



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

MHS Overview

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



Claim Submission Process

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.

Paper Claim Correction

- A corrected claim can be submitted following IHCP claim adjustment processes.
- A claim adjustment code is required on all claims, based on the type of claim submitted.
 - Example: Frequency 7 entered in Box 22 of the CMS-1500 form.
- The original claim number must also be listed on the corrected claim.
 - Box 22 on the CMS-1500
- A rejection, must be submitted as 1st time claim, not as a corrected claim.
- Handwriting or stamping on a claim will not be accepted as submission of a corrected claim, and will be rejected with code RE.

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/centene/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

MHS Provider Claims Issue Resolution Process

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/centene/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.

___ 1st Level (Informal Dispute/Reconsideration)
 ___ 2nd 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 denial 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).
 - 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;
 2nd 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 | mhsindiana.com
 Appeal from MHS | Appeal from MHS | Healthy Indiana Plan (HIP) | Hoosier Care Connect | Hoosier Healthwise

1220 QS 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://www.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>

Additional Claim Assistance

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
 - North Central Region: MHS_ProviderRelations_NC@mhsindiana.com
 - Central Region: MHS_ProviderRelations_C@mhsindiana.com
 - Northwest Region: MHS_ProviderRelations_NW@mhsindiana.com
 - Southwest Region: MHS_ProviderRelations_SW@mhsindiana.com
 - Southeast Region: MHS_ProviderRelations_SE@mhsindiana.com
 - South Central Region: MHS_ProviderRelations_SC@mhsindiana.com
 - Tier 1 Providers: IndyProvRelations@mhsindiana.com

Portal Functionality

Secure Web Portal Login or Registration

The screenshot displays the MHS Secure Web Portal interface. 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. Below the navigation is a contrast and language control bar. The main content area is divided into three tabs: 'FOR MEMBERS', 'FOR PROVIDERS', and 'GET INSURED'. The 'FOR PROVIDERS' tab is active, showing a 'Portal Login' section. On the left, a vertical menu lists various provider services. The main content area features a 'Portal Login' heading, a 'Create your own online account today!' call to action, and a 'Secure Provider Portal Login/Register' button. Below this is a 'Provider Email Sign Up' button. A 'PORTAL TRAINING GUIDES' section 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 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 \(PDF\)](#).

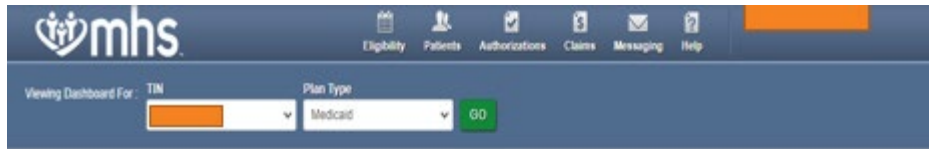
Vision and Dental Providers

[Vision Provider Portal Login](#)

[Dental Provider Portal Login](#)

- Verify member eligibility
- View member benefits

Homepage-MHS (Medicaid)



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 screenshot displays the mhs web portal interface for submitting a new claim. The top navigation bar includes icons for Eligibility, Patients, Authorizations, Claims, Messaging (with a notification badge of 98), and Help. Below the navigation bar, there are dropdown menus for 'Viewing Claims For' (set to '3') and 'Medicaid', with a green 'GO' button. To the right, there are buttons for 'Upload EDI' and 'Create Claim'. Below this, there is a 'Claims' section with tabs for 'Individual', 'Saved', 'Submitted', 'Batch', 'Payment History', 'My Downloads', and 'Claims Audit Tool', along with a 'Filter' button. The bottom section shows a search form with fields for 'Member ID or Last Name' (containing '123456789 or Smith') and 'Birthdate' (containing 'mm/dd/yyyy'), with a 'Find' button.

Claim Submission

Choose the Claim Type

- Professional or Institutional claim submission

The screenshot displays the mhs Claims Submission interface. At the top, there is a navigation bar with the mhs logo and icons for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. A dropdown menu for 'Provider Name' is also visible. Below the navigation bar, there is a section for 'Viewing Claims For:' with a dropdown menu set to 'Tax ID Number' and another dropdown menu set to 'Medicaid'. A green 'GO' button is next to the 'Medicaid' dropdown. To the right, there are two buttons: 'Upload EDI' and 'Create Claim'. Below this, there is a section titled 'Choose Claim for,' followed by a dropdown menu. Underneath, there is a section titled 'Choose a Claim Type' with two large green buttons: 'Professional Claim →' and '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.'

Facility Billing

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 dropdown menu shows 'Viewing Claims For:' with 'Medicaid' selected. A 'GO' button and 'Upload EDI' button are also visible. The main section is titled 'Institutional Claim for [redacted]' and includes a 'Your Progress' indicator with several arrows. The current section is 'General', with the instruction 'Enter Information for the Admission and Condition Codes'. A 'Next' button is located in the top right of the form area. The form contains several fields: 'Patient Control #' (with a pink arrow pointing to it), 'Medical Record #', 'Type Of Bill*' (a dropdown menu), 'Statement Dates*' (with 'From' and 'To' date pickers), 'Prior Payments', and 'Prior Authorization Number'. On the right side of the form, there are numbered tabs: 3.a, 3.b, 4, 5, 54, and 63. The word 'Admission' is visible at the bottom left 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. The form includes fields for Billing Provider (NPI, Taxonomy), Pay-to Provider (NPI, Taxonomy, IRS Tax ID Number, Pay-To Name, Address, City, State, Zip), and Attending Provider (NPI, Taxonomy, First Name, Last Name). A large pink arrow points from the 'Next' button at the top right to the 'Billing Provider' section. Another pink arrow points from the 'Billing Provider' section to the 'Next' button at the bottom right.

The screenshot shows the 'Service Lines' section of the mhs Institutional Claim form. The form includes a 'Total: \$0.00' summary, a 'New Service Line' button, and a table for adding service lines. The table has columns for Revenue Code, HCPCS / Rate / HPPS Code, NDC, Modifiers, Service Date, Service Units, and Charge Amount. A large pink arrow points from the 'Next' button at the top right to the 'Add New Service Line' button.

UB-04 Billing

- Enter Additional Insurance (if applicable)

The screenshot shows 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 header indicates 'Viewing Claims For:' with a dropdown menu set to 'Medicaid' and a 'GO' button. To the right are 'Upload EDI' and 'Create Claim' buttons. The main content area is titled 'Institutional Claim for [redacted]' and includes a 'Your Progress' indicator with a series of arrows. The current section 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. The 'Primary Insurance' section is highlighted with a pink arrow. Below this heading is a notice: '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 contains several input fields: 'Carrier Type' (a dropdown menu), 'Policy Number' (a text field with 'XXXXXXXX'), 'Amount Allowed' (a text field with 'XXXX.XX'), 'Deductible' (a text field with 'XXXX.XX'), 'Copay' (a text field with 'XXXX.XX'), and 'Co-Insurance' (a text field with 'XXXX.XX').

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 icons for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below this, a header indicates 'Viewing Claims For:' followed by a dropdown menu set to 'Medicaid' and a green 'GO' button. To the right are 'Upload EDI' and 'Create Claim' buttons. The main content area is titled 'Institutional Claim for [redacted]' and includes a 'Your Progress' indicator with a series of arrows. The section is labeled 'THIS SECTION: Diagnosis Codes' with the instruction 'Enter all relevant diagnosis codes.' Below this is a 'Required field' section with 'Back' and 'Next' buttons. The main form contains several rows for entering codes:

- ICD Version Indicator***: Radio buttons for 'ICD 10' (selected) and 'ICD 9'. A note states: 'Please note that for the claim statement dates entered, valid ICD-10 codes only are accepted.'
- Principal Diagnosis Code***: Input field with placeholder 'XXXX e.g. V87', a 'POA Indicator' dropdown menu, and a 'Select...' button. A pink arrow points to this field.
- Admitting Diagnosis Code***: Input field with placeholder 'XXXX e.g. V87'.
- Diagnosis Codes (87A-Q)**: Input field with placeholder 'XXXX e.g. 140X', a 'POA Indicator' dropdown menu, an 'Add' button, and a 'Select...' button.
- Patient Reason for Visit**: Input field with placeholder 'XXXX e.g. V87' and an 'Add' button.
- External Cause of Injury Code (ECI)**: Input field with placeholder 'XXXX e.g. V87'.
- Prospective Payment Code**: Input field.
- Condition Codes**: Input field with placeholder 'V, A, P' and an 'Add' button.

Add Attachment(if applicable)

mhs Eligibility Patients Authorizations Claims Messaging Help

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* **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 shows 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 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 progress bar labeled 'Institutional Claim for [redacted]' and 'Your Progress' with a series of green arrows indicating the current step. Below the progress bar, the text reads 'THIS SECTION: Review and Submit Please review your claim before submitting.'

A pink arrow points to a box titled 'Almost done!' which contains the text 'You can go back to review your claim or submit now.' and a 'Submit' button with a plus sign.

Below this box, there is a section for 'Claim ID: [redacted]' and 'General Info Edit'. The 'General Info' section lists the following details:

- 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

Below the 'General Info' section is a 'Provider Details Edit' section with a table. The table has columns for Provider Type, NPI, Taxonomy, Name, Tax ID, Address (1), Address (2), City, State, and Zip. The rows are for 'Billing Provider' and 'PayTo Provider', with their details redacted.

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]

At the bottom of the provider details section, there is another table with columns for Provider Type, NPI, Taxonomy, First Name, Last Name, IRS/Tax ID Num, and Organization.

Web Portal Claim and Payment Review

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).

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. Other sub-menu options include 'Saved', 'Submitted', 'Batch', 'Payment History', 'My Downloads', and 'Claims Audit Tool'. A 'Filter' button is also present. Below the sub-menu 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 a green thumbs up icon, indicating they are paid. The fifth row shows an orange thumbs down icon, indicating it is denied. A pink box highlights the CLAIM STATUS column, and a text box 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	👍
Q 31	CMS-1500	JE [REDACTED] EN	07/24/2017 - 07/24/2017	\$171.00 / \$106.34	👍
Q 66	CMS-1500	E [REDACTED] R	07/24/2017 - 07/24/2017	\$253.00 / \$101.04	👍
Q 1	CMS-1500	EI [REDACTED] R	07/24/2017 - 07/24/2017	\$2,783.00 / \$118.86	👍
Q 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.

Viewing Claims For : 3/13 Medicaid GO Upload EDI Create Claim

Claims **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...	1019	Q...3	\$54,159.07	Edit	Delete
08/07/2017	Institutional	8105	P...	1019	Q...1	\$461.75	Edit	Delete
08/02/2017	CMS-1500	8100	A...	1019	C...34	\$292.00	Edit	Delete
08/01/2017	Institutional	8107	J...	1019	C...6	\$461.75	Edit	Delete
08/01/2017	Institutional	8101	F...	1019	Q...1	\$461.75	Edit	Delete
07/17/2017	Institutional	8103	...	1019		\$507.00	Edit	Delete

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 ↓
06/24/2021 (PDF)	[]	06/23/2021	[]	\$100.64
06/24/2021 (PDF)	[]	06/23/2021	[]	\$145.73
06/24/2021 (PDF)	[]	06/23/2021	[]	\$72.01
06/24/2021 (PDF)	[]	EFT	[]	\$0.00
06/24/2021 (PDF)	[]	EFT	[]	\$208.65
06/24/2021 (PDF)	[]	EFT	[]	\$578.92

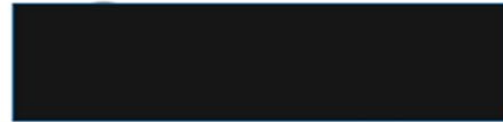
Provider EOP

PT6460027



Electronic Service Requested

24000700113



606 0.7648 AV 0.386 5-DIGIT 30374

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 Provider ID: [REDACTED]
 Service Provider: [REDACTED] LNPI: [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	.00	.00	.00	.00	.00	A0 SR 30	258.47
0300	[REDACTED]	[REDACTED]	G5	1.00	6388.16	263.75	.00	.00	.00	.00	.00	.00	A0 SR 30	258.47
0400	[REDACTED]	[REDACTED]	G5	1.00	6388.16	263.75	.00	.00	.00	.00	.00	.00	A0 SR 30	258.47
0500	[REDACTED]	[REDACTED]	G5	1.00	6388.16	263.75	.00	.00	.00	.00	.00	.00	A0 SR 30	258.47
0600	[REDACTED]	[REDACTED]	G5	1.00	6388.16	263.75	.00	.00	.00	.00	.00	.00	A0 SR 30	258.47
0700	[REDACTED]	[REDACTED]	G5	1.00	6388.16	263.75	.00	.00	.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](#) and click **Register**.
- 2** Enter your registration code and click **Submit**.
- 3** Enter your PIN, TIN or EIN, and NPI. Then, click **Start Registration**.

Personal Provider Identifier (PIN)

Provider Federal Tax Identification Number (TIN) (Employer Identification Number (EIN))

My Tax ID (NPI) (NPI)

OR

Day Code

State (Drop Down)

Submit

- 4** Populate the requested Personal Information. Click **Next**.

Provider Contact Name

Address (Full Name)

Street Address

Healthcare will be used to bill this area.

Confirm Email Address

Telephone Number

Please call us the 800-331-7154 format.

City (Drop Down)

State (Drop Down)

Zip (Drop Down)

Minimum 8 characters and may include letters (a-z), numbers (0-9), dashes (-), underscores (_), apostrophes ('), periods (.)

Personal

Qualify Password

Challenge Question (Drop Down)

Challenge Answer

Submit

- 5** Designate an account for fund transfers by completing the required fields. Click **Next**.

Account Name

This is the account that will be used to debit this recurring account through the PaySpan system.

Financial Institution Routing Number

Provider's Account Number with Financial Institution

Confirm Provider's Account Number with Financial Institution

Type of Account at Financial Institution (Drop Down)

Enable Electronic Payments

Request Paper Remittance (The Paper does not allow paper remittance.)

Assign new or additional Papers to this recurring account

Back 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

mhsindiana.com
© 2021 Managed Health Services.
All rights reserved.

0221.PR.P.FL 2/21

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

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	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 ': Claim #T1234P1235'. The main content area is white and 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




Claim Accepted



Claim Denied





Dispute Submitted



Claim Denied (Decision Upheld)

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: 20px; 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						
Coordination of Benefits						
Claims						

Prior Authorization

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	C [redacted]	02/06/2018	05/06/2018	M51.36	OUTPATIENT	Office Visit
APPROVE	C [redacted]	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 interface for providers. At the top, there is a navigation bar with links for Home, Find a Provider, Portal Login, Events, Careers, and Contact Us, along with a search bar and a contrast toggle. Below the navigation, there are three main tabs: FOR MEMBERS, FOR PROVIDERS (selected), and GET INSURED. On the left side, there is a sidebar menu for providers with options like Login, Enrollment and Updates, Prior Authorization (selected), 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, and Coronavirus Information. The main content area is titled "Medicaid Pre-Auth" and includes a disclaimer, verification requirements for various services, and a question about emergency department or urgent care billing. Below this is a form with a table of service types and a "Check" button. The result shows that code 58270 requires pre-authorization for all providers.

Home Find a Provider Portal Login Events Careers Contact Us

Contrast On Off a a a language-

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

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 +

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:

Y
Yes

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

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

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

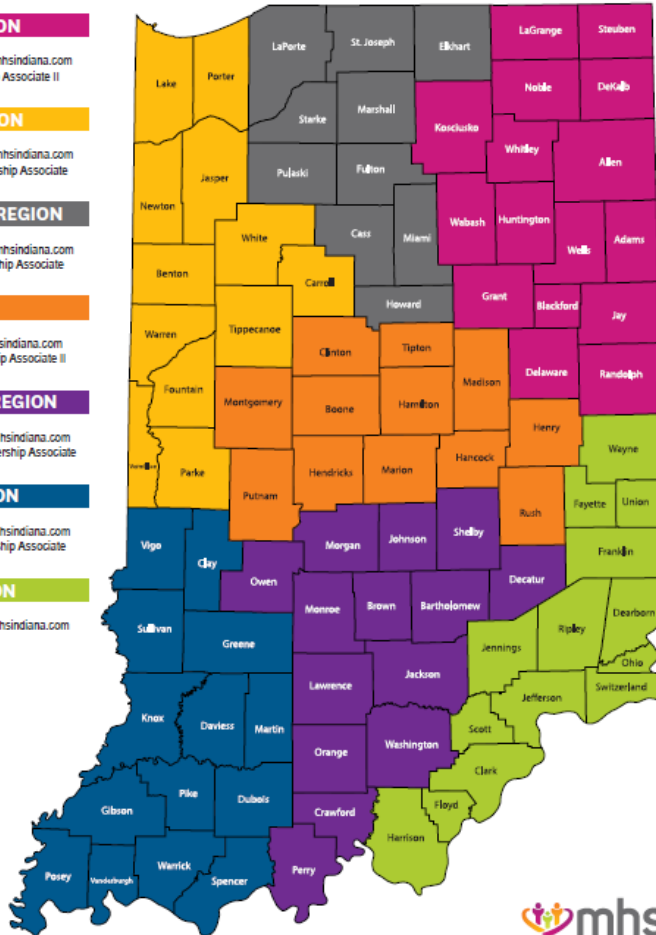
For claims issues, email:
MHS_ProviderRelations_SC@mhsindiana.com
 Dalesia Denning, Provider Partnership Associate
 1-877-647-4848, ext. 20026

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

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

MHS Team

MHS Provider Network Territories

NETWORK LEADERSHIP

JILL CLAYPOOL

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

MARK VONDERHEIT

Senior Director, Provider Network
1-877-647-4848 Ext. 20340
mvonderheit@mhsindiana.com

JENNIFER GARNER

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

NETWORK OPERATIONS

KELVIN ORR

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

NEW PROVIDER CONTRACTING

TIM BALKO

Director, Network Development & Contracting
1-877-647-4848 ext. 20720
tbalko@mhsindiana.com

MICHAEL FUNK

Manager, Network Development & Contracting
1-877-647-4848 ext. 20077
michael.j.funk@mhsindiana.com

ENVOLVE VISION, INC.

SIERRA HICKS

Sierra.Hicks@EnvolveHealth.com
Vision Provider Services: 1-844-820-6523
Questions: Envolve_AdvancedCaseUnit@EnvolveHealth.com

ENVOLVE DENTAL, INC.

THOMAS "TONY" SMITH

Thomas.Smith@EnvolveHealth.com
Dental Provider Services: 1-855-609-5157
Questions: ProviderRelations@EnvolveHealth.com

DALESIA DENNING

Provider Partnership Associate
1-877-647-4848, ext. 20026
ddenning@mhsindiana.com

PROVIDER GROUPS

Columbus Regional Health
HealthNet
Indiana Health Centers

NATALIE SMITH

Provider Partnership Associate
1-877-647-4848 ext. 20127
MHS_ProviderRelations_NC@
mhsindiana.com

PROVIDER GROUPS

South Bend Clinic

DAWN MCCARTY

Provider Partnership Associate
1-877-647-4848, ext. 20117
MHS_ProviderRelations_SW@
mhsindiana.com

PROVIDER GROUPS

American Health Network

CAROLYN VALACHOVIC MONROE

Provider Partnership Associate II
1-877-647-4848, ext. 20114
CMONROE@mhsindiana.com

PROVIDER GROUPS

Community Health Network
Indiana University Health
Eskenazi Health

CANDACE ERVIN

Provider Partnership Associate
1-877-647-4848, ext. 20187
candace.v.ervin@mhsindiana.com

PROVIDER GROUPS

HealthInc

MONA GREEN

Provider Partnership Associate II
1-877-647-4848, ext. 20080
mona.green@mhsindiana.com

PROVIDER GROUPS

St. Vincent Medical Group
Ascension Complete
Franciscan Health

CHAD PRATT

Provider Partnership Associate II
1-877-647-4848, ext. 20454
rpratt@mhsindiana.com

PROVIDER GROUPS

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



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

Thank you for being our partner in care.

Questions?
