and Box 33 W
- Billing for physician visits
- Requesting SUD services

Behavioral Health Updates

Therapies and Testing

CareSource received the following question from providers through the IHCP Listens inbox:

Q: **Does CareSource follow IHCP guidelines regarding the service limitations below:**

Service limitations: Per IHCP, the following CPT codes *in combination* subject to 20 units per member, per provider, per rolling 12-month period:

**90832 – 90834*

**90836 – 90840*

**90845 – 90853*

**96151 – 96155 new code set (96156-96171)*

A: ***No, CareSource does not have any limits or PA requirements on the above codes.***

Additionally, CPT codes 90791 and 90792 do not require authorization from CareSource. OMPP approved CareSource's request to not implement PA requirements stated in BT201866, Neurological/Psychological Testing.

Behavioral Health Updates
IOP/IOT

CareSource would like to remind providers that ALL IOT (Intensive Outpatient Therapy) and IOP (Intensive Outpatient Services) services require authorization as of 6/1/2019. Please see network notification dated 2/29/19 subject: Intensive Outpatient & Partial Hospitalization Program Authorization Requirements.

Please refer to BT201929 on how to bill for IOT/IOP and Peer Recovery.

Behavioral Health Updates

COVID-19 Reminders

Please see network notification dated 4/3/20 subject: COVID-19: Temporary Telehealth Services – UPDATE for questions regarding claims submission.

CareSource is following IHCP policies for COVID-19.

BH Access Standards

Please see network notification dated 6/13/19: ***Access Standards Update***

Patient with…..	Should be Seen…..
Emergency needs	Immediately upon presentation
Non-life threatening emergency	Not to exceed 6 hours
Urgent care*	Not to exceed 48 hours
Initial visit for routine care	Not to exceed 10 business days
Follow-up routine care	Not to exceed 30 calendar days based on the condition

*A member should be seen as expeditiously as the member's condition warrants based on severity of symptoms. It is expected that if a health partner is unable to see the member within the appropriate time frame, CareSource will facilitate an appointment with a participating health partner or non-participating health partner, if necessary.

Prior Authorization

REQUIREMENTS FOR AUTHORIZATION & CHANGES

CareSource™

Retro Prior Authorization

Effective 4/1/19, the retro prior authorization timeframe requirements changed. Please refer to the network notification dated 1/30/19 subject: Notices of Changes to Retro Prior Authorization Timeframe requirements

WHAT YOU SHOULD KNOW:

Upon written request, CareSource *shall not permit* retrospective authorization submission for after the date of service or admission where a prior authorization was required but not obtained (Retro Authorization) except in the following circumstances as outlined in the IAC rule below:

- 405 IAC 5-3-9 Requirement Sec. 9. Prior authorization will be given after services have begun or supplies have been delivered only under the following circumstances:

(1) Pending or retroactive member eligibility. The prior authorization request must be submitted within twelve (12) months of the date of the issuance of the member's Medicaid card.

(2) Mechanical or administrative delays or errors by the office.

(3) Services rendered outside Indiana by a provider who has not yet received a provider manual.

(4) Transportation services authorized under 405 IAC 5-30. The prior authorization request must be submitted within twelve (12) months of the date of service.

Retro Prior Authorization

(5) The provider was unaware that the member was eligible for services at the time services were rendered. Prior authorization will be granted in this situation only if the following conditions are met:

(A) The provider's records document that the member refused or was physically unable to provide the member identification (RID) number.

(B) The provider can substantiate that the provider continually pursued reimbursement from the patient until Medicaid eligibility was discovered.

(C) The provider submitted the request for prior authorization within sixty (60) days of the date Medicaid eligibility was discovered

Unless the CareSource member is transitioning and qualifies under the retroactive coverage requirements, all of the above criteria will need to be met to qualify for a retro authorization review.

- Claims not meeting the necessary criteria as described above will be administratively denied.

NEXT STEPS:

- When submitting a retro authorization request, the following documentation must be provided:
- □ Member name and CareSource ID number
- □ Authorization number of the previously authorized service to which the request is related
- □ All supporting documentation related to the service

PA Requirements
Frequently Asked Services

**IOP/IOT – PA required effective 6/1/2019 and after for all services*

**PHP – All services require PA*

**OT/ST – ABA setting – all services require PA*

**ABA Services – All services require PA*

**SUD – All services require PA*

**Peer Recovery – No PA required*

**Psychological and Neurological Testing – No PA required prior to 1/1/2020*

**Individual and Group Psychotherapy – No PA required prior to 09/01/2020*

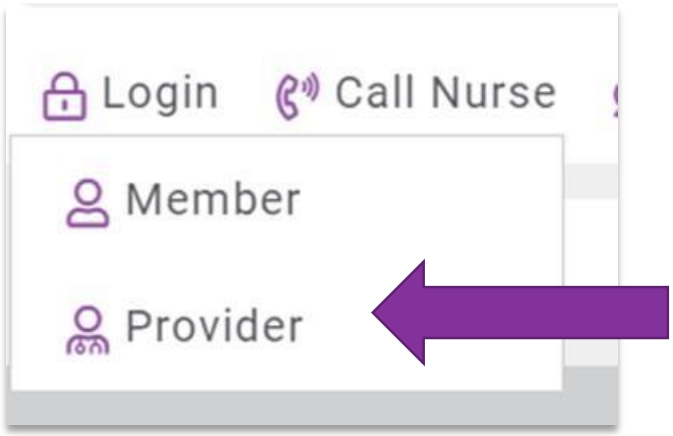
**OTP – No PA required*

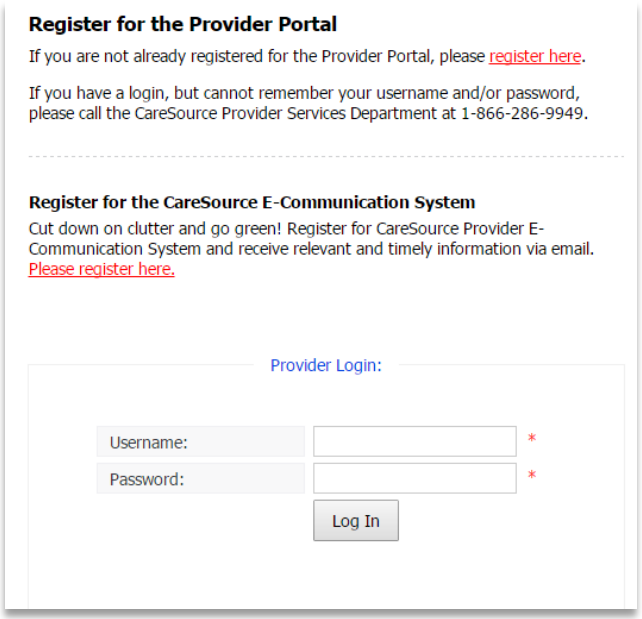
Provider Portal

REGISTRATION, ENHANCEMENTS, OVERVIEW

CareSource™

Provider Portal Registration

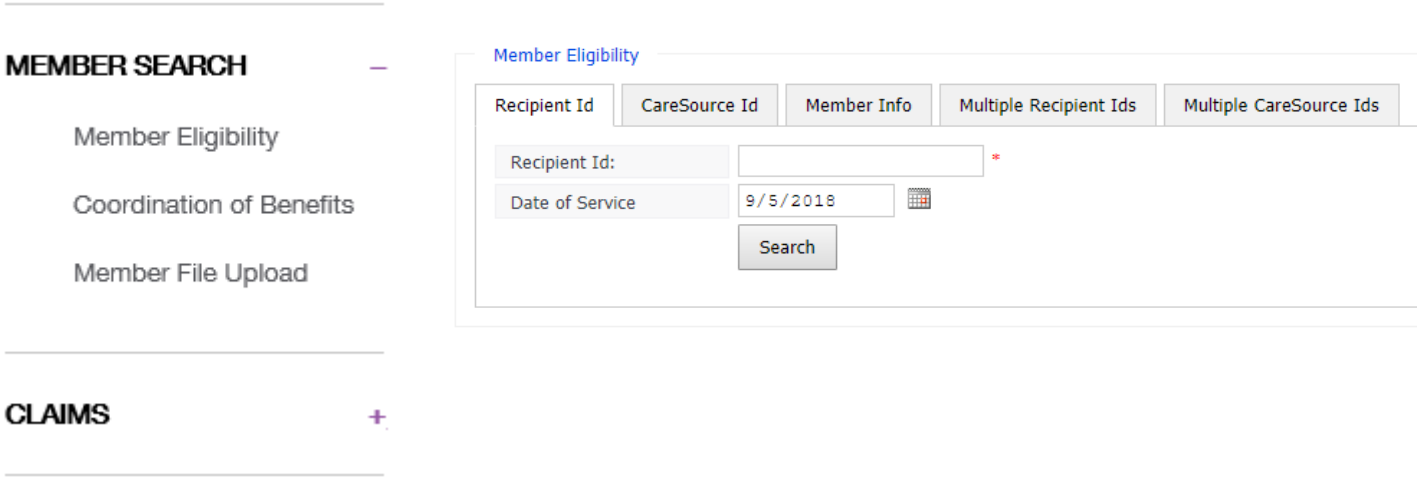




1. Go to **CareSource.com**.
2. On the top right corner of the page, hover over Login and select **Provider**.
3. Select Indiana.
4. Click register here under **Register for the Provider Portal.**
5. Enter your information, including your CareSource Provider Number (located in your welcome letter).
6. Follow remaining steps to register.

Helpful Hint:
The zip code is the practitioner's primary location.

Member Eligibility

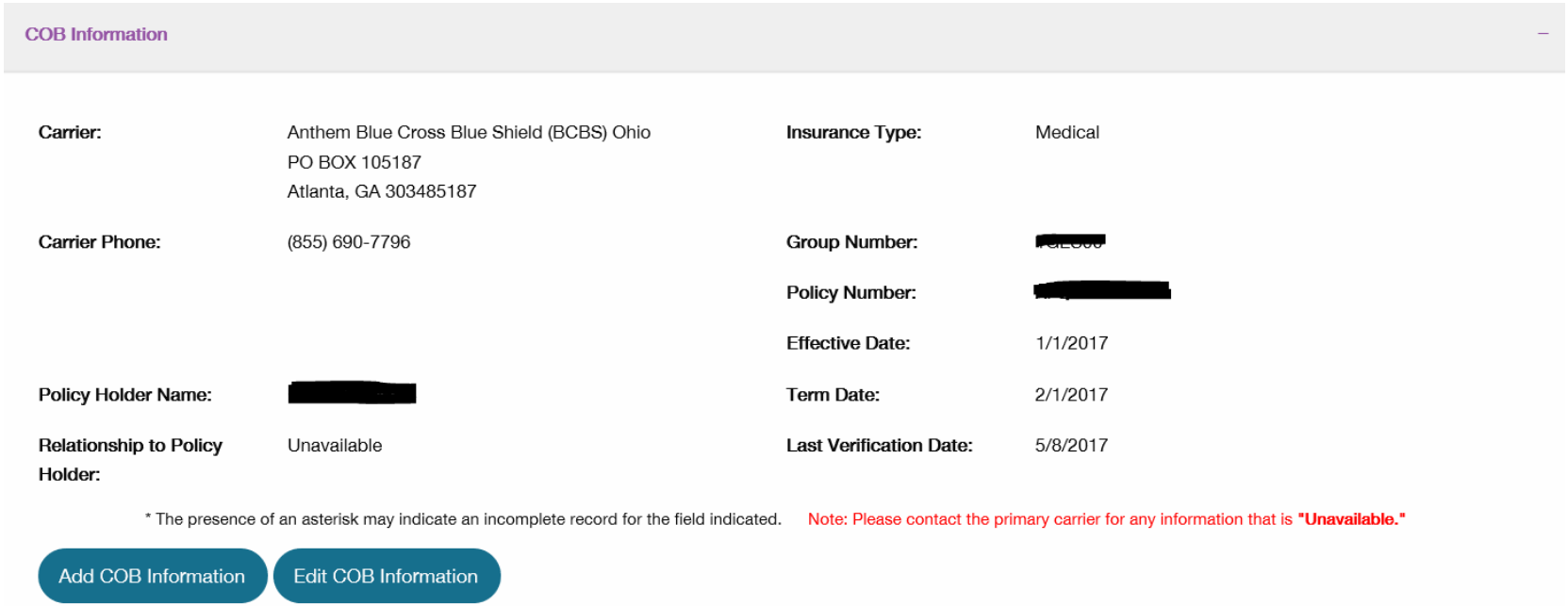


Upon logging into the Provider Portal, health partners will be able to view member eligibility:

- 24 months of history
- Member span information
- Multiple member look-up (up to 50)

✓ **Verify eligibility at every visit prior to rendering services.**

Coordination of Benefits


COB Information

Carrier:	Anthem Blue Cross Blue Shield (BCBS) Ohio PO BOX 105187 Atlanta, GA 303485187	**Insurance Type:**	Medical
Carrier Phone:	(855) 690-7796	**Group Number:**	[redacted]
		Policy Number:	[redacted]
		Effective Date:	1/1/2017
Policy Holder Name:	[redacted]	**Term Date:**	2/1/2017
Relationship to Policy Holder:	Unavailable	**Last Verification Date:**	5/8/2017

* The presence of an asterisk may indicate an incomplete record for the field indicated. Note: Please contact the primary carrier for any information that is **"Unavailable."**

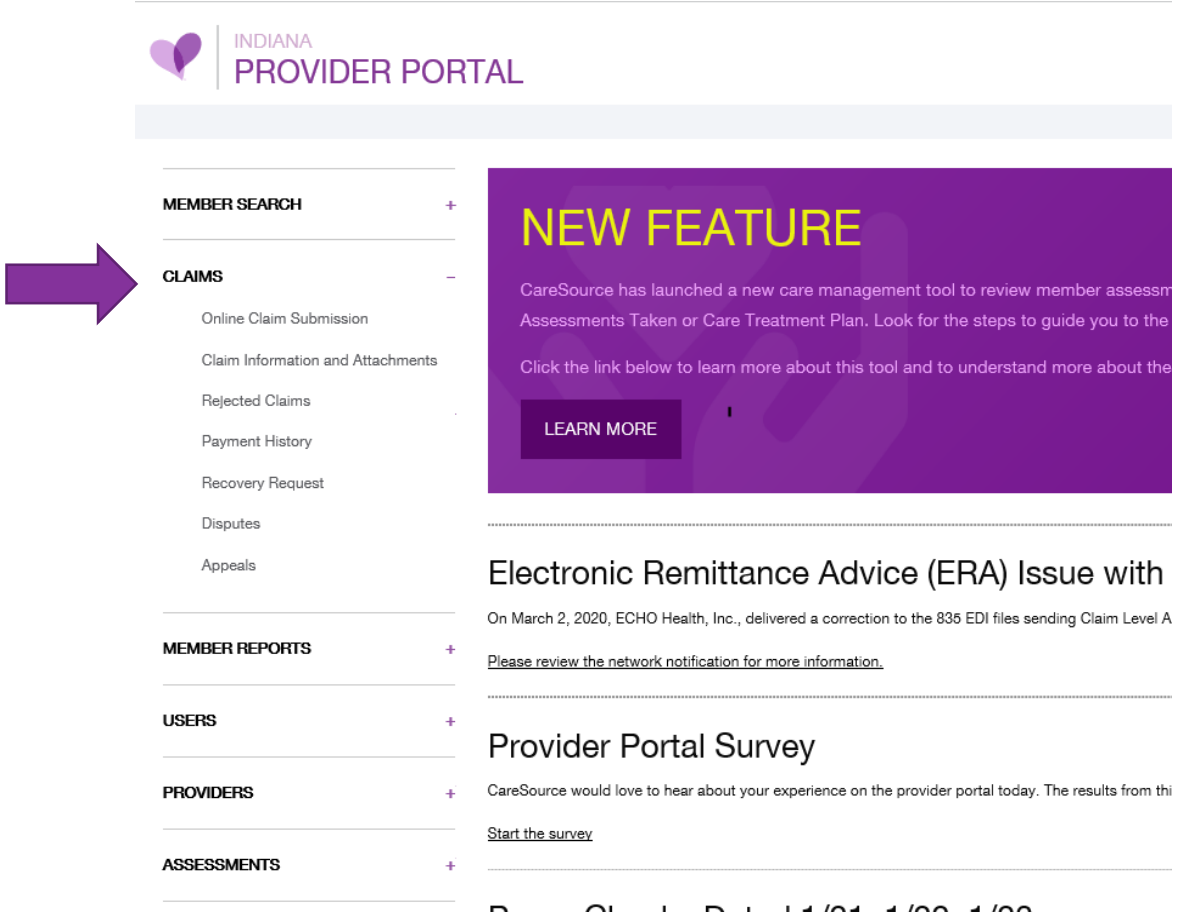
Add COB Information | Edit COB Information

Providers can now search across multiple members when checking for Coordination of Benefits (COB) information.
New search tabs (**Multiple CareSource IDs**, and **Multiple Medicaid IDs**) have been added to the **Coordination of Benefits** search page.

Claim Information & Attachments

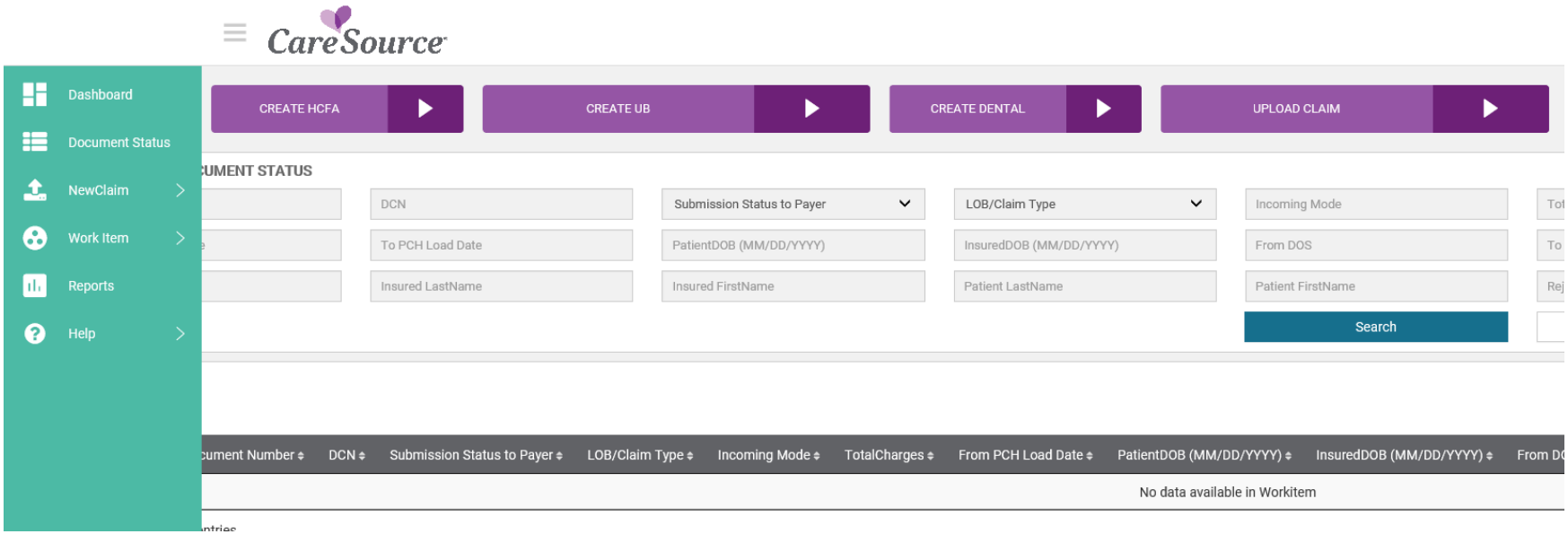
- Claim status is updated daily on our Provider Portal
- Check claims submissions for the previous 24 months.
- Additional details are now available when viewing a denied claim on the Provider Portal, including additional clinical edits.
- You can search by Recipient ID number, member name and date of birth or claim number, patient number, check number and external reference number.
- Additional details are now available when viewing a denied claim on the Provider Portal.
- Clinical edits, which provide detailed information regarding the claim denial, can now be viewed in the Process Reason when viewing the claim details.
- A more streamlined experience is now available for submitting attachments for denied claims.
- A new Document Upload tab is available on the Claims Detail view when a claim is denied due to missing attachments.
    - You are then prompted to upload the appropriate attachment for the denied claim. (attachments up to 100MB can be uploaded)

Claims



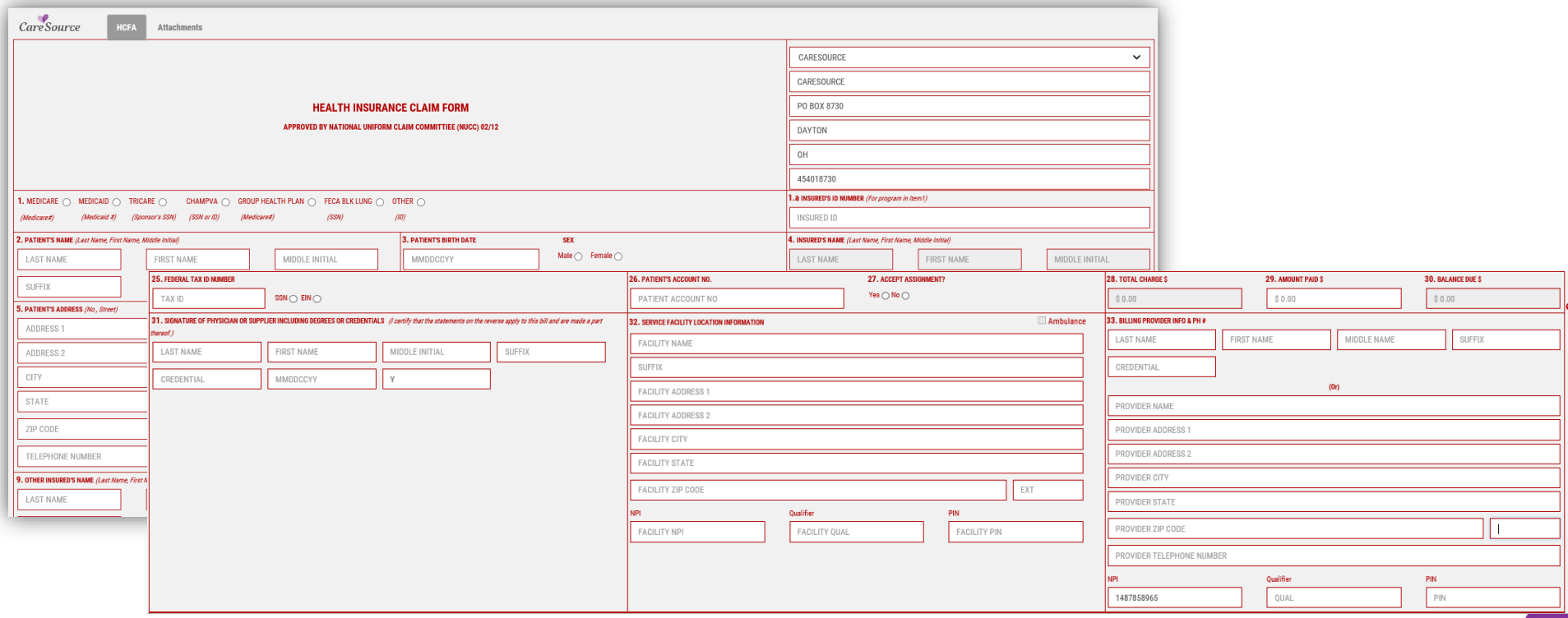
Under Claims, click on **Online Claim Submission**.

Online Claim Submission



Once you click on **Online Claim Submission** from our portal, a new window will open. From your main dashboard, you can view claim submission status to validate successful submission. To submit a claim, click **Create HCFA**, **Create UB**, or **Create Dental** to generate the claim form image.

Online Claim Submission



Complete all fields by keying in all fields and scrolling down. Remember to update Box 33 so that it matches billing information on file with the State. Attach any necessary items such as primary EOP, consent form, itemized statement, etc. If you need to come back and complete the claim later, you can **Save Draft**. Otherwise once complete, click **Submit**.

Paper Claim Submission
UB-04 or CMS-1500 Paper Claims

- Submission must be done using the most current form version as designated by CMS.

  CareSource does not accept handwritten claims, black and white claim forms or SuperBills.

- Detailed instructions for completing the *UB-04* and the *CMS-1500* claim forms can be found in the Claim Submission and Processing provider reference module on the Indiana Medicaid Provider website.

  Please note: On paper *UB-04* claims, the billing providers NPI number should be placed in Box 56.

  Please note: On paper *CMS-1500* claims, the rendering NPI number should be placed in Box 24J and the billing provider NPI number in Box 33a and Group Taxonomy in 33b.

Paper Claim Submission

To ensure optimal claims processing timelines:

- Use only original claim forms; do not submit claims that have been photocopied or printed from a website.
- Font should be 10-14 point with printing in ***black ink.***
- Do not use liquid correction fluid, highlighters, stickers, labels or rubber stamps.
- Ensure printing is aligned correctly so that all data is contained within the corresponding boxes on the form.
- NPI, TIN and taxonomy are required for all claim submissions.

Send all paper claim forms to CareSource at:

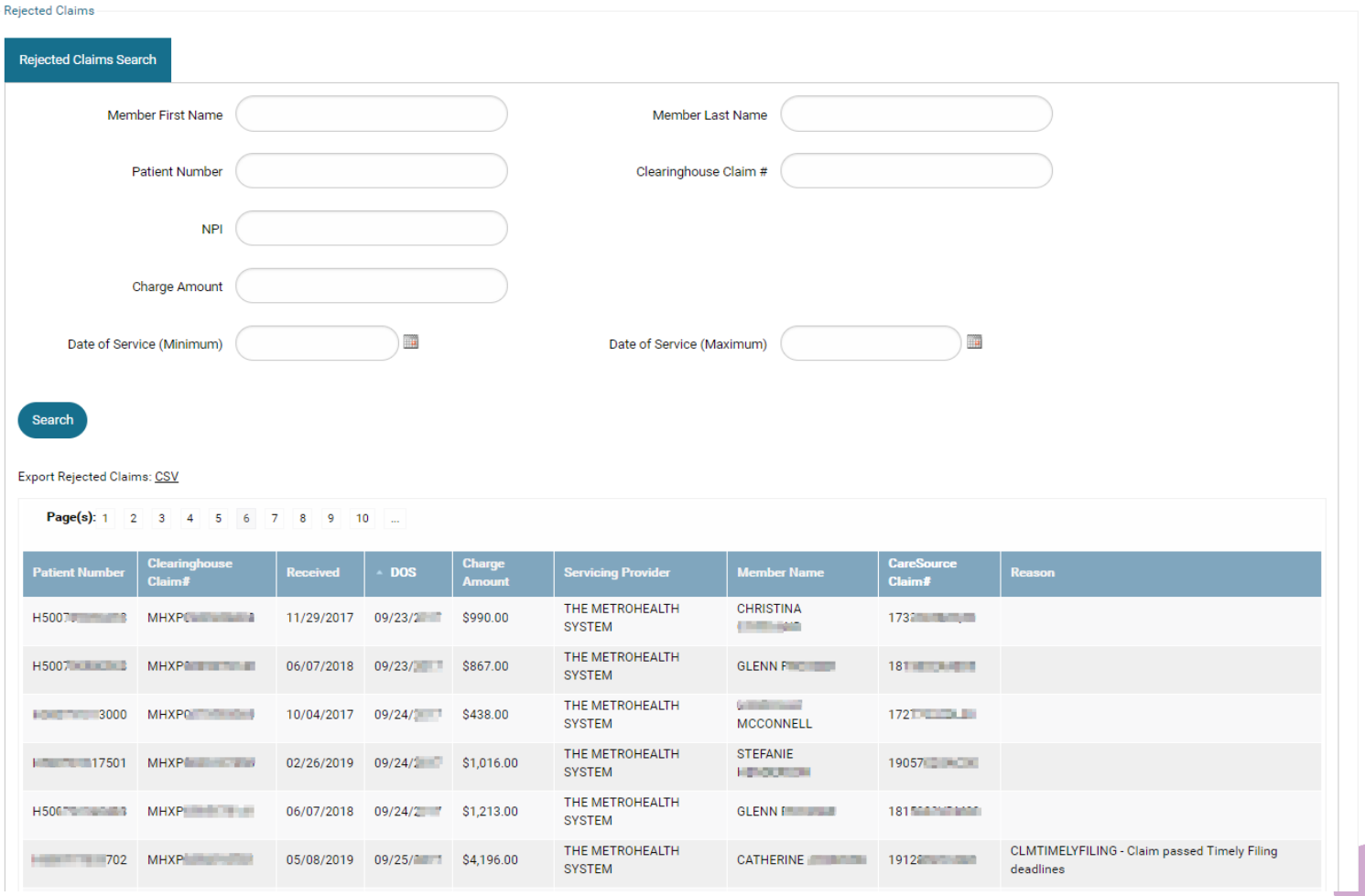
CareSource

Attn: Claims Department

P.O. Box 3607

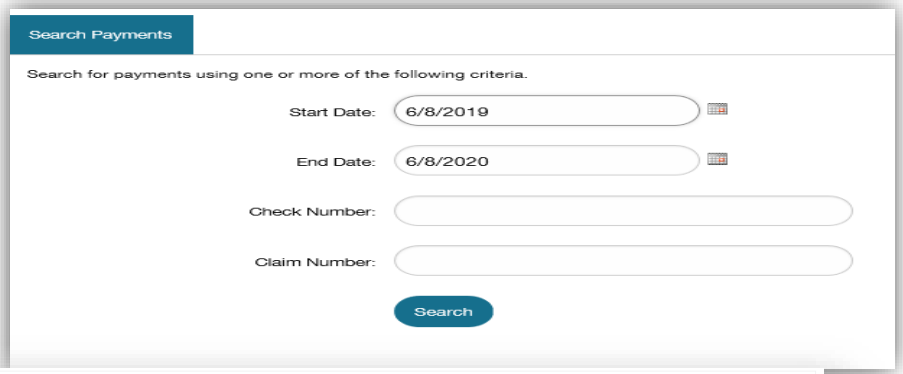
Dayton, OH 45401

Rejected Claims



Payment History

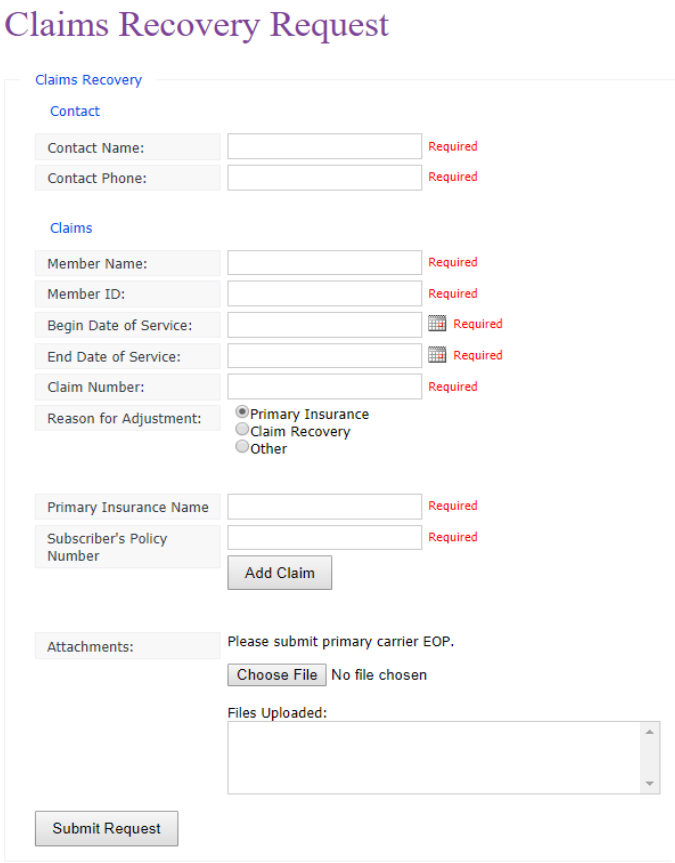
- Upon entering your date range and check OR claim number, the Provider Portal will list applicable remittance advice.
- Full EOB can be viewed
- Search by date range, check number, or claim number
- Depending on your search criteria, results will show applicable remits



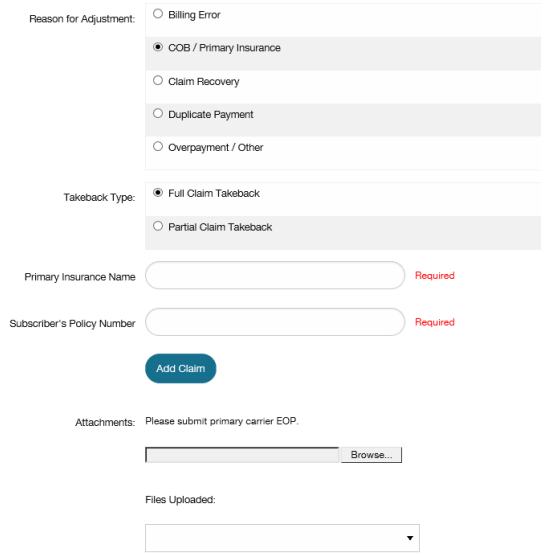
EOP	Check Number	Processed Date	Remit Address	Check Amount
View EOP	Not Applicable	6/3/2020	230 N Main St Dayton, OH 454021263	$0.00
View EOP	Not Applicable	5/16/2020	230 N Main St Dayton, OH 45402	$0.00
View EOP	Not Applicable	5/16/2020	230 N Main St Dayton, OH 45402	$0.00
View EOP	Not Applicable	5/16/2020	230 N Main St Dayton, OH 45402	$0.00
View EOP	Not Applicable	5/13/2020	230 N Main St Dayton, OH 45402	$0.00
View EOP	Not Applicable	5/9/2020	230 N Main St Dayton, OH 45402	$0.00
View EOP	Not Applicable	5/9/2020	230 N Main St Dayton, OH 45402	$0.00

Recovery Request

Recoupment



- Claim should be reviewed and recovered (if needed) within 30 days.
- Please note that Member ID will be their Subscriber ID when completing this form.
- The Member ID is your Subscriber ID.



Claims Concerns

HOW TO RESOLVE CLAIM ISSUES

CareSource™

Top 5 Claims Denials

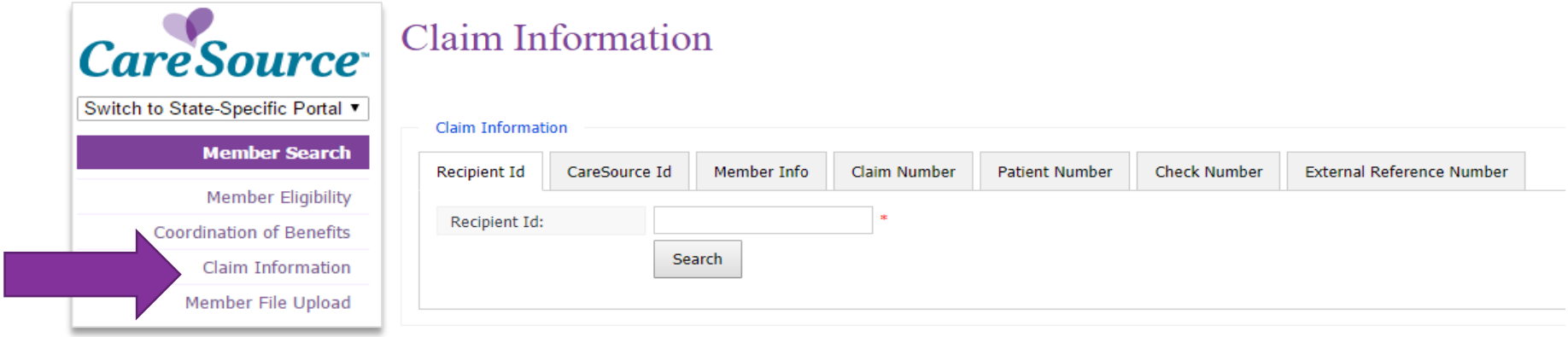
The top 5 reasons for BH claim denials for dates of service between March 15, 2020 and May 1, 2020 are:

RANK	DENIAL REASON	CLAIM COUNT
1	Duplicate Claim	465
2	Termination	170
3	Service requires auth	86
4	Invalid procedure code	29
5 (tied)	Required modifier is missing or invalid	23
5 (tied)	Invalid or missing claim/line data	23

Claim Concerns

Claim Status

Claim status is updated daily on the CareSource Provider Portal. You can check claims that were submitted for the previous 24 months.



Additional information on the portal:

- Determine reason for payment or denial
- Check numbers and dates
- Procedure/diagnosis
- Claim payment date
- View and print remittance advice
- Check status of claim disputes or appeals

Claim Concerns

Corrected Claims

In alignment with IHCP claim adjustment policy, providers have **60 calendar days** from the date of the EOP to submit a corrected claim for a paid claim, even if the claim paid $0.

A denied claim that is resubmitted with corrected information is considered to be an initial claim and, as such, is subject to the 90-day timely filing limit. If a claim is submitted with incorrect or unclear information, health partners have **60 calendar days** from the date of service or discharge to submit a corrected claim.

Claim Concerns

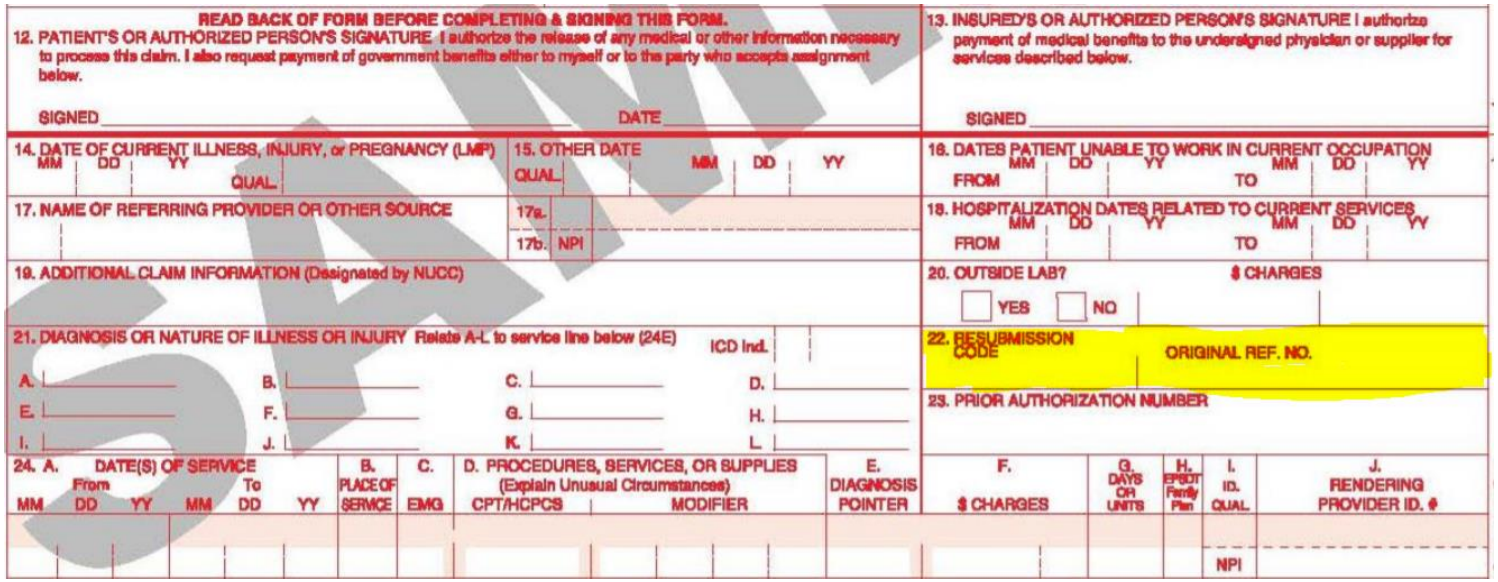
UB-04 Corrected Claims

The health partner must include the original CareSource claim number in Box 64 and a valid type of bill frequency code in Box 4.

Claim Concerns

CMS-1500 Corrected Claims

The health partner must include the original CareSource claim number in the right side of Box 22 and a frequency code of “7” on the left side of Box 22.



READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
										NPI	

Claim Concerns

Claim Dispute

Definition: A provider's first response indicating disagreement with the adjudication of a claim.

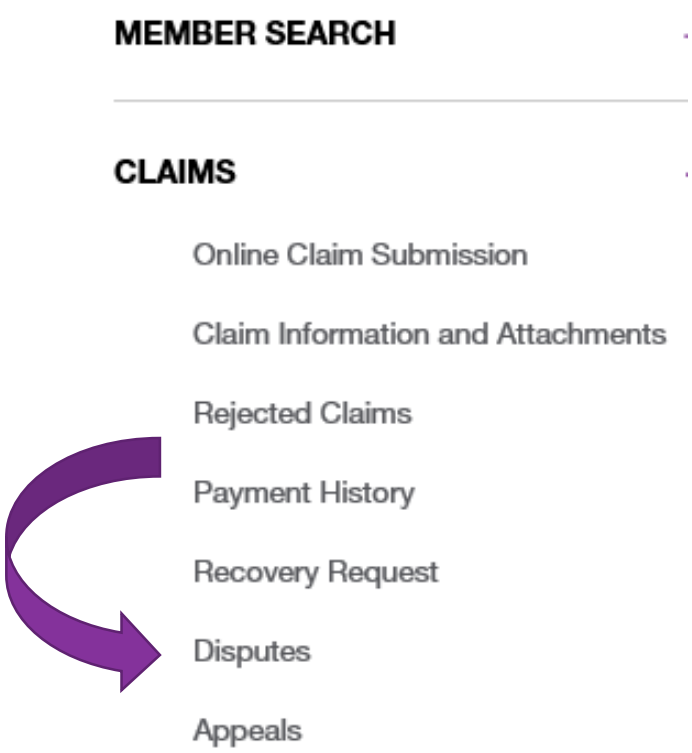
- Available for participating and non-participating providers

All disputes must be:

- Submitted in writing via the CareSource Provider Portal or on paper
- Submitted within **60 days** after receipt of the EOP
- Completed **prior** to requesting an appeal

If CareSource fails to render a determination for the dispute within **30 days** after receipt, an appeal may be submitted.

Claim Disputes



CareSource allows you to submit Claim Disputes on the Provider Portal.

Click on **Claims.** Click on **Disputes.**

Claim Disputes

Enter Claim ID and click Find, then follow the prompts.

Disputes

File a claim payment dispute for a claim underpayment, a partially or fully denied claim (*please see below for a few exceptions*), or for an adverse claim payment decision.

A claim number is required to submit your claim dispute through the Portal. Any supporting documentation should also be attached.

The following should not be submitted as a Dispute:

If you are responding to a denied authorization that requires medical necessity review, please submit an appeal.

If you are submitting a request due to overpayment, please submit a claim recovery request.

If your claim was denied due to a missing consent form, please upload the consent form.

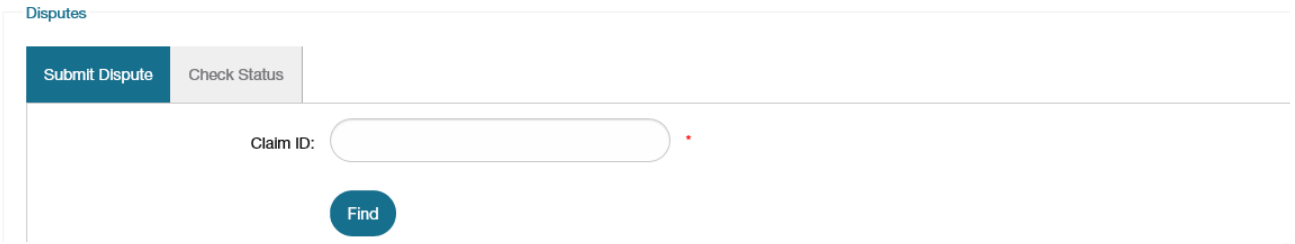
If your hospital claim was denied due to missing medical records, please upload the medical records.

Notice:

CareSource is currently unable to receive dental appeals or disputes through the Portal. If you need to submit an appeal or dispute involving a dental claim, please mail your submission to:

CareSource
Attn: Grievance and Appeals
P.O. Box 1947
Dayton, OH 45401-1947

You can also fax your submission to **937-531-2398**.



Claim Concerns
Claim Appeals

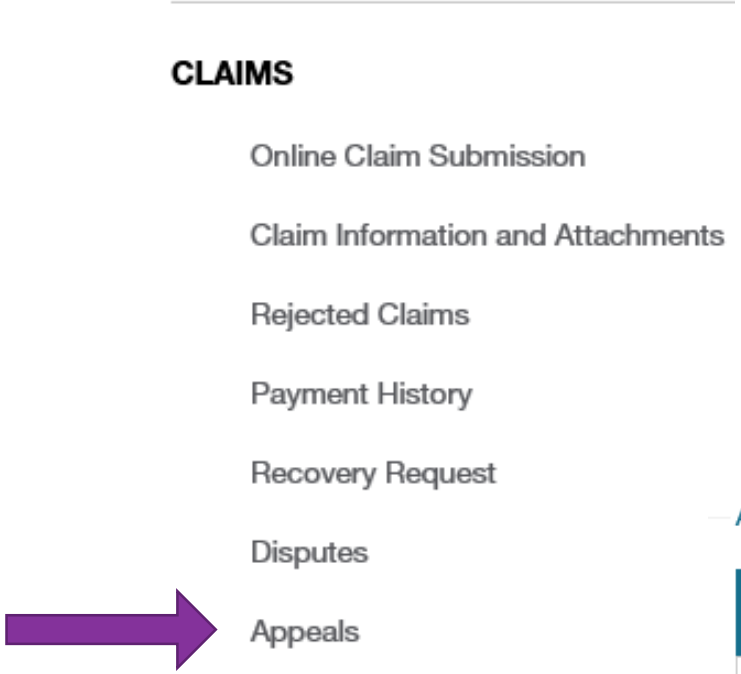
CareSource.com/documents/in-med-provider-clinicalclaim-appeal-form/

- May only submit appeal ***after*** completing dispute process
- Must be submitted within **60 days** of the resolution of the dispute determination OR if dispute was not responded to timely, appeal must be filed w/in **60 days** after the **30 day** dispute response window.
- CareSource must issue a written decision **45 days** of receipt of the written request for appeal
- If CareSource does not resolve appeal within the **45 day** timeframe, the appeal will be determined to be in favor of the provider
- May submit via the CareSource Provider Portal, fax (937-531-2398), or by paper to:

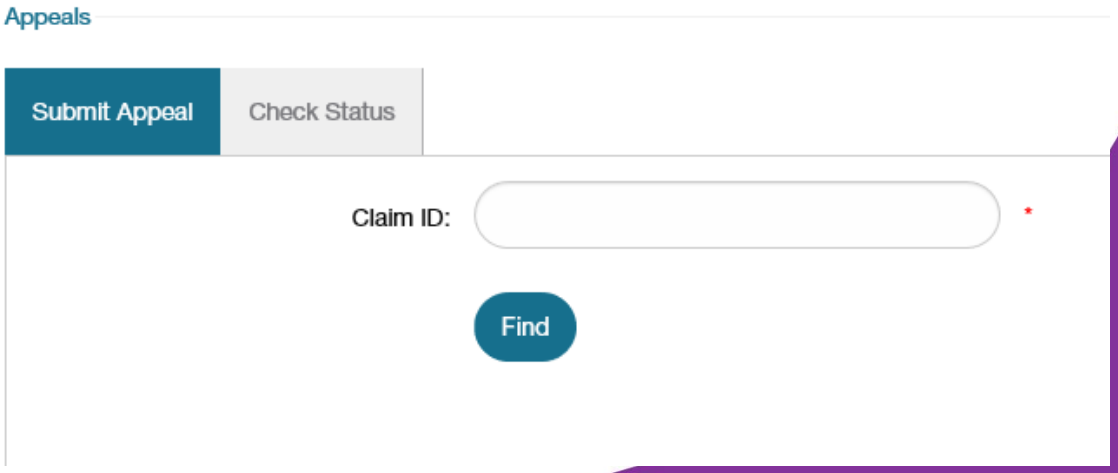
  Claim Appeals Department
  P.O. Box 2008
  Dayton, OH 45401-2008

- Timely filing appeals must include proof of original receipt of the appeal by fax or EDI for reconsideration

File an Appeal



Under **Claims** click **Appeals**. Enter claim ID and follow the prompts.



Updates & Announcements

Visit the **Updates and Announcements page** located on our website for frequent network notifications.

Updates may include:

- Medical, pharmacy and reimbursement policies
- Authorization requirements

Quality Initiatives

HEDIS MEASURES

CareSource™

HEDIS® Measure

Follow-Up After Hospitalization for Mental Illness

MEASURE OVERVIEW

The National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) Follow-Up After Hospitalization measure looks at the continuity of care for mental illness. It measures the percentage of members six years of age and older who were hospitalized for treatment of selected mental disorders or intentional self-harm and who had follow-up visits with a mental health provider within seven days and again within 30 days after their discharge from the hospital. The specifications for this measure are consistent with guidelines of the National Institute of Mental Health and the Centers for Mental Health Services.

An outpatient visit with a mental health practitioner after discharge is recommended to make sure that gains made during hospitalization are not lost to early post-hospitalization reactions or medication problems.

HOW TO IMPROVE MEASURE PERFORMANCE

- Educate the member before their hospital stay, if possible, and at the time of discharge about the importance of seeing a mental health practitioner within seven days and again within 30 days from the date of discharge or intentional self-harm diagnoses. The first visit cannot occur on the same day as the discharge.
- Use correct HIPAA-compliant codes when billing for the follow-up visit.
- Promote transition and support resources available in the community.
- Collaborate with CareSource on care coordination to connect the member to needed services, such as transportation.
- Telehealth visits with a qualified mental health professional and billed with appropriate codes are sufficient to qualify for this measure.
- Keep in mind, visits that occur on the date of discharge do not qualify.

HEDIS® Measure

Follow-Up After Hospitalization for Mental Illness

QUALIFIED MENTAL HEALTH PROFESSIONALS INCLUDE:

An MD or doctor of osteopathy (DO) who is:

1. certified as a psychiatrist or child psychiatrist by the American Medical Specialties Board of Psychiatry and Neurology or bythe American Osteopathic Board of Neurology and Psychiatry
2. if not certified, successfully completed an accredited program of graduate medical or osteopathic education in psychiatry orchild psychiatry and is licensed to practice patient care psychiatry or child psychiatry, if required by the state of practice.

An individual who is licensed as a psychologist in his/her state of practice, if required by the state of practice.

An individual who is:

1. certified in clinical social work by the American Board of Examiners and listed on the National Association of Social Worker's Clinical Register
2. has a master's degree in social work and is licensed or certified to practice as a social worker, if required by the state ofpractice.

A registered nurse (RN) who is:

1. certified by the American Nurses Credentialing Center (a subsidiary of the American Nurses Association) as a psychiatric nurse or mental health clinical nurse specialist
2. has a master's degree in nursing with a specialization in psychiatric/mental health and two years of supervised clinical experience and is licensed to practice as a psychiatric or mental health nurse, if required by the state of practice.

An individual (normally with a master's or a doctoral degree in marital and family therapy and at least two years of supervised clinical experience) who is:

1. practicing as a marital and family therapist and is licensed or a certified counselor by the state of practice
2. if licensure or certification is not required by the state of practice, who is eligible for clinical membership in the American Association for Marriage and Family Therapy.

An individual (normally with a master's or doctoral degree in counseling and at least two years of supervised clinical experience) who is:

1. practicing as a professional counselor and who is licensed or certified to do so by the state of practice
2. if licensure or certification is not required by the state of practice, is a National Certified Counselor with a Specialty Certification in Clinical Mental Health Counseling from the National Board for Certified Counselors (NBCC).

HEDIS® Measure

Follow-Up After Hospitalization for Mental Illness

Follow-Up Visit Compliance Codes			
Individual Codes:	Combination Codes:		
CPT: 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99383-99387, 99393-99397, 99401-99404, 99411, 99412, 99510, 99496, 99495 (valid for 30-day compliance only) **HCPCS:** G0155, G0176, G0177, G0409-G0411, G0463, H0002,H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, M0064, S0201, S9480, S9484, S9485, T1015 **Revenue Code:** 0513, 0900-0905, 0907, 0911-0917, 0919	**CPT:** 99221-99223, 99231-99233, 99238, 99239, 99251-99255 **-With-** **Place of Service:** 02, 52, 53	**CPT:** 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90867-90870, 90875, 90876 **-With-** **Place of Service:** 02, 03, 05, 07, 09, 11-20, 22, 24, 33, 49,50, 52, 53, 71, 72	**Revenue Code:** 0510, 0515-0517, 0519-0523, 0526-0529, 0982, 0983 **-With-** **ICD-10:** F20-F39, F42-F43.9, F44.89, F53, F60-F63.9, F68.xx, F84.x, F90-F94.9

Please Note: The codes in this document are derived from the NCQA HEDIS 2018 Volume 2 Technical Specifications for Health Plans. These codes are examples of codes typically billed for this type of service and are subject to change. Submitting claims using these codes helps improve reporting of quality measure performance. Billing these codes does not guarantee payment.

Providers should check the Indiana Medicaid Fee Schedule prior to claim submission at **http://provider.indianamedicaid.com/.**

HEDIS® Measure

Follow-Up After ED Visit for AOD or Dependence

The HEDIS measure Follow-up after Emergency Department Visit for Alcohol & Other Drug Abuse or Dependence (FUA) focuses on the standard of care for the percentage of emergency department visits for patients 13 years and older. These patients have a principal diagnosis of alcohol or other drug (AOD) abuse and had a follow up visit for AOD.

The FUA measure has two reportable rates:

- The percentage of ED visits members received follow-up within 30 days of the ED visit.
- The percentage of ED visits members received follow-up within 7 days of the ED visit.

Criteria for a Follow-Up Visit - For both indicators (30-day & 7-day):

- Initiation and Engagement (IET) Stand Alone Visits with a principal diagnosis of AOD abuse or dependence
- IET Visits Group 1 ***with*** IET POS Group 1 and a principal diagnosis of AOD abuse or dependence
- IET Visits Group 2 Value Set ***with*** IET POS Group 2 Value Set and a principal diagnosis of AOD abuse or dependence.
- An observation visit with a principal diagnosis of AOD abuse or dependence.
- A telephone visit with a principal diagnosis of AOD abuse or dependence.
- An online assessment with a principal diagnosis of AOD abuse or dependence

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CareSource

PARTNER with Purpose

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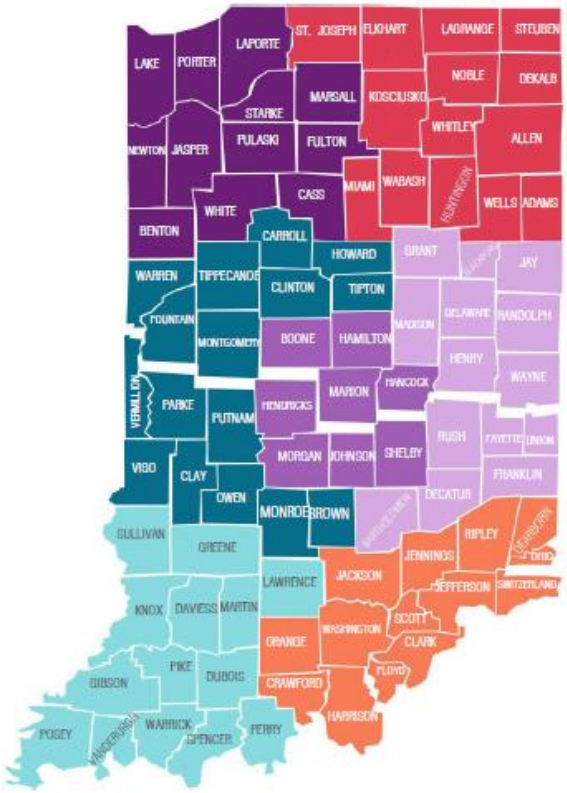

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IN-P-0190h
Date Issued: 08/04/2020
OMPP Approved: 07/30/2020

CareSource®

IN-P-0798a Issue Date: 9/9/20

OMPP Approved: 9/9/20

Q&A

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