

MHS Secure Provider Web Portal Overview



Agenda

Save Time by Utilizing the MHS Secure Web Portal

Account Creation/Login and Training Materials

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

Quality Reports

- Provider Analytics
- P4Q

Member Eligibility and Overview

- Member panel for PMPs
- Member Record

Authorizations

- Check Status
- Submit DME Request

Claims




- Submit, Correct and Review Claims
- Payment History

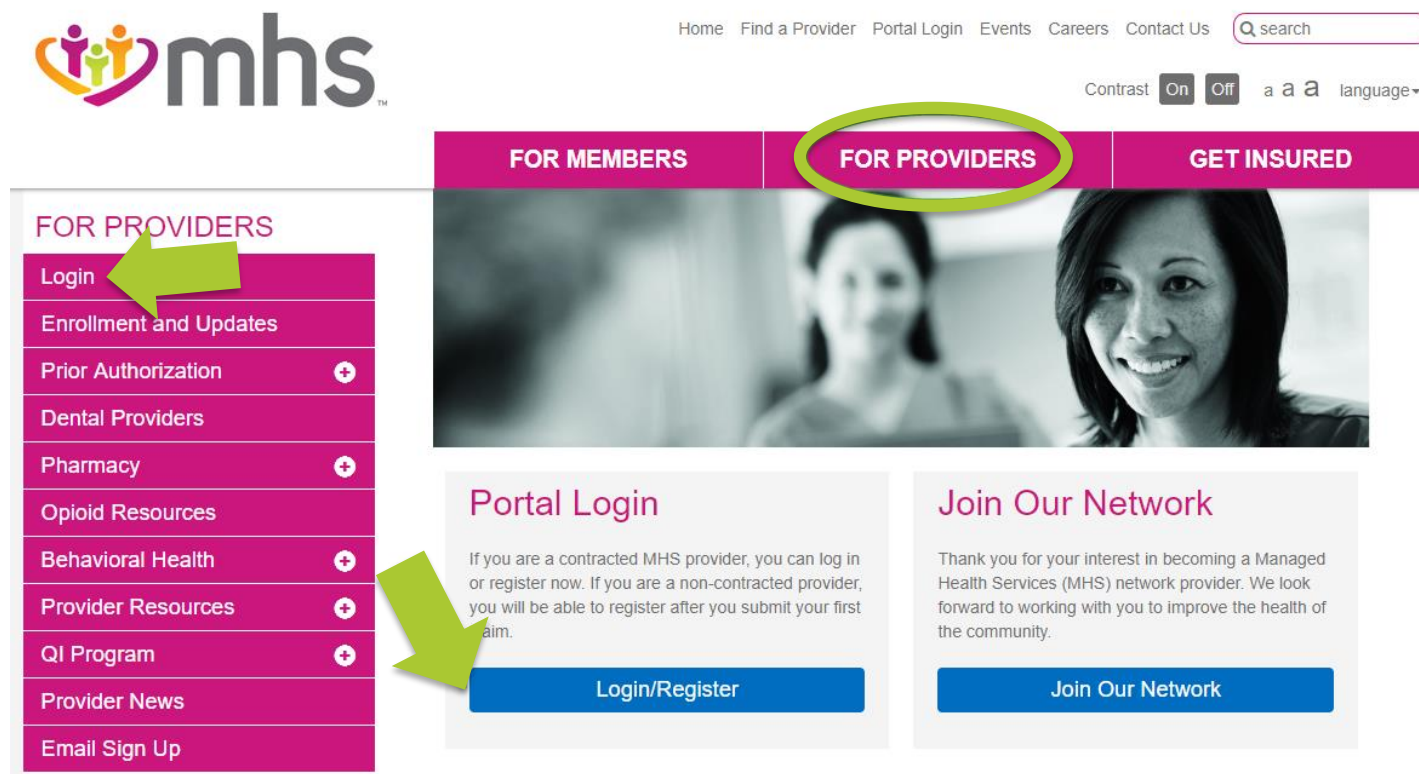
Secure Messaging

Portal Enhancements

Account Creation/Login and Training Materials

Provider Portal Login

-  Go mhsindiana.com and click on **For Providers**
-  Then click **Login/Register** for the **MHS Provider Portal**
-  Click **Login** tab to view Vision/Dental Portal Login and Training Materials



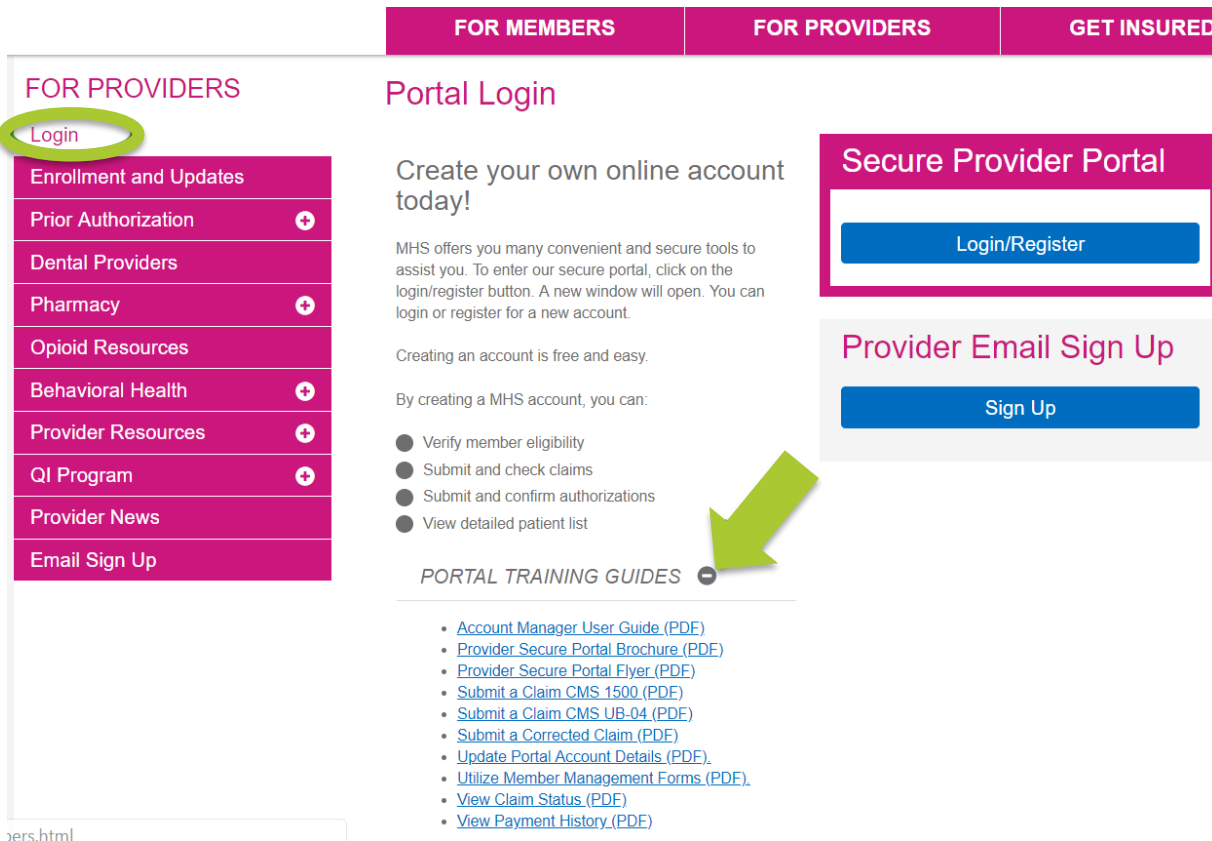
The screenshot shows the MHS website header with navigation links: Home, Find a Provider, Portal Login, Events, Careers, Contact Us, and a search bar. Utility links for Contrast (On/Off) and language are also present. The main navigation bar has three tabs: FOR MEMBERS, FOR PROVIDERS (circled in green), and GET INSURED. A left sidebar menu under 'FOR PROVIDERS' includes: Login (pointed to by a green arrow), Enrollment and Updates, Prior Authorization (+), Dental Providers, Pharmacy (+), Opioid Resources, Behavioral Health (+), Provider Resources (+), QI Program (+), Provider News, and Email Sign Up. The main content area features a 'Portal Login' section with a 'Login/Register' button (pointed to by a green arrow) and a 'Join Our Network' section with a 'Join Our Network' button. A background image of two women is visible behind the main content.

Web Portal Training Documents

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

Training Documents Include:

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



The screenshot shows the MHS web portal interface. At the top, there are three navigation tabs: "FOR MEMBERS", "FOR PROVIDERS", and "GET INSURED". Below these, the "FOR PROVIDERS" section is active, displaying a list of resources on the left and a main content area on the right. The "Login" link in the left sidebar is circled in green. The main content area features a "Portal Login" section with a "Secure Provider Portal" box containing a "Login/Register" button and a "Provider Email Sign Up" box containing a "Sign Up" button. A green arrow points to the "PORTAL TRAINING GUIDES" link, which is expanded to show a list of PDF documents.

FOR PROVIDERS

FOR MEMBERS FOR PROVIDERS GET INSURED

FOR PROVIDERS

Login

Enrollment and Updates

Prior Authorization +

Dental Providers

Pharmacy +

Opioid Resources

Behavioral Health +

Provider Resources +

QI Program +

Provider News

Email Sign Up

Portal Login

Create your own online account today!

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

Creating an account is free and easy.

By creating a MHS account, you can:

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

Secure Provider Portal

Login/Register

Provider Email Sign Up

Sign Up

PORTAL TRAINING GUIDES

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

Complete Portal Registration or Login

The Tools You Need Now!
Our site has been designed to help you get your job done. For registration or secure website questions call (866) 912-0327. Manage all products with ease in one location.

Check Eligibility
Find out if a member is eligible for service.

Authorize Services
See if the service you provide is reimbursable.

Manage Claims
Submit or track your claims and get paid fast.

Need To Create An Account?
Registration is fast and simple, give it a try.

How to Register
Our registration process is quick and simple. Please click the button to learn how to register.

Registration Complete! Your Progress

Quick Eligibility Check
Member ID or Last Name: 123456789 or Smith | Birthdate: mm/dd/yyyy | **Check Eligibility**

Recent Claims

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

Welcome

- Add a TIN to My ACCOUNT >
- Manage Accounts >
- Reports >
- Patient Analytics >
- Provider Analytics >

Recent Activity

Date	Activity

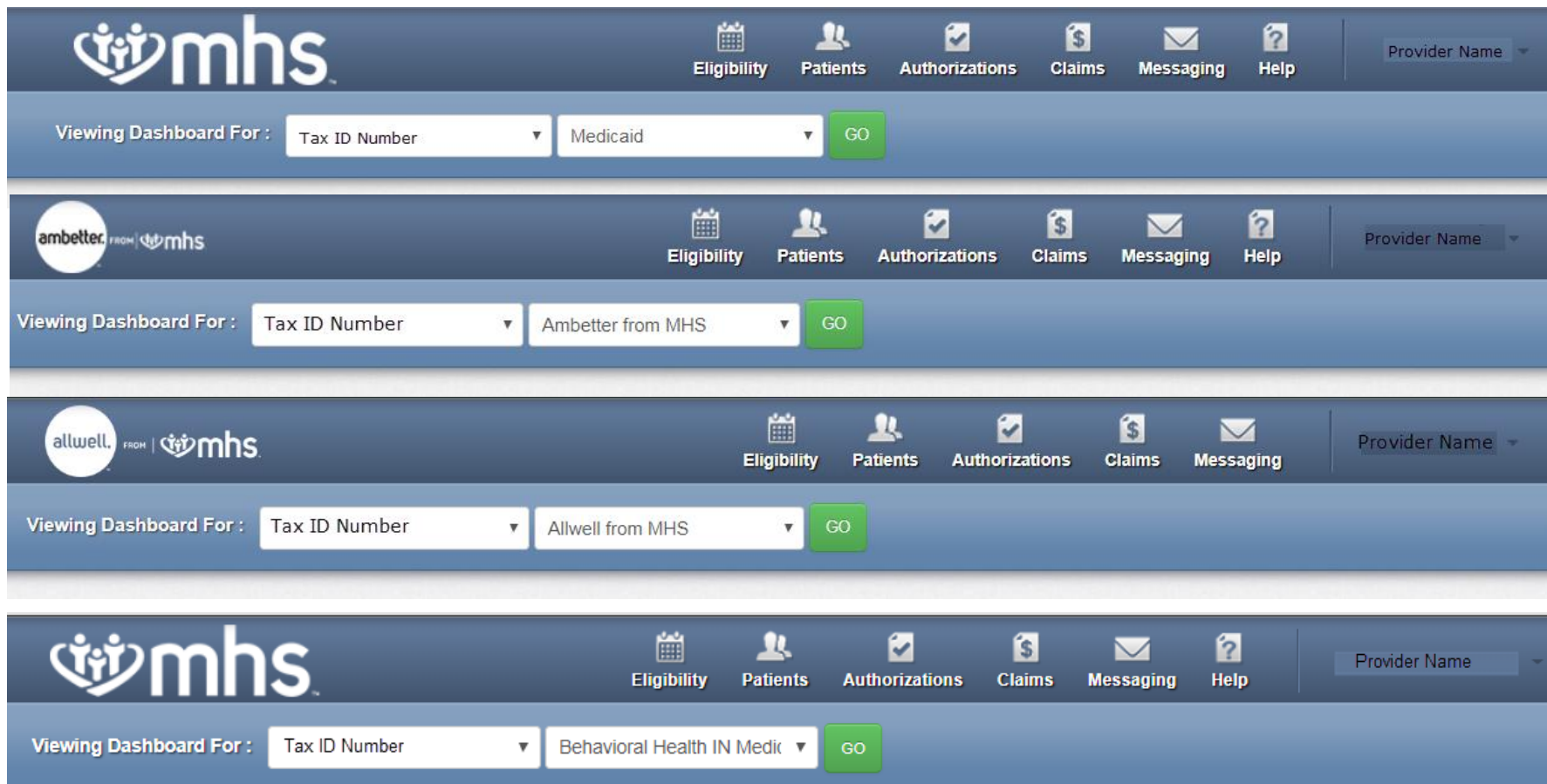
Quick Links

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

Login ←

Dashboard Change

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



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

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

Homepage – MHS (Medicaid)

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

Eligibility Patients Authorizations Claims Messaging Help
Provider Name ▾

Viewing Dashboard For : Tax ID Number Medicaid GO

Quick Eligibility Check

Member ID or Last Name Birthdate Check Eligibility

Recent Claims

STATUS	RECEIVED DATE	MEMBER NAME	CLAIM NO.
	06/07/2019	B ██████████ S	█ ██████████ 6
	06/07/2019	K ██████████ N	█ ██████████ ?
	06/07/2019	C ██████████ N	█ ██████████ 3
	06/07/2019	F ██████████ N	█ ██████████ 3
	06/07/2019	J ██████████ N	█ ██████████ 5

Quick Links

[Provider Resources](#)

[Member Management Forms](#)

Notification of Pregnancy (NOP): NOP must be accessed through the IHCP Provider Healthcare Portal and electronically submitted. If the member is not enrolled with Medicaid, the NOP option does not display. You must create a login and password in order to access the NOP form through the Provider Healthcare Portal.

Learn more about submitting a NOP through the [IHCP Provider Healthcare Portal](#).

Go to the [IHCP Provider Healthcare Portal](#)

[Late Notification of Services Submission Form](#)

[Peer to Peer Contact Form](#)

Please note: Claims information is updated every 24 hours.

For HIP Pharmacy information and PDLs, please visit the [Pharmacy](#) page.

Go Paperless

Empower your practice with electronic settlement. Now you can receive EFT's and ERA's without investing in new technology and without changes to current systems.

PaySpan Site

Welcome

Add a TIN to My ACCOUNT >

Manage Accounts >

Reports >

Patient Analytics >

Provider Analytics >

Recent Activity

Date	Activity

Quick Links

[Provider Resources](#)

[Member Management Forms](#)

MHS Member Management Forms

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

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

Viewing Dashboard For: Tax ID Number Medicaid GO

Quick Eligibility Check

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

Recent Claims

STATUS	RECEIVED DATE	MEMBER NAME	CLAIM NO.
🕒	06/07/2019	B ██████████ S	█ 6
🕒	06/07/2019	K ██████████ N	█ ?
🕒	06/07/2019	C ██████████ N	█ 3
🕒	06/07/2019	F ██████████ N	█ 3
🕒	06/07/2019	A ██████████ N	█ 5

Quick Links

[Member Management Forms](#)

Home Find a Provider Portal Login Events Contact Us Q search

Contrast On Off a a language

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

FOR PROVIDERS

- Login
- Become a Provider
- Prior Authorization
- Dental Providers
- Pharmacy
- Behavioral Health
- Provider Resources
- QI Program
- Provider News

Member Management Forms

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

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

Member Disenrollment

[Click Here](#)

Panel Management Form

[Click Here](#)

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

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

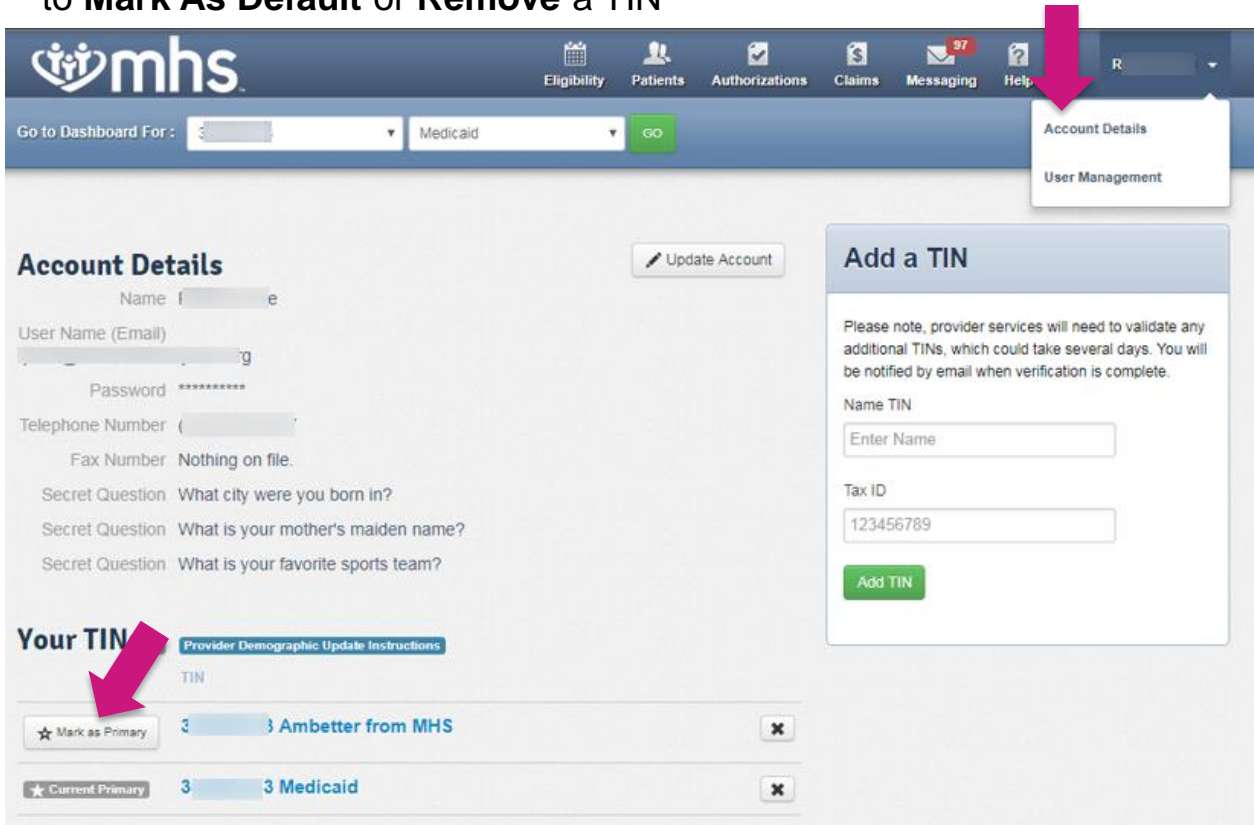
Account Details

 To view **Account Details**:

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

Note: Under Your TINs you see the Current **Primary** Default TIN for the account, and can select another TIN to **Mark As Default** or **Remove** a TIN

 [Update Account Details User Guide](#)



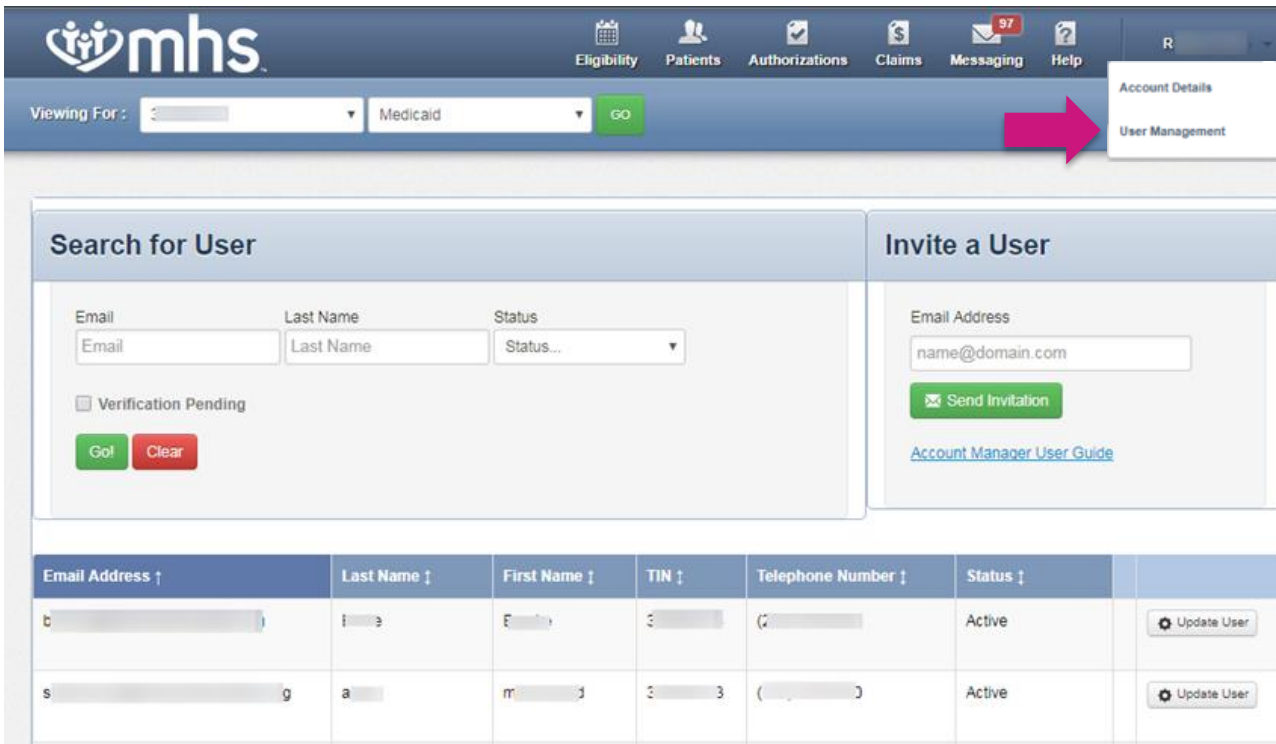
The screenshot shows the mhs dashboard with a navigation bar containing icons for Eligibility, Patients, Authorizations, Claims, Messaging (97), and Help. A dropdown menu is open next to the user name 'R.', showing 'Account Details' and 'User Management'. A pink arrow points to the 'Account Details' option. Below the navigation bar, there are fields for 'Go to Dashboard For:' with a dropdown set to 'Medicaid' and a 'GO' button. The main content area is divided into two sections: 'Account Details' and 'Add a TIN'. The 'Account Details' section includes fields for Name, User Name (Email), Password, Telephone Number, Fax Number, and three Secret Questions. An 'Update Account' button is located to the right. The 'Add a TIN' section contains a warning message, a 'Name TIN' field with the placeholder 'Enter Name', a 'Tax ID' field with the value '123456789', and an 'Add TIN' button. At the bottom, the 'Your TIN' section shows a list of TINs. The first entry is 'Ambetter from MHS' with a 'Mark as Primary' button and a close button. The second entry is '3 Medicaid' with a 'Current Primary' button and a close button. A pink arrow points to the 'Mark as Primary' button.

Account Manager



User Management

For **Account Managers** to manage their office staff/users associated with their practice: you can disable/enable users, and manage permissions for your account

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



The screenshot shows the mhs Account Manager interface. At the top, there is a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, Messaging (with a 97 notification), and Help. A user profile dropdown menu is open in the top right corner, showing 'Account Details' and 'User Management'. A pink arrow points to the 'User Management' option. Below the navigation bar, there is a 'Viewing For' section with a dropdown menu set to 'Medicaid' and a 'GO' button. The main content area is divided into two panels: 'Search for User' and 'Invite a User'. The 'Search for User' panel has input fields for Email, Last Name, and Status, a 'Verification Pending' checkbox, and 'Go' and 'Clear' buttons. The 'Invite a User' panel has an 'Email Address' input field with the placeholder 'name@domain.com', a 'Send Invitation' button, and a link to the 'Account Manager User Guide'. Below these panels is a table of users with columns for Email Address, Last Name, First Name, TIN, Telephone Number, Status, and an 'Update User' button for each row.

Email Address ↑	Last Name ↓	First Name ↓	TIN ↓	Telephone Number ↓	Status ↓	
b	i	E		(	Active	 Update User
s	a	m	3	(	Active	 Update User

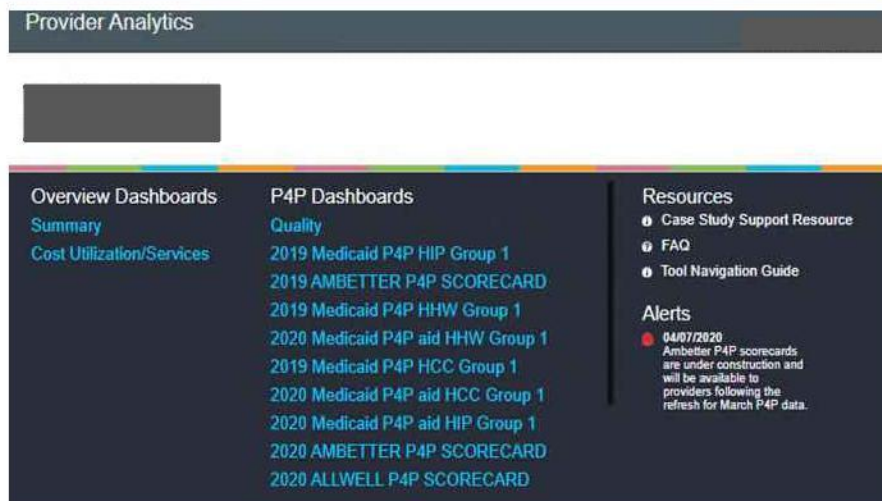
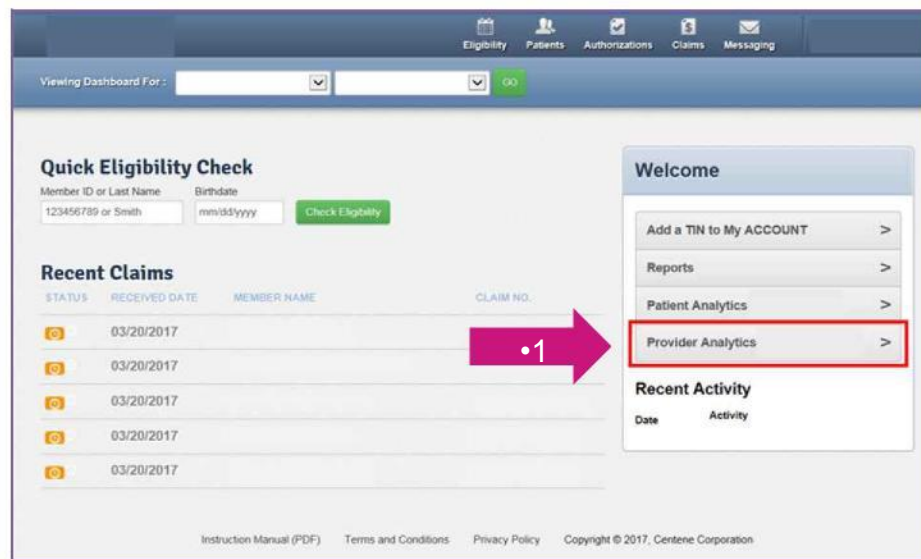
 [Account Manager User Guide](#)

Quality Reports

Provider Analytics

To navigate Provider Analytics:

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



Provider Analytics Summary Page



Here you will be able to view four dashboards:

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



Dashboard View

Cost/Utilization: This dashboard will show your actual Per Member Per Month compared to expected on a monthly basis

Quality: The Quality dashboard in the lower left quadrant shows HEDIS and Value Based Contract (VLC) performance

Engagement Analysis: This dashboard will show a view of your members' utilization of PMP and healthcare services

Readmission by Disease State: This dashboard will show total inpatient visits and total readmits. It will show the number of total readmits and those without PMP follow-up and follow-up rate

The Cost/Utilization and Quality sections have dashboards providing more specific data down to the member level. To view this data, click on the **blue computer monitor icons**




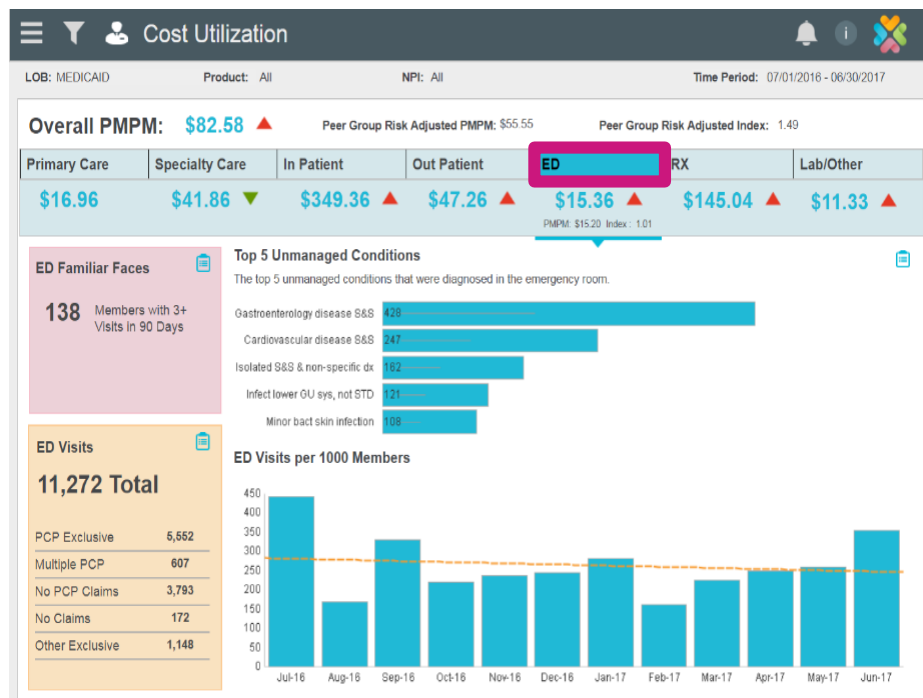
Cost & Utilization: ED

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

 Four sections:

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

 Click on the charts for patient-level detail



Summary Page Overview

Summary Banner

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

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



Summary Page Overview



Payment History

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



Summary Page Overview

Funnel Icon: Use this to select an option to view data specific to selected criteria

- **Line of Business**

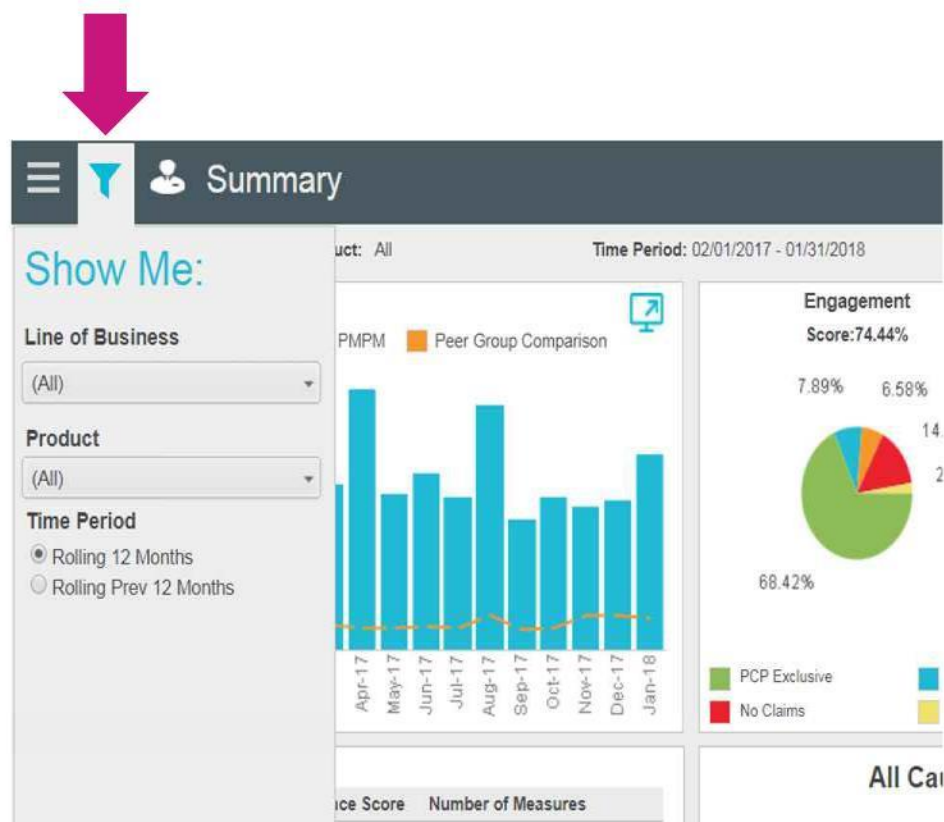
- Commercial
- Medicaid
- Medicare

- **Product**

- Medicaid
- Marketplace
- Medicare

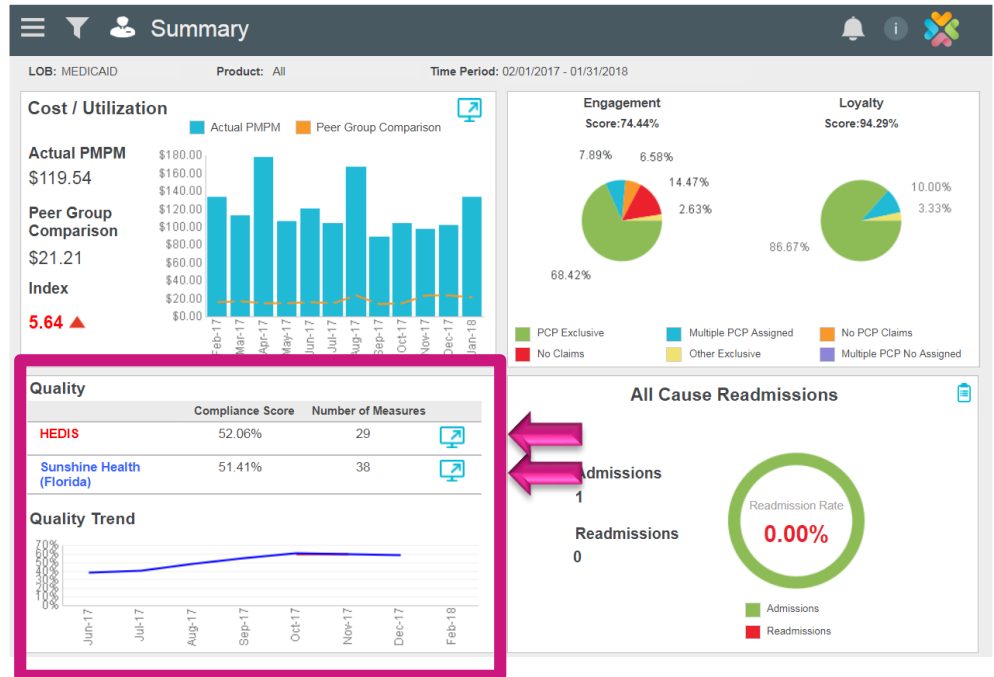
- **Time Period**

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



Quality HEDIS View

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



Quality HEDIS View: Gaps in Care

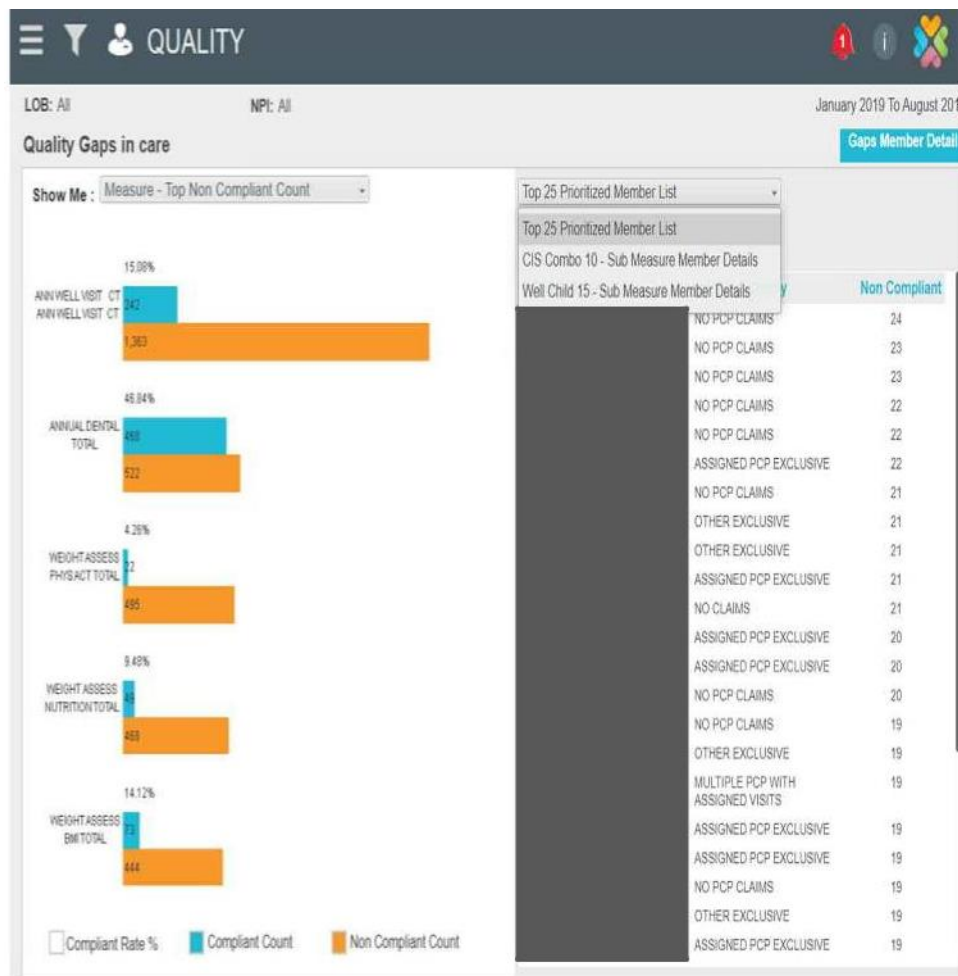
Left defaults to top five measures by non-compliant count.

Drop-down arrow changes view to see:

- Measures – Non-compliant count, compliant count, compliant rate % or all.
- NPI – Non-compliant count, compliant count, compliant rate % or all

Right side displays top 25 members with the most open care gaps

New drop down options for Combo 10 and W15 Member details



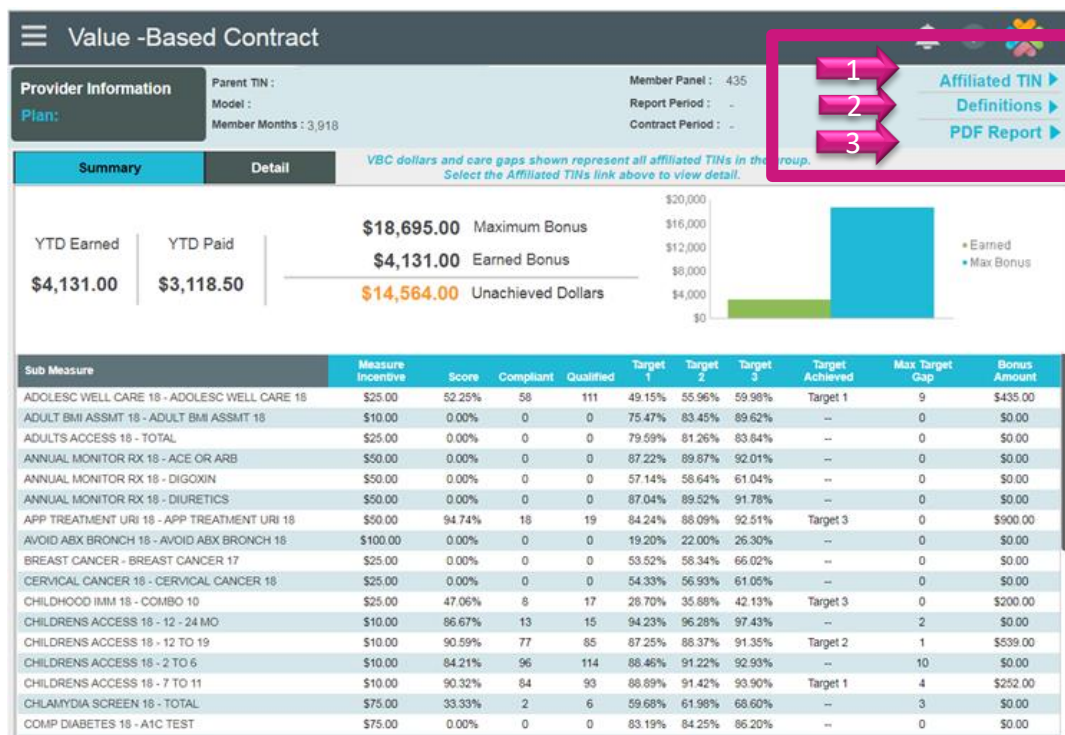
Quality HEDIS View

For providers in P4P arrangement

Scorecard shows measure incentive, amount earned, and unachieved dollars

In right hand corner

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



Quality HEDIS: Scorecards

You can also view:

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

Value -Based Contract

Provider Selection
 Plan: IN

Parent TIN:
 Model: 2019 Medicaid P4P HIP

Report Period: 1/1/2019 - 8/31/2019
 Contract Period: 1/1/2019 - 12/31/2019
 Member Months: 7,809

[Affiliated TIN](#)
[Definitions](#)
[PDF Report](#)

Summary	Detail
Qualifying Measures :	11
Measures Receiving Payment :	0
Minimum Qualified Measure :	1

PMPM Rate :	\$1.80	Earned Amount :	\$0.00
Member Months :	7,809	Unearned Amount :	\$14,056.20
Paid Amount :	\$0.00	Maximum Bonus :	\$14,056.20

VBC dollars and care gaps shown represent all affiliated TINs in the group. Select the Affiliated TINs link above to view detail.

Maximum potential bonus is contingent on care gap closure of actionable members following applicable technical specifications.

Measure	Measure Incentive	Score	Compliant	Qualified	Min Member Threshold	Target 1	Target Achieved	Max Target Gap	Bonus Amount
ADULTS ACCESS - TOTAL	\$0.40	66.21%	384	580	10	85.09%	--	110	\$0.00
ANTIDEPRESS MEDS - ACUTE PHASE	\$0.12	50.00%	19	38	5	57.82%	--	3	\$0.00
BREAST CANCER - NON-MCR TOTAL	\$0.10	56.52%	26	46	5	64.12%	--	4	\$0.00
CERVICAL CANCER - CERVICAL CANCER	\$0.10	46.54%	148	318	5	66.01%	--	62	\$0.00
CHLAMYDIA SCREEN - TOTAL	\$0.10	42.42%	14	33	5	65.43%	--	8	\$0.00
COMP DIAB NON MCR - NON-MCR EYE EXAM	\$0.12	40.00%	18	45	5	64.23%	--	11	\$0.00
COMP DIAB NON MCR - NON-MCR NEPHATTN	\$0.12	82.22%	37	45	5	92.05%	--	5	\$0.00
MED MGMT ASTHMA - TOTAL 5 TO 64 75% COVERED	\$0.10	8.33%	1	12	5	43.06%	--	5	\$0.00
PRENAT POST CARE - POSTPARTUM	\$0.20	50.00%	18	36	5	69.34%	--	7	\$0.00
PRENAT POST CARE - PRENATAL	\$0.20	61.11%	22	36	5	87.06%	--	10	\$0.00

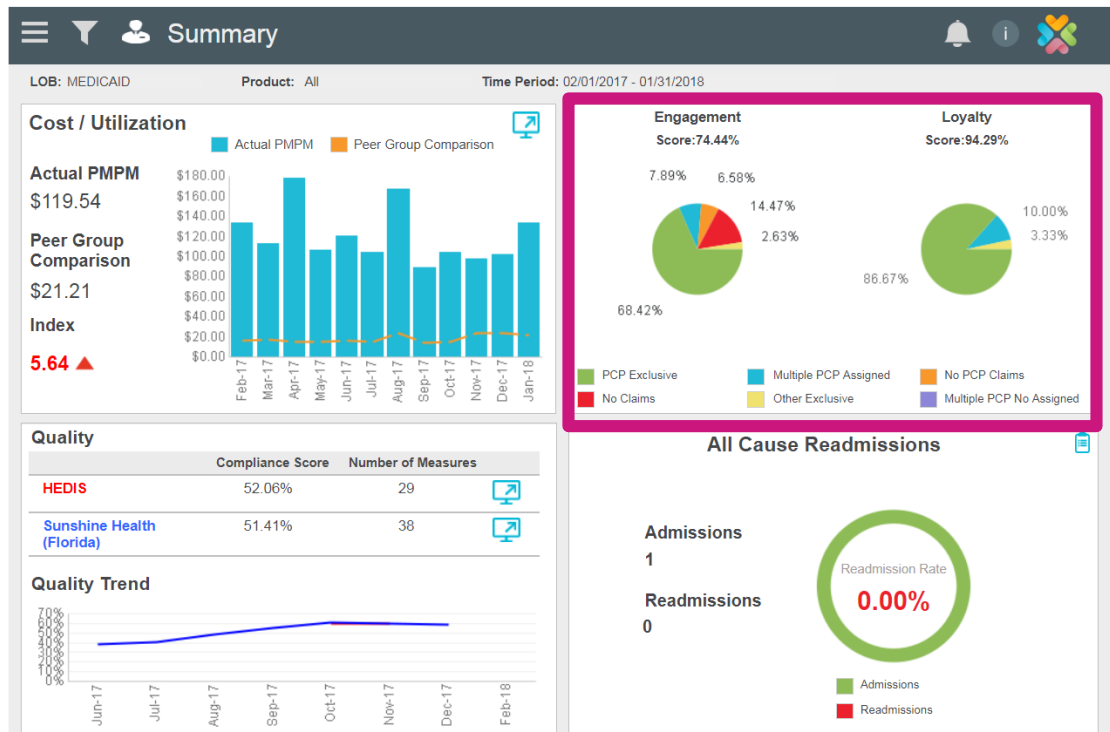
AMB ER Measure	Measure Incentive	Visits	Months AMB	Score	Target 1	Target Achieved	Months HBR	Bonus Amount
EMERGENCY DEPARTMENT VISITS	\$0.24	690	10,244	67.36	43.06	--	7,809	\$0.00

Engagement & Loyalty Analysis


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

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

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



Engagement & Loyalty Analysis

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

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

Partnership for Quality (P4Q)

What is the Partnership for Quality (P4Q) and what is in it for members and providers?

P4Q is Risk Adjustment bonus program for our Providers partners aimed at increasing PCP visibility into members' existing as well as suspected conditions for better quality of care for chronic condition management and prevention.

What is in it for members?

Members with existing or newly suspected chronic conditions will receive more regular and proactive assessment and fewer chronic conditions will go undiagnosed or untreated.

What is in it for providers?

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

Who is included in the P4Q Program?

The intent of P4Q is to promote proactive management of chronic conditions and preventative services.

Targeted Lines of Business (LOB)

- Ambetter, Allwell and Medicaid
- Eligible providers and members are loaded into the P4Q Dashboard (Provider Analytics)

Who is included in the program?

- Members included in the program are those with disease conditions that need to be assessed year over year

Provider Guide for P4Q

 Log into Provider Portal

 View condition assessment report in Provider Analytics

 Quality tab

 P4Q

P4Q Portal Navigation

Member ID column will contain both Marketplace and Medicaid Member ID's.

Member Status:
 Dark Green: Completed
 Light Green: Claim in Process
 Yellow: Not Completed

Providers can also choose to filter by Line of Business.

Member ID	Member Last Name	Member First Name	Date of Birth	NPI	Assessed	Unassessed	Assessed %
					5	3	62.5%
					5	1	83.3%
					5	0	100.0%
					4	1	80.0%
					4	3	57.1%
					3	6	33.3%
					3	2	60.0%
					3	4	42.9%

Disease Condition	Diagnosis	Status	Active Diagnosis & Documented	Resolved Not Present			
Gastro, low	R16.0 HEPATOMEGALY NEC	Assessed	07/05/2019	05/14/2020	Light Green	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Hematological, very high	D57.00 HB-SS DISEASE WITH CRISIS UNS	Coded Through Claims	02/19/2020	05/14/2020	Dark Green	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Malignancies	49884072401 HYDROXYUREA CAP 500MG	Coded Through Claims	03/24/2020		Dark Green	<input type="checkbox"/>	<input type="checkbox"/>
Metabolic, high	E83.111 HEMOCHROMATOSIS D/T REPEATED RBC TX	Coded Through Claims	02/20/2020		Dark Green	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric, medium low	F43.10 POST-TRAUMATIC STRESS DISORDER UNS	Unassessed	10/24/2018		Yellow	<input type="checkbox"/>	<input type="checkbox"/>

All data shown here is for illustrative purposes only. No actual PHI data is presented.

Member Eligibility and Overview

Check Member Eligibility

The **Eligibility** tab offers an **Eligibility Check** tool designed to quickly check the status of any member.

- Update the **Date of Service**, if necessary.
- Enter the **Member ID** or **Last Name** and **DOB (Date of Birth)**.
- Click **Check Eligibility**.

Eligibility status is indicated by a **Green** Thumbs-Up for **Eligible** and an **Orange** Thumbs-Down for **Ineligible**.

Eligibility Check

Date of Service: 08/28/2017 Member ID or Last Name: |123456789 or Smith DOB: mm/dd/yyyy **Check Eligibility**

ELIGIBLE	DATE OF SERVICE	PATIENT NAME	DATE CHECKED	CARE GAPS	RIGHT CHOICE PROGRAM
Ineligible	08/28/2017	F [redacted] N	08/28/2017		
	08/28/2017	T [redacted] S	08/28/2017	Risk Category Alerts: COPD/Asthma	
	08/28/2017	T [redacted] S	08/28/2017	Risk Category Alerts: COPD/Asthma Member has had 3 or more emergency room visits in past 90 days.	Yes

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

Care Gaps can also be seen within the search results.

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

Right Choice Program indicator labeled **Yes**.

MHS Member Overview

Back to Patient List

Member Name

Overview

Cost Sharing

Assessments

Health Record

Care Plan

Authorizations

Referrals


Coordination of Benefits

Claims

Power Account Service Estimate

Document Resource Center

Notes

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

Patient Information

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

PCP Information

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

[View PCP History](#)

[EPSDT](#)

[Care Gaps](#)

Eligibility History

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

[View Clinical Information](#)

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

[Allergies](#)

None On File

Overview Tab

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

View Patient List

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

The screenshot shows the mhs web application interface. The 'Patients' tab is highlighted in the top navigation bar. Below the navigation bar, there are search filters for 'Viewing Patients For' (Tax ID Number) and 'Medicaid'. A 'Find Patient' button is visible. The main content area shows a 'Patient List as of 11/13/2017' with a 'Download' button and a 'Filter' button. A disclaimer states: 'Care Gaps do not reflect claims processed after most current data refresh. Non-Compliant Pay for Performance lists do not reflect claims processed after the report run date and also excludes members who have lost HEDIS eligibility.' Below this is a table of patient records.

Eligible	Preferred Language ↑	Member Name ↑	Member ID ↑	Member # ↑	Date of Birth ↑	Phone Number ↑	ALERTS	Right Choice Program
👍		T. A	1 9 0		0	()	CG DM	<input type="checkbox"/>
👍		T. E	1 3 1		01/31	(7) 14	CG DM	<input checked="" type="checkbox"/>
👍		H. J	1 9 0		0	() 6	CG DM	<input type="checkbox"/>
👍		H. R	1 3 0		0 37	(7) 58	CG	<input type="checkbox"/>
👍		T. S	1 9 0		0	()	CG DM	<input type="checkbox"/>
👍		T. V	1 9 1		1/13	(7) 36	CG DM	<input type="checkbox"/>

Authorizations

Authorizations

View, create and filter group Authorizations

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

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

Authorizations Processed Errors Disclaimer Filter

Please call the health plan for questions regarding voided authorization submissions. The authorization page is updated every 24 hours.

STATUS	AUTH ID	MEMBER	FROM DATE	TO DATE	DIAGNOSIS	AUTH TYPE	SERVICE
DENY	[REDACTED]	4 K [REDACTED] 3	07/03/2019	12/31/9999	E66.01	INPATIENT	Surgical
APPROVE	[REDACTED]	5 T [REDACTED] R	07/01/2019	01/01/2020	M81.0	OUTPATIENT	Biopharmacy
APPROVE	[REDACTED]	3 J [REDACTED] R	07/01/2019	01/01/2020	M81.0	OUTPATIENT	Biopharmacy
APPROVE	[REDACTED]	8 V [REDACTED] 3	06/28/2019	07/27/2019	M51.26	OUTPATIENT	Outpatient Services
APPROVE	[REDACTED]	3 V [REDACTED])	06/26/2019	07/26/2019	K43.9	OUTPATIENT	DME
APPROVE	[REDACTED]	) C [REDACTED] T	06/18/2019	12/31/9999	E66.01	INPATIENT	Surgical
APPROVE	[REDACTED]	4 C [REDACTED] *	06/18/2019	06/18/2019	E66.01	OUTPATIENT	Inpatient Services (S&P)

Authorization Details

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

Back to Authorizations
Member Name

Overview

Cost Sharing

Assessments

Health Record

Care Plan

Authorizations

Referrals

Coordination of Benefits

Claims

Auth Status: APPROVE

Auth Nbr: C-3

Service: DME

Provider of Service(s): RI

Diagnosis Code(s): K43.9

Explanation: Pay

Auth Type: OUTPATIENT

From Date: 06/26/2019

To Date: 07/26/2019

Procedure Code(s):
49652

Notes & Attachments: [View](#)

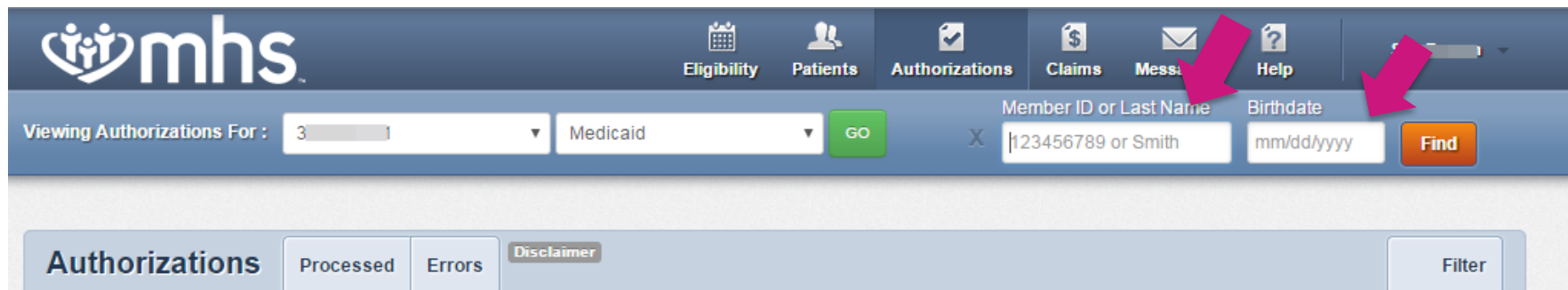
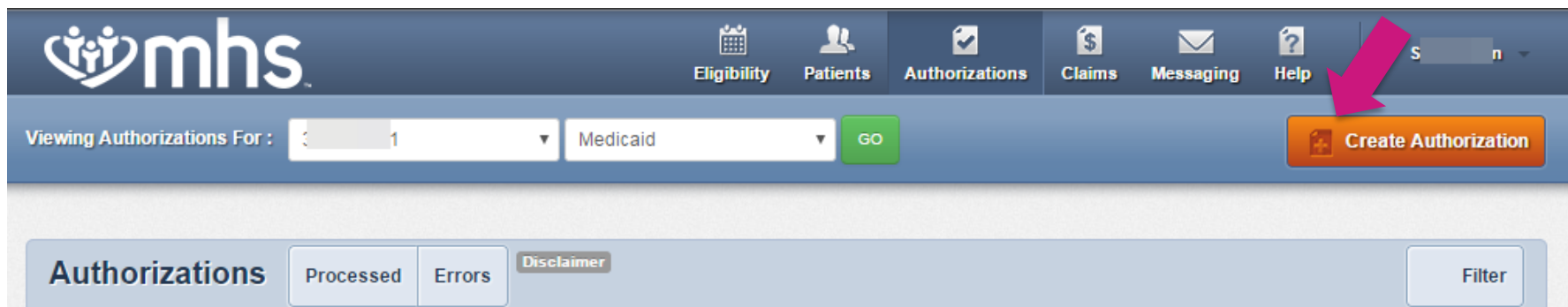
Line Item	Service type	Start Date	End Date	Units Req.	Units Apprd	Servicing Provider	Location	Status	Medical Necessity	Decision Date
1	DME	06/26/2019	07/26/2019	1	1	F- (blacked out)	Unspecified	APPROVE	Met as requested	06/09/2019
2	DME	06/26/2019	07/26/2019	1	1	F- (blacked out)	Unspecified	APPROVE	Met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

Back to Authorization List

Create a New Authorization

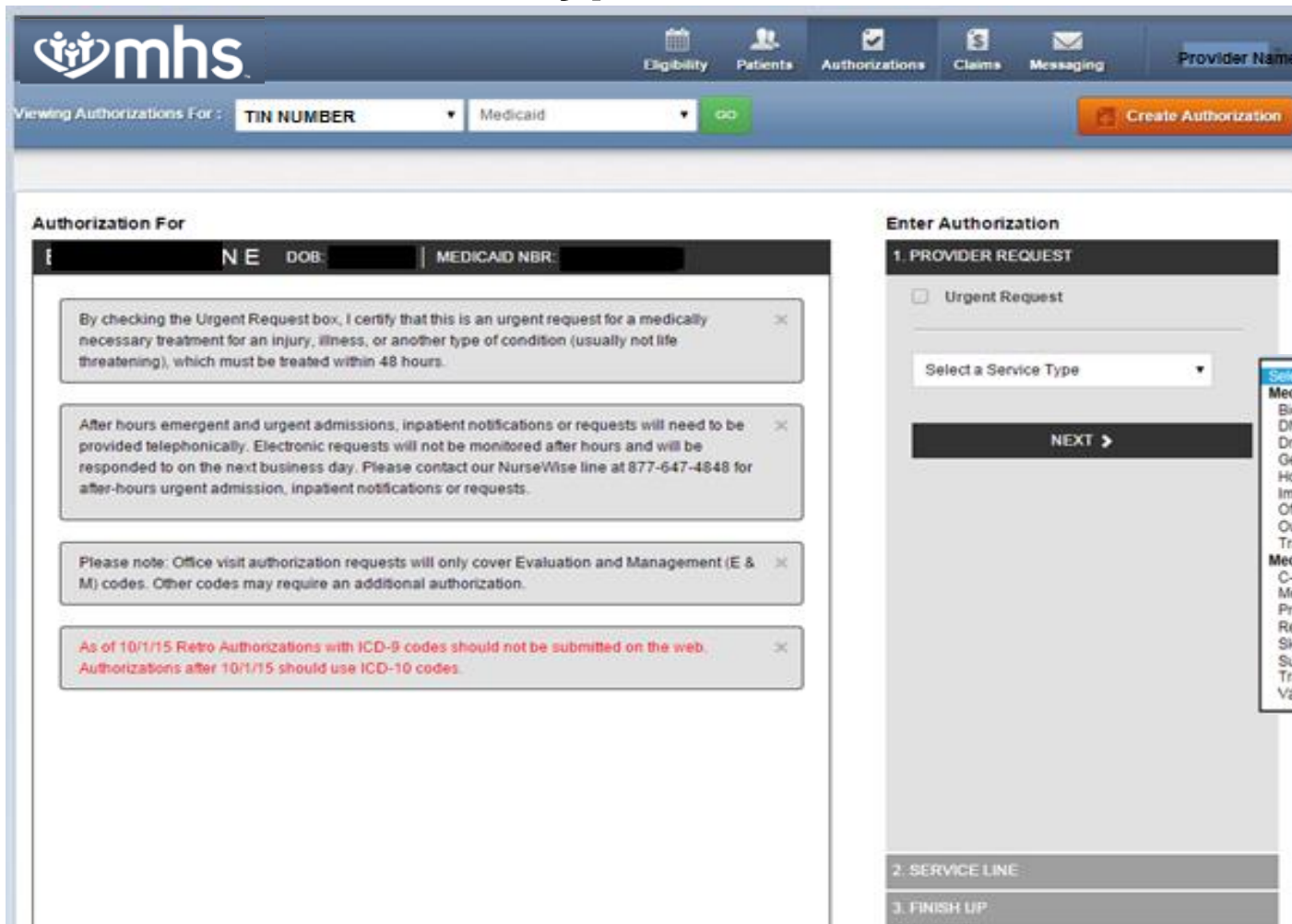
New Authorization

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



Creating a New Authorization

Select a Service Type



Viewing Authorizations For : TIN NUMBER Medicaid GO Create Authorization

Authorization For

NE DOB: MEDICAID NBR:

By checking the Urgent Request box, I certify that this is an urgent request for a medically necessary treatment for an injury, illness, or another type of condition (usually not life threatening), which must be treated within 48 hours.

After hours emergent and urgent admissions, inpatient notifications or requests will need to be provided telephonically. Electronic requests will not be monitored after hours and will be responded to on the next business day. Please contact our NurseWise line at 877-647-4848 for after-hours urgent admission, inpatient notifications or requests.

Please note: Office visit authorization requests will only cover Evaluation and Management (E & M) codes. Other codes may require an additional authorization.

As of 10/1/15 Retro Authorizations with ICD-9 codes should not be submitted on the web. Authorizations after 10/1/15 should use ICD-10 codes.

Enter Authorization

1. PROVIDER REQUEST

Urgent Request

Select a Service Type

NEXT >



2. SERVICE LINE

3. FINISH UP

Select a Service Type

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

Inpatient Prior Authorization

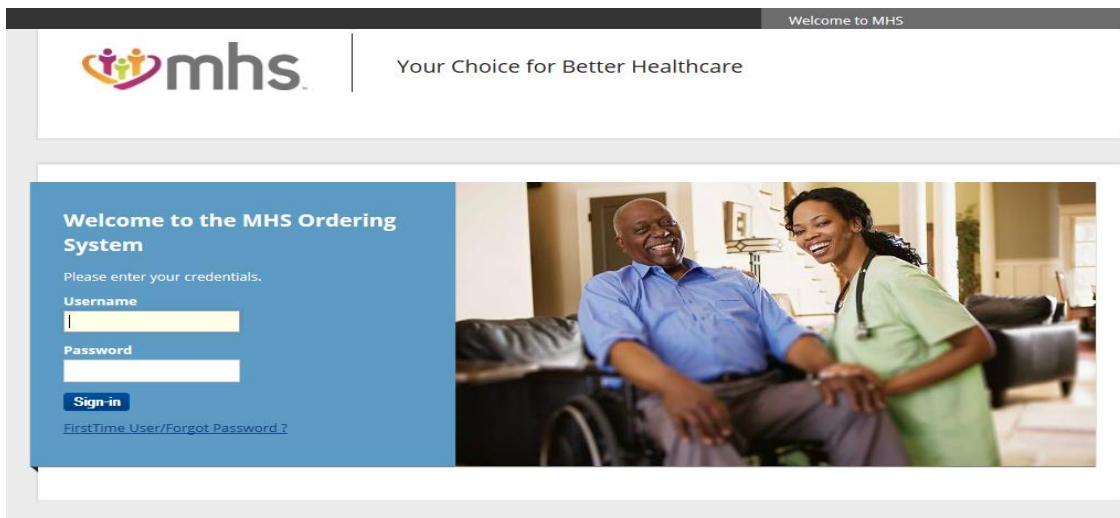
-  To ensure timely and accurate medical necessity review of a Medicaid inpatient admission, **effective as of November 1, 2019, MHS will accept notification of an inpatient admission and any clinical information submitted for medical necessity review via fax, using the IHCP universal prior authorization form or via the MHS Secure Provider Portal**
-  Please submit timely notification and clinical information to support an inpatient admission via fax to 1-866-912-4245 or upload via the MHS Secure Provider Portal

Authorization for Durable & Home Medical Equipment



Requests should be initiated via **MHS Secure portal on MHSIndiana.com**

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



Claims

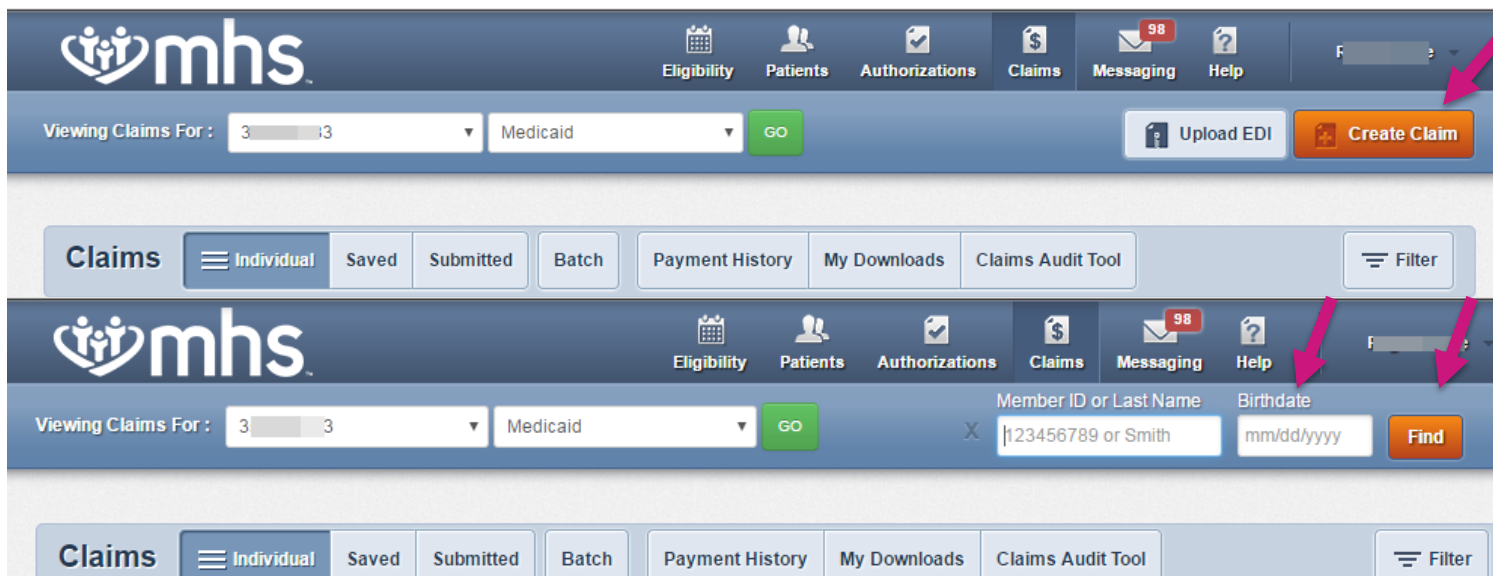
Claims

Claims Features

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

Submit a New Claim

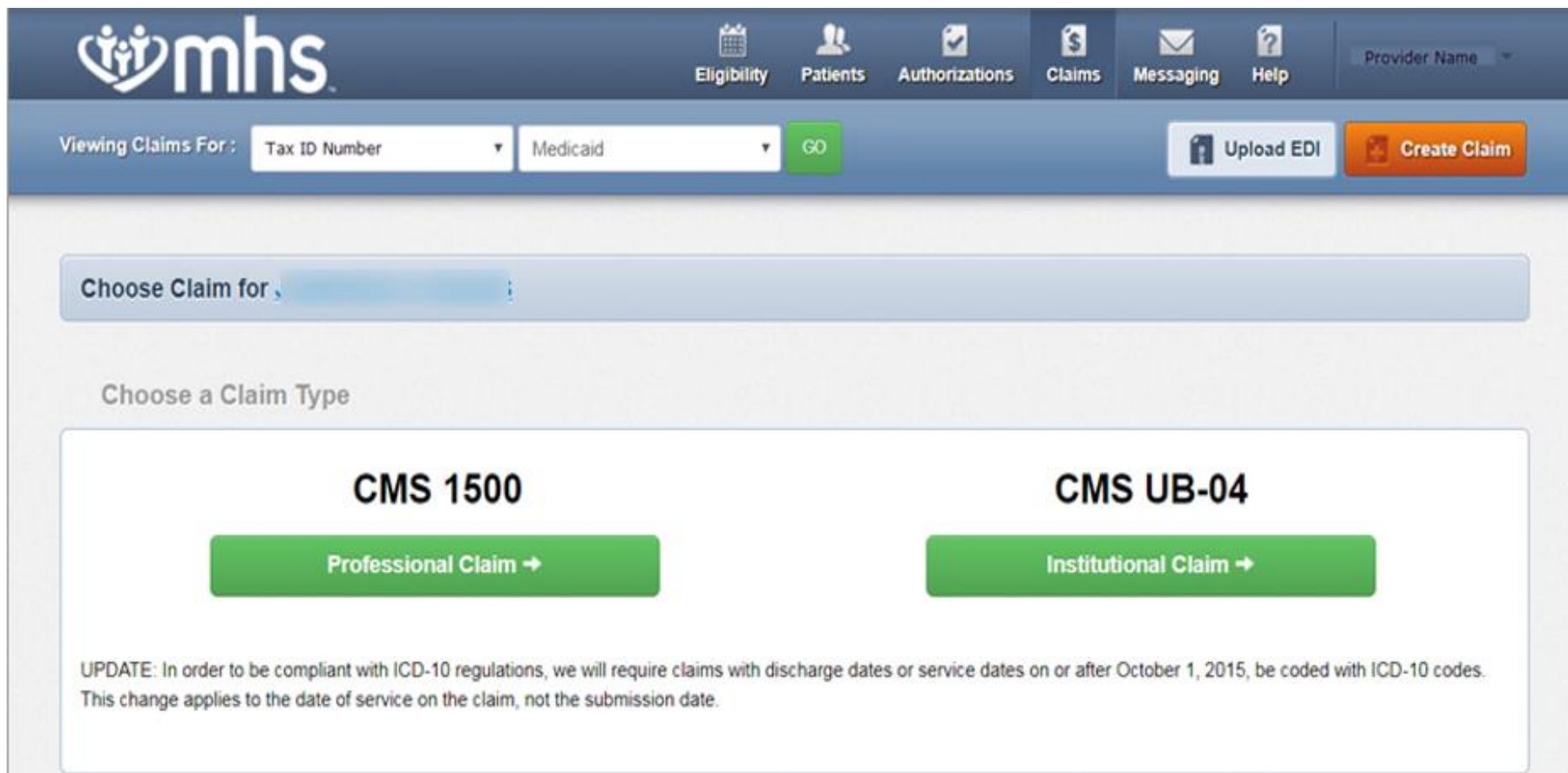
- Click **Create Claim** and enter **Member ID** and **Birthdate**



The screenshot displays the mhs Claims interface. At the top, there is a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, Messaging (with a notification badge of 98), and Help. Below this is a search bar with a dropdown menu and a 'GO' button. The main content area features a 'Claims' section with tabs for Individual, Saved, Submitted, Batch, Payment History, My Downloads, and Claims Audit Tool. A 'Filter' button is also present. Below the navigation bar, there is a search form with fields for 'Member ID or Last Name' (containing '|123456789 or Smith') and 'Birthdate' (containing 'mm/dd/yyyy'). A 'Find' button is located to the right of these fields. A red arrow points to the 'Create Claim' button in the top right corner, and two red arrows point to the search fields.

Claim Submission

Choose the Claim Type



The screenshot shows the mhs web application interface for claim submission. At the top, there is a navigation bar with the mhs logo and several menu items: Eligibility, Patients, Authorizations, Claims, Messaging, and Help. A dropdown menu for 'Provider Name' is also visible. Below the navigation bar, there is a search area with the text 'Viewing Claims For:' followed by two dropdown menus: 'Tax ID Number' and 'Medicaid', and a green 'GO' button. To the right of the search area are two buttons: 'Upload EDI' and 'Create Claim'. Below the search area, there is a large blue button labeled 'Choose Claim for'. Underneath this, the text 'Choose a Claim Type' is displayed. Two large green buttons are shown: 'CMS 1500 Professional Claim →' and 'CMS UB-04 Institutional Claim →'. At the bottom of the page, there is an update notice: 'UPDATE: In order to be compliant with ICD-10 regulations, we will require claims with discharge dates or service dates on or after October 1, 2015, be coded with ICD-10 codes. This change applies to the date of service on the claim, not the submission date.'

Professional Claim Submission

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

Professional Claim for €

Your Progress



THIS SECTION:

Review

Please review your claim and submit.

[← Back](#)

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

[Validate →](#)

Almost done!

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

Claim Id: 8

Member Record Number: 3

Member Claim Amount Paid:

Patient's Account Number: 1 7

Institutional Claim Submission

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

Institutional Claim for **E**

Your Progress



THIS SECTION:

Review and Submit

Please review your claim before submitting.

Almost done!

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



Claim ID: **E**

General Info [Edit](#)

Submitted Claims

The **Submitted** tab will show only claims created via the MHS portal

- **Paid** is a green thumbs up
- **Denied** is a orange thumbs down
- **Pending** is a clock

RTEP (Real Time Editing and Pricing) claims also show if eligible. (i.e. line 3 was submitted. But was not eligible for RTEP)

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	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		C	CMS-1500	S	1		\$150.00	RTEP 👍

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

Individual Claims

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

- View the Claim Number, Claim Type, Member Name, Service Dates, Billed/Paid, and Claim Status

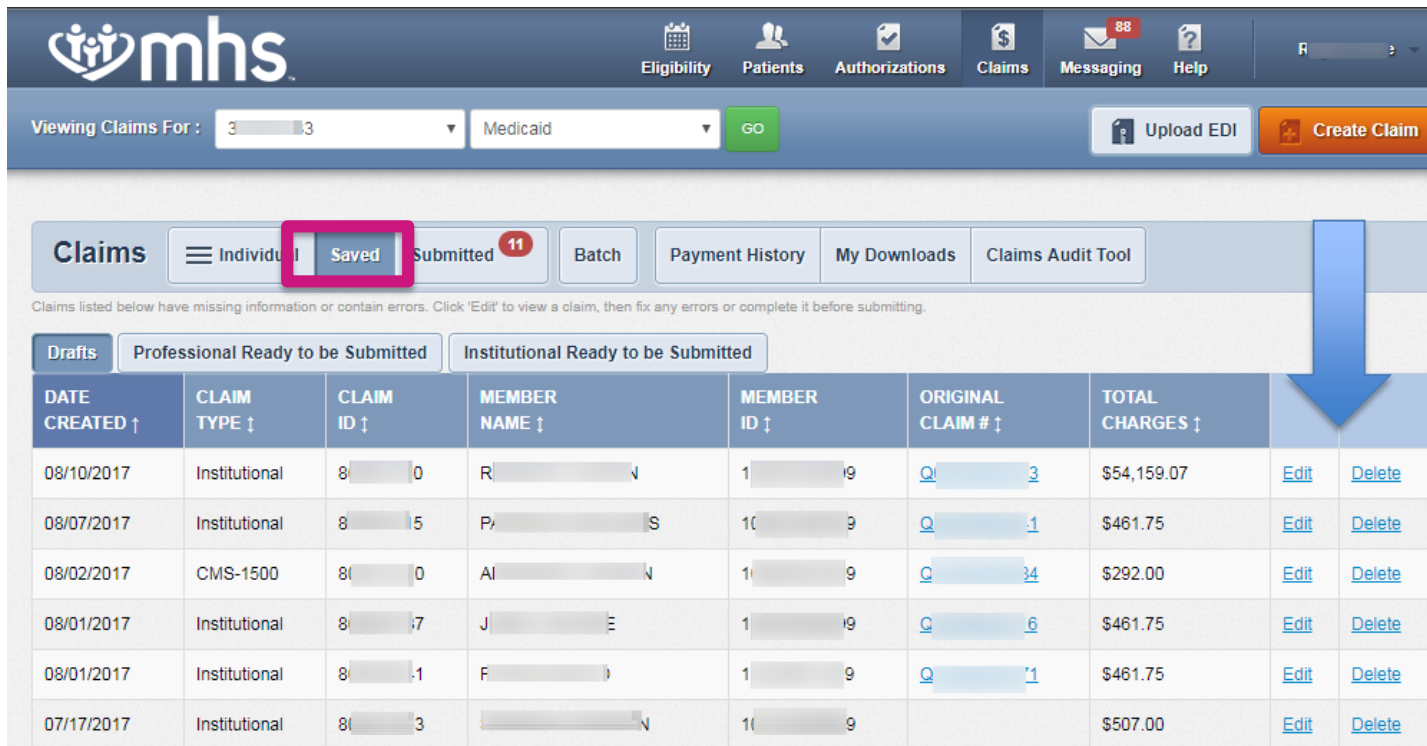
The screenshot shows the mhs Claims portal interface. At the top, there is a navigation bar with icons for Eligibility, Patients, Authorizations, Claims (highlighted with a red box), Messaging (46), and Help. Below this is a search bar for 'Viewing Claims For:' with dropdowns for 'Tax ID Number' and 'Medicaid', and a 'GO' button. To the right are 'Upload EDI' and 'Create Claim' buttons. Below the search bar is a tabbed interface with 'Claims' selected, and sub-tabs for 'Individual' (highlighted with a red box), 'Saved', 'Submitted', 'Batch', 'Payment History', 'My Downloads', and 'Claims Audit Tool'. The main content area is titled 'Claims: Recent' and includes a search filter for 'Date Range : 01/18/2019 to 02/18/2019' and buttons for 'Filter' and 'Search' (both highlighted with red boxes). A table of claims is displayed below.

CLAIM NO. ↑	CLAIM TYPE ↓	MEMBER NAME ↓	SERVICE DATE(S) ↓	BILLED/ PAID ↓	CLAIM STATUS ↓
§ [redacted]	CMS-1500	L [redacted]	02/14/2019 - 02/14/2019	\$100.00 / \$0.00	🕒 Pending
§ [redacted]	CMS-1500	C [redacted]	02/14/2019 - 02/14/2019	\$100.00 / \$0.00	🕒 Pending
§ [redacted]	CMS-1500	S [redacted]	02/14/2019 - 02/14/2019	\$100.00 / \$0.00	🕒 Pending
§ [redacted]	CMS-1500	C [redacted]	02/14/2019 - 02/14/2019	\$149.00 / \$0.00	🕒 Pending
§ [redacted]	CMS-1500	[redacted] K	02/14/2019 - 02/14/2019	\$229.00 / \$0.00	🕒 Pending

Saved Claims

 To view **Saved** claims: Drafts, Professional or Institutional

1. Select **Saved**
2. Click **Edit** to view a claim
3. Fix any errors or complete before submitting
Or
4. Click **Delete** to delete saved claim that is no longer necessary
5. Click **OK** to confirm the deletion



Viewing Claims For : 3 Medicaid GO Upload EDI Create Claim

Claims: Individual **Saved** Submitted 11 Batch Payment History My Downloads Claims Audit Tool

Claims listed below have missing information or contain errors. Click 'Edit' to view a claim, then fix any errors or complete it before submitting.


DATE CREATED ↑	CLAIM TYPE ↑	CLAIM ID ↑	MEMBER NAME ↑	MEMBER ID ↑	ORIGINAL CLAIM # ↑	TOTAL CHARGES ↑		
08/10/2017	Institutional	8100	R...	109	Q13	\$54,159.07	Edit	Delete
08/07/2017	Institutional	815	P...	109	Q1	\$461.75	Edit	Delete
08/02/2017	CMS-1500	8100	AI...	109	Q34	\$292.00	Edit	Delete
08/01/2017	Institutional	817	J...	109	Q6	\$461.75	Edit	Delete
08/01/2017	Institutional	811	F...	109	Q1	\$461.75	Edit	Delete
07/17/2017	Institutional	813	...	109		\$507.00	Edit	Delete

Correcting Claims

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

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

Back to Claims **Claim Details**

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

Claim #S158INE03385: Paid

+ Copy Claim **Correct Claim**

Claim Accepted — In Process — Paid

Member	Provider	Claim
Member Name: A [REDACTED] EY	Ref/Acct No.: E [REDACTED] 0	DOS Range: 06/06/2019 - 06/06/2019
Member ID: 1([REDACTED])	Servicing Provider: C [REDACTED] Y	Received Date: 06/07/2019
Member DOB: 1 [REDACTED] 7	Servicing NPI: 1[REDACTED] 2	Billed Amount: \$120.00

Service Lines

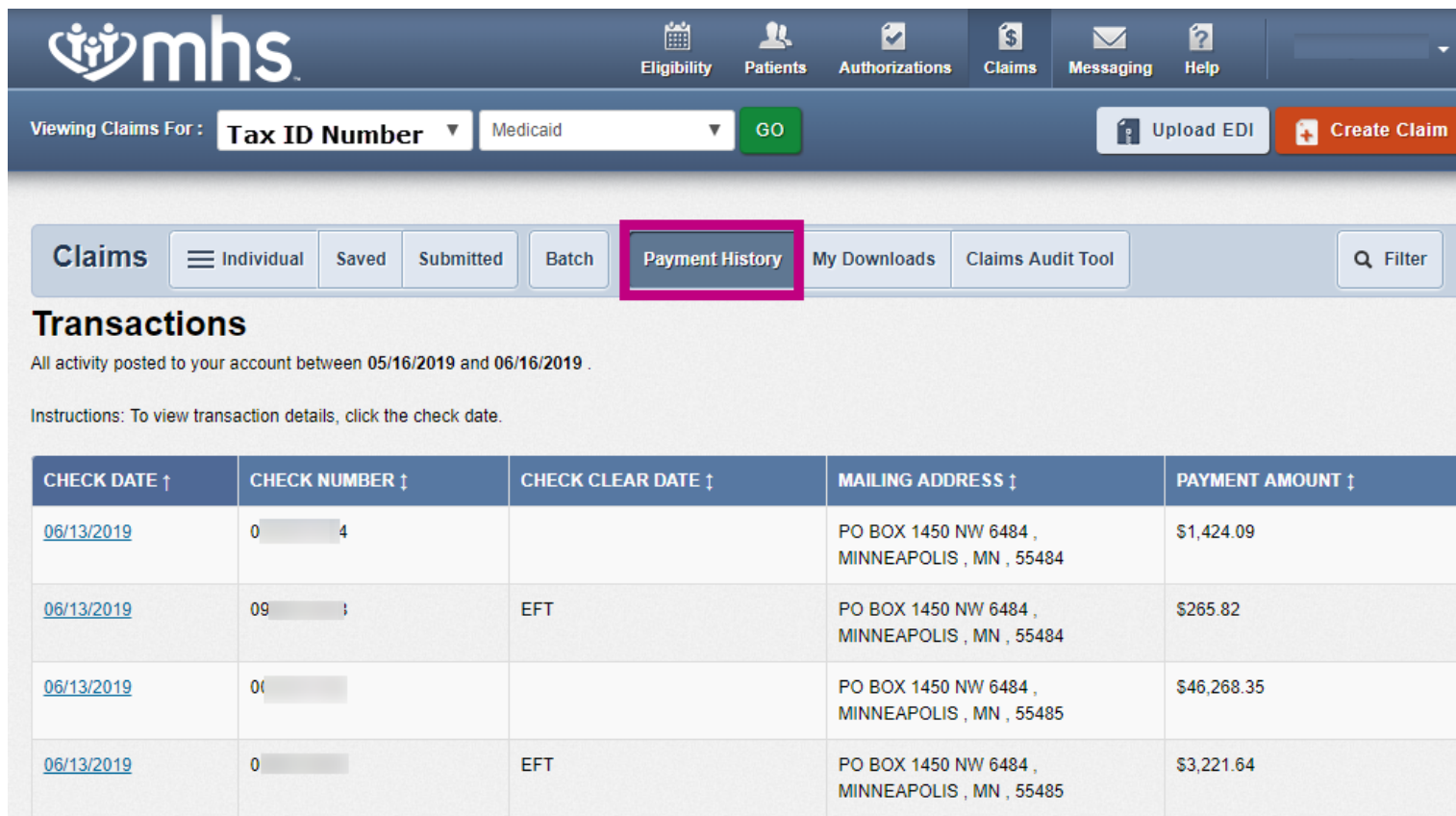
Line	DOS	Proc	Dx	Modifiers	Place of Service	Charged	Payment Amount	Payment Date	Check No.	Status	Payment Codes
1	06/06/2019	99213	K120		11	\$120.00	\$51.99	06/13/2019	00103717 46	PAID	92

 [Submit a Correct Claim Guide](#)

Payment History

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

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



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

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

Transactions

All activity posted to your account between 05/16/2019 and 06/16/2019 .

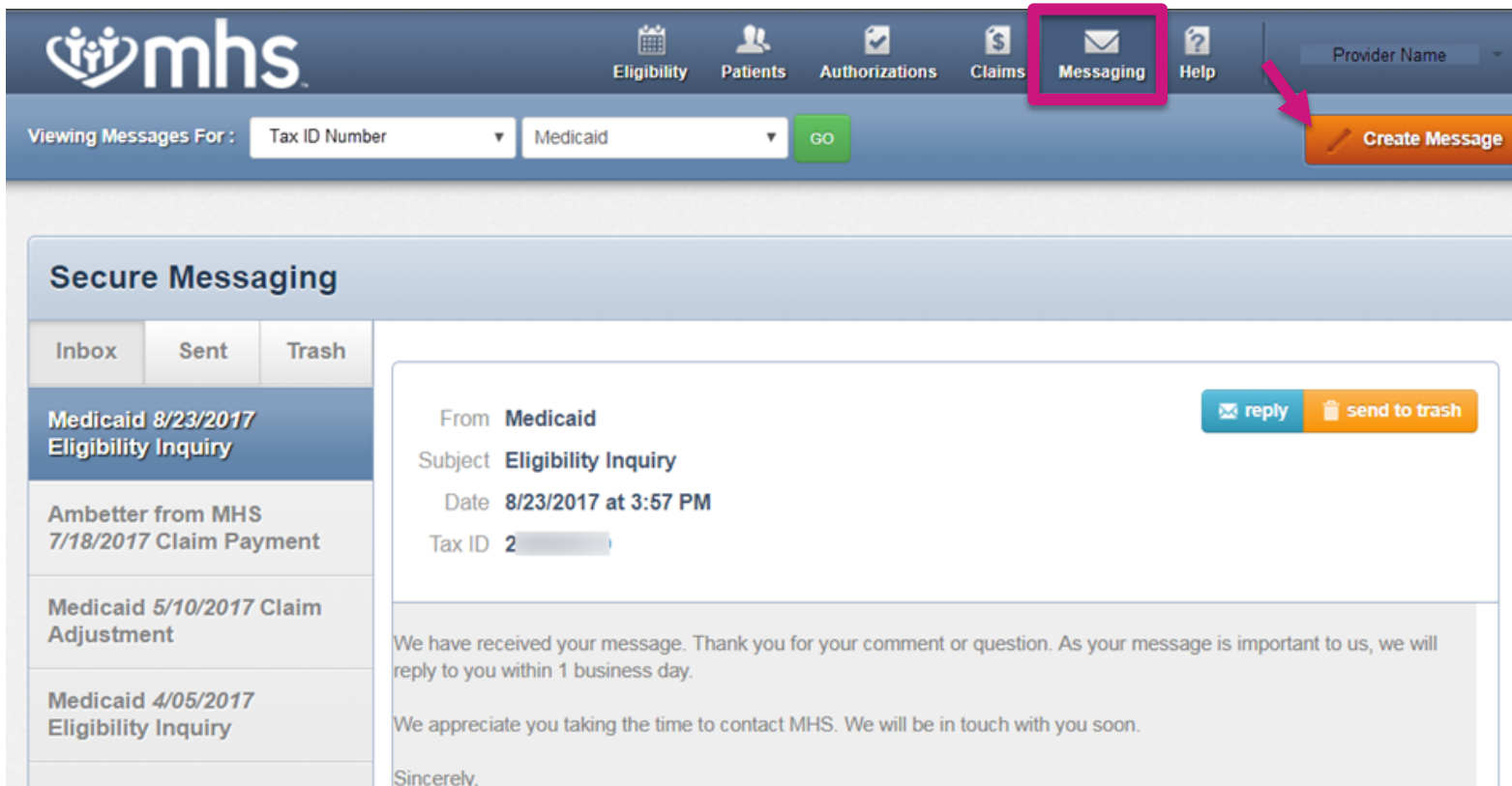
Instructions: To view transaction details, click the check date.

CHECK DATE ↑	CHECK NUMBER ↓	CHECK CLEAR DATE ↓	MAILING ADDRESS ↓	PAYMENT AMOUNT ↓
06/13/2019	0 [REDACTED] 4		PO BOX 1450 NW 6484 , MINNEAPOLIS , MN , 55484	\$1,424.09
06/13/2019	09 [REDACTED] ;	EFT	PO BOX 1450 NW 6484 , MINNEAPOLIS , MN , 55484	\$265.82
06/13/2019	00 [REDACTED]		PO BOX 1450 NW 6484 , MINNEAPOLIS , MN , 55485	\$46,268.35
06/13/2019	0 [REDACTED]	EFT	PO BOX 1450 NW 6484 , MINNEAPOLIS , MN , 55485	\$3,221.64

Secure Messaging

Create a New Secure Message

- Click **Messaging** tab from the Dashboard
- Click **Create Message**



Secure Messaging

Viewing Messages For: Tax ID Number Medicaid GO

Create Message

Inbox	Sent	Trash
Medicaid 8/23/2017 Eligibility Inquiry		
Ambetter from MHS 7/18/2017 Claim Payment		
Medicaid 5/10/2017 Claim Adjustment		
Medicaid 4/05/2017 Eligibility Inquiry		

From **Medicaid** [reply](#) [send to trash](#)

Subject **Eligibility Inquiry**

Date **8/23/2017 at 3:57 PM**

Tax ID **2**

We have received your message. Thank you for your comment or question. As your message is important to us, we will reply to you within 1 business day.

We appreciate you taking the time to contact MHS. We will be in touch with you soon.

Sincerely,

Provider Portal Enhancement (Online Claim Reconsiderations)

Summary Of Online Reconsiderations



Skip the phone call.

- Providers will make their case directly on the portal



Make the case.

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



Add context.


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



Stay current.

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

Submit Reconsideration

 Step 1- Provider will search for the claim from the claims tab.

 Step 2- The **Reconsider Claim** button will be visible from the claims sub navigation screen.

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

Submit Reconsideration

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

The main content area is titled 'Claim Details' and shows a 'Claim # [redacted] Denied'. A pink arrow points to the 'Reconsider Claim' button. Below this, there is a progress bar with three stages: 'Claim Accepted' (green checkmark), 'In Process' (green checkmark), and 'Denied' (red X). Below the progress bar, there are three sections: 'Member', 'Provider', and 'Claim'. The 'Member' section shows Member Name, Member ID, and Member DOB. The 'Provider' section shows RefAcct No., Servicing Provider, and Servicing NPI. The 'Claim' section shows DOS Range (01/22/2019 - 01/22/2019), Received Date (01/25/2019), and Billed Amount (\$160.00).

Below these sections is a 'Service Lines' table:

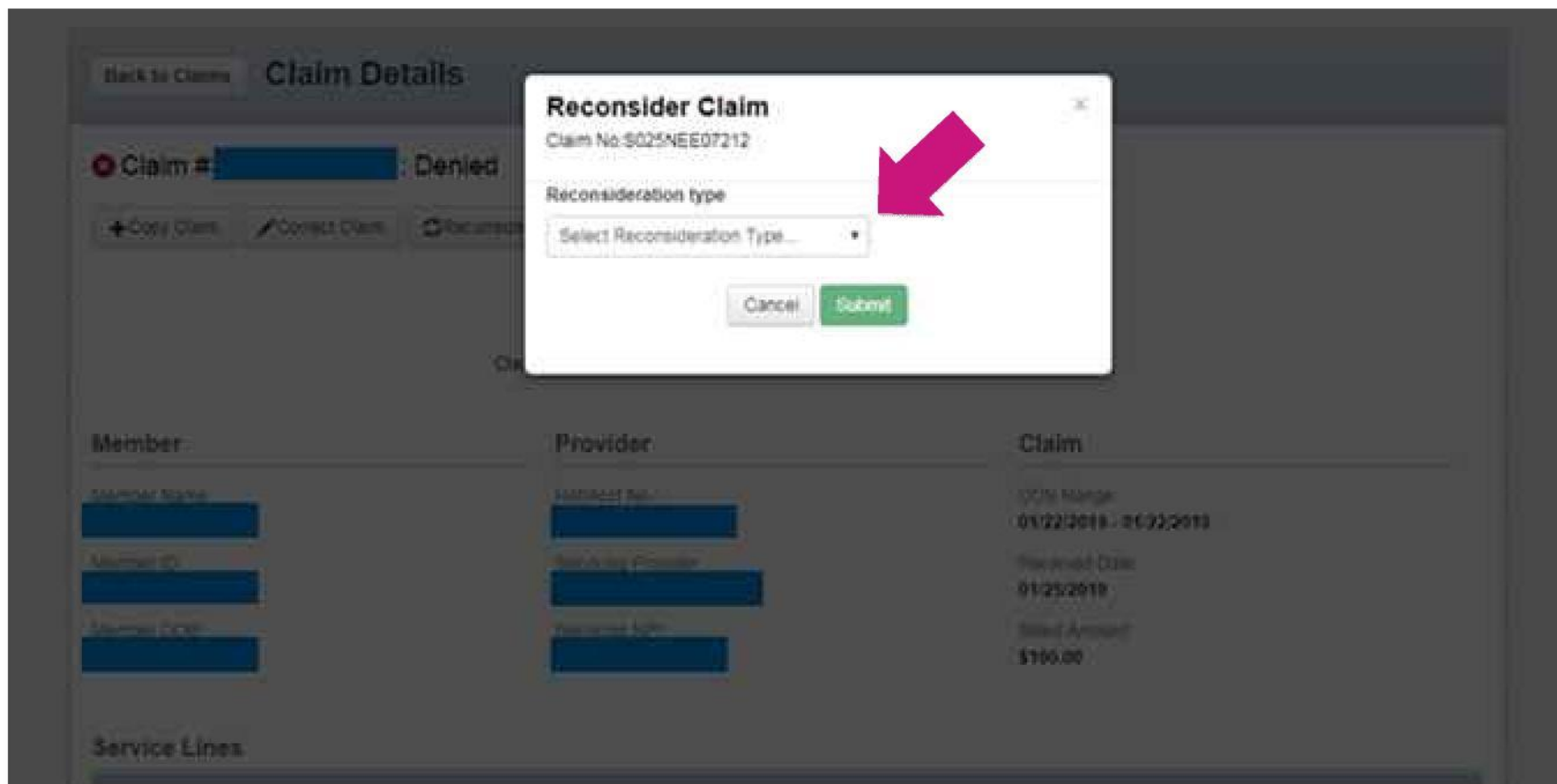
Line	DOS	Proc.	Dx	Modifiers	Place of Service	Charged	Payment Amount	Payment Date	Check No.	Status	Payment Codes
1	01/22/2019	99213	S82132 D; S82112 D; W010X XD		22	\$160.00	\$0.00	02/01/2019		VOID	L6

Submit Reconsideration – Pop-Up Window

 Once the provider selects Reconsider Claim, a pop up window will show.

 The pop-up window displays a Reconsideration Type dropdown menu.

Submit Reconsideration – Pop-Up Window



Submit Reconsideration – Select Reconsideration Type



Providers will select a Reconsideration Type.

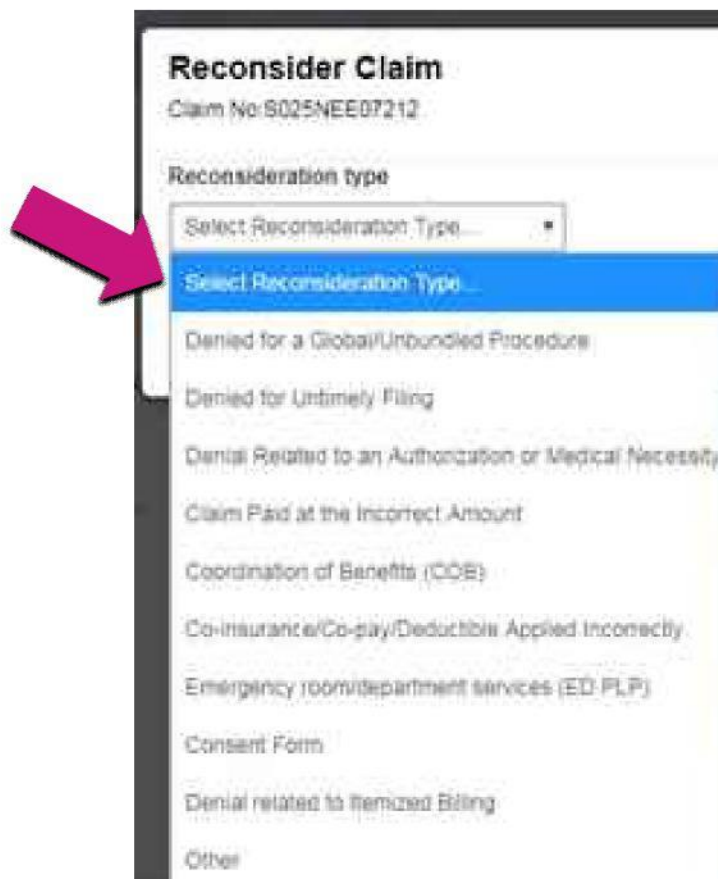
Examples include:

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



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

Submit Reconsideration – Select Reconsideration Type

A screenshot of a web application interface for submitting a reconsideration claim. The form is titled "Reconsider Claim" and shows "Claim No: S025NEE07212". Under the heading "Reconsideration type", there is a dropdown menu. A pink arrow points to the dropdown menu, which is currently open, showing a list of options. The first option, "Select Reconsideration Type...", is highlighted in blue. The other options listed are: "Denied for a Global/Unbundled Procedure", "Denied for Untimely Filing", "Denial Related to an Authorization or Medical Necessity", "Claim Paid at the Incorrect Amount", "Coordination of Benefits (COB)", "Co-insurance/Co-pay/Deductible Applied Incorrectly", "Emergency room/department services (ED/PLP)", "Consent Form", "Denial related to Itemized Billing", and "Other".

Reconsider Claim
Claim No: S025NEE07212

Reconsideration type

Select Reconsideration Type...

- Select Reconsideration Type...
- Denied for a Global/Unbundled Procedure
- Denied for Untimely Filing
- Denial Related to an Authorization or Medical Necessity
- Claim Paid at the Incorrect Amount
- Coordination of Benefits (COB)
- Co-insurance/Co-pay/Deductible Applied Incorrectly
- Emergency room/department services (ED/PLP)
- Consent Form
- Denial related to Itemized Billing
- Other

Submit Reconsideration – Enter Information



Once the provider selects the reconsideration reason, the provider has two options:

- Add notes
- Upload documents




The form is dynamic; depending on the dropdown item selected, notes and/or documents may be required.



Select **Submit** after populating all required fields.


Submit Reconsideration – Updated Tracker

 Upon submission, a success banner will be displayed



The screenshot displays the 'Claim Details' page. At the top, there is a 'Back to Claims' button and the title 'Claim Details'. Below this, the claim information is shown: 'Claim # [redacted] Reconsideration'. There are two buttons: '+ Copy Claim' and 'Correct Claim'. A green success banner with a checkmark icon and the text 'Your Reconsideration request has been submitted Successfully.' is prominently displayed. A large pink arrow points to this banner. Below the banner is a progress tracker with five stages: 'Claim Accepted' (green checkmark), 'In Process' (green checkmark), 'Denied' (red X), 'Submitted' (green checkmark), and 'Outcome TBD' (white circle). A bracket labeled 'RECONSIDERATION' spans the 'Submitted' and 'Outcome TBD' stages.

Submit Reconsideration – Updated Tracker

 The tracker graphic will be updated to reflect that a reconsideration is in progress.



Provider Relations Team

MHS Provider Network Territories

Indiana

NORTHEAST REGION

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

NORTHWEST REGION

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

NORTH CENTRAL REGION

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

CENTRAL REGION

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

SOUTH CENTRAL REGION

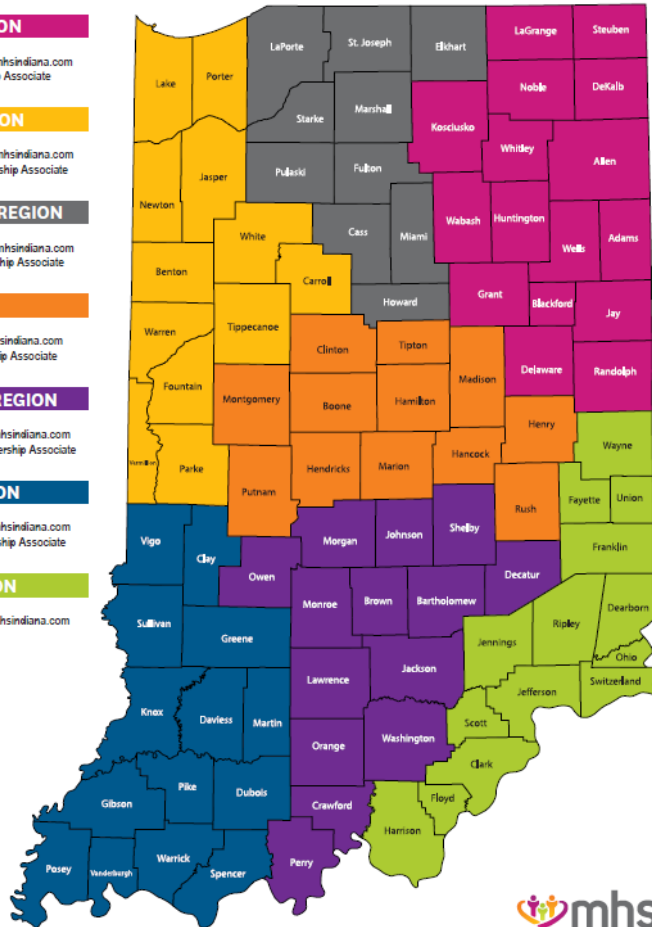
For claims issues, email:
MHS_ProviderRelations_SC@mhsindiana.com
Dalesia Denning, Provider Partnership Associate
1-877-647-4848, ext. 20026

SOUTHWEST REGION

For claims issues, email:
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Available online:

https://www.mhsindiana.com/content/dam/centene/mhsindiana/medicaid/pdfs/ProviderTerritory_map_2020.pdf



MHS Provider Network Territories

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PROVIDER GROUPS

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

JENNIFER GARNER

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PROVIDER GROUPS

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

NETWORK LEADERSHIP

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ENVOLVE DENTAL, INC.

MICHAEL J. WILLIAMS











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Available online:

https://www.mhsindiana.com/content/dam/centene/mhsindiana/medical/pdfs/ProviderTerritory_map_2020.pdf

What did you learn?

-  Analytic/Web Tool Resources
-  Navigating the web portal
-  Navigating provider analytics
-  How to view Gaps In Care
-  Navigating patient analytics
-  Eligibility verification
-  Authorization requests and information
-  How to submit a corrected claim
-  Reviewing claim information
-  How to submit request on line

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