



Indiana Health Coverage Programs Portal Claim Tips

Indiana Health Coverage Programs (IHCP)
Gainwell Technologies
IHCP Works Annual Seminar October 2025

Agenda

- Eligibility
- Common Claim Denials
- IHCP Portal Claim Submission Tips for Secondary Claims
- Claim Adjustments On the IHCP Portal
- Remittance Advice Basics
- Submitting Medicare Exhaust Inpatient Claims on the IHCP Portal
- Helpful Tools
- Questions





Eligibility



Verifying Eligibility

- Members may have periods of inactive coverage due to varying circumstances; therefore, always check eligibility **prior** to rendering services for **every** date of service
- You can check online on the [IHCP Portal](#), with the virtual assistant (GABBY) at 800-457-4584, option 2, or through an approved vendor software for the 270/271 batch or interactive eligibility benefit transactions
- Eligibility **cannot** be verified for future dates
- Use one of the following: the Member's ID; Social Security Number (SSN) and Birth Date; or Last Name, First Name, and Birth Date

My Home Eligibility Claims Care Management Resources

Eligibility Tuesday 09/02/2025 10:21 PM

Eligibility Verification Request ?

* Indicates a required field.
Enter the member information. If Member ID is not known, enter SSN and Birth Date, or Last Name, First Name, and Birth Date.

Member ID	<input type="text"/>	Last Name	<input type="text"/>	First Name	<input type="text"/>
SSN	<input type="text"/>	Birth Date	<input type="text"/>		
*Effective From	<input type="text" value="09/02/2025"/>	Effective To	<input type="text"/>		

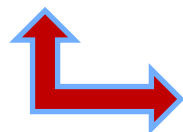


Member is Eligible

Continue to Review the Following:

- **Benefit Details** lists the member's coverage, including benefit plan name and description, and copayment requirements if applicable.

Benefit Details 			
Coverage	Description	Effective Date	End Date
Aged and Disabled HCBS Pathways	Aged and Disabled HCBS Pathways	09/03/2025	09/03/2025
Full Medicaid	Full Medicaid for individuals who are 65 years old, blind, or disabled (FFS or Managed Care)	09/03/2025	09/03/2025
Qualified Medicare Beneficiary	Qualified Medicare Beneficiary - Members for whom co-insurance and deductibles are paid as well as Medicare Part B premiums	09/03/2025	09/03/2025
Coverage	Description and Copayment Message		Copay Amount
Full Medicaid	Chiropractic - Copay is not applicable to this type of service.		\$0.00
Full Medicaid	Medical Care - Copay is not applicable to this type of service.		\$0.00



Some searches may have more than one coverage type listed.

Eligibility Limits, Managed Care Assignment and Other Insurance Details

Limit Details lists many member benefit limits.

Managed Care Assignment Details lists any Managed Care Program such as Healthy Indiana Plan (HIP), Hoosier Care Connect, Hoosier Healthwise or Indiana PathWays for Aging.

Review for the Managed Care Entity (MCE) name such as United Healthcare, CareSource, MDwise, Humana, etc.

Other Insurance Details lists any other insurance on file.

Limit Details						
The Dollar Limits and Service Limits may not reflect recent claims.						
Dollar Limits		Limit	Remaining			
6085 INCONTINENCE SUPPLIES LIMITED \$1950/ROLLING Y		\$1,950.00	\$1,859.00			
Service Limits		Limit	Remaining			
6195 FRAMES INITIAL OR REPAIR/REPLACEMENT 21 YRS O		1	-			
6223 PERIODONTAL ROOT PLAN 21 YR OR > 4/LIFE NON-I		4	1			
6272 LENSES INITIAL REPAIR/REPLACEMENT MEMBER 21 Y		2	1			

Managed Care Assignment Details			
Managed Care Program		Primary Medical Provider	Provider Phone
Indiana Pathways for Aging			
Effective Date	End Date	MCO / CMO Name	MCO / CMO Phone
09/03/2025	09/03/2025	UNITEDHEALTHCARE COMMUNITY PLAN	1-877-610-9785

Other Insurance Details						
Carrier Name (Carrier ID)	Address	Phone Number	Policy ID	Group ID	Policy Holder	Coverage Type
Medicare						MEDICARE A
Medicare						MEDICARE B



Common Claim Denials



Denial Example #1

Denial EOB Code 2017 and Claim Adjustment Reason Code 24:

Claim EOB Information				
Claim / Service #	Disposition	EOB Code	Description	
Svc # 1	Deny	2017	THE MEMBER IS ENROLLED IN RISK BASED MANAGED CARE. PLEASE SUBMIT TO APPROPRIATE RISK BASED MANAGED CARE PROCESSOR..	
Claim Adjustment Reason Code Information				
Claim / Service #	ARC Code	Adjustment Amount	System	Description
Svc # 1	24	\$90.00	System	Charges are covered under a capitation agreement/managed care plan.

When you receive a denial like this, check eligibility and review the Managed Care Assignment Details section on the [IHCP Portal](#).

Managed Care Assignment Details



Denial Reason Example #1:

The claim denied because the member is enrolled with Anthem Blue Cross and Blue Shield Indiana PathWays for Aging.

Always check the Managed Care Assignment Details and submit your claims to the correct payer.

Benefit Details				-
Coverage	Description	Effective Date	End Date	
Aged and Disabled HCBS Pathways	Aged and Disabled HCBS Pathways	07/19/2025	07/19/2025	
Full Medicaid	Full Medicaid for individuals who are 65 years old, blind, or disabled (FFS or Managed Care)	07/19/2025	07/19/2025	
Coverage	Description and Copayment Message			Copay Amount
Full Medicaid	Chiropractic - Copay is not applicable to this type of service.			\$0.00
Full Medicaid	Medical Care - Copay is not applicable to this type of service.			\$0.00
Full Medicaid	Urgent Care - Copay is not applicable to this type of service.			\$0.00
Full Medicaid	Mental Health - Copay is not applicable to this type of service.			\$0.00
Limit Details				+

Managed Care Assignment Details				
Managed Care Program		Primary Medical Provider	Provider Phone	
Indiana Pathways for Aging				
Effective Date	End Date	MCO / CMO Name	MCO / CMO Phone	
07/19/2025	07/19/2025	ANTHEM BLUE CROSS AND BLUE SHIELD	1-844-533-1995	

Denial Example #2

Denial EOB Code 2505 and Claim Adjustment Reason Code 22:



Claim EOB Information				
Claim / Service #	Disposition	EOB Code	Description	
Svc # 1	Deny	2505	THIS MEMBER IS COVERED BY PRIVATE INSURANCE WHICH MUST BE BILLED PRIOR TO MEDICAID.	
Svc # 1	Pay	2505	THIS MEMBER IS COVERED BY PRIVATE INSURANCE WHICH MUST BE BILLED PRIOR TO MEDICAID.	
Svc # 2	Pay	2505	THIS MEMBER IS COVERED BY PRIVATE INSURANCE WHICH MUST BE BILLED PRIOR TO MEDICAID.	
Svc # 2	Deny	2505	THIS MEMBER IS COVERED BY PRIVATE INSURANCE WHICH MUST BE BILLED PRIOR TO MEDICAID.	
Claim Adjustment Reason Code Information				
Claim / Service #	ARC Code	Adjustment Amount	System	Description
Svc # 1	22	\$352.00	System	This care may be covered by another payer per coordination of benefits.
Svc # 1	22		System	This care may be covered by another payer per coordination of benefits.
Svc # 2	22		System	This care may be covered by another payer per coordination of benefits.
Svc # 2	22	\$150.00	System	This care may be covered by another payer per coordination of benefits.

When you receive a denial like this, check eligibility and review the Other Insurance Details section on the [IHCP Portal](#).

Other Insurance Details – Third-Party Liability (TPL)



Denial Reason Example #2:

The claim denied because the member has other insurance primary to IHCP Medicaid Fee-For-Service (FFS).

Other Insurance Details						
Carrier Name (Carrier ID)	Address	Phone Number	Policy ID	Group ID	Policy Holder	Coverage Type
US ABLE ADMINISTRATORS	P.O. BOX 1460 TPL LITTLE ROCK, AR 72203	1-855-279-2398				MENTAL HEALTH
ANTHEM BC/BS	PO BOX 105187 N/A ATLANTA, GA 30348	1-800-676-2583				HOSPITALIZATION, MEDICAL AND MAJOR MEDICAL

The IHCP requires members and providers to follow the rules of their primary insurance carrier.

**If the member goes out of network OR the provider does not get authorization and the TPL denies,
Medicaid Fee-For-Service will NOT cover the services.**

For more information, see the [Third-Party Liability](#) provider reference module.

Secure Correspondence – Other Insurance



If your TPL-Other Insurance details differ from those in the [IHCP Portal](#) or Electronic Verification System, you can submit a TPL Update through Secure Correspondence while logged in to the [IHCP Portal](#).

This screenshot shows the top portion of the IHCP Portal. At the top is a green navigation bar with links: 'My Home', 'Eligibility', 'Claims', 'Care Management', and 'Resources'. Below this, the 'My Home' section is visible. On the left, there are two main user sections: 'User Details' (with links for 'My Profile' and 'Manage Accounts') and 'Provider' (with fields for 'Name' and 'Provider ID'). The main content area has a 'WELCOME HEALTH CARE PROFESSIONAL!' message, a 'Contact Us' link, a 'Notify Me' link, and a 'Secure Correspondence' link which is highlighted with a red rectangular box. A red arrow points from the 'Secure Correspondence' link in the text on the left towards this box.This screenshot shows the 'Secure Correspondence - Select Category' form. At the top right is a 'Back to Message Box' link with a question mark icon. The main heading is '*Tell us why you are here today. Select the statement below that best fits the reason you are submitting a Secure Message.' Below this is a list of radio button options. The option 'I need Gainwell to add/remove/update Other Insurance information on a member. I understand I need to have the member's Carrier information and may need to upload supporting documentation.' is selected, indicated by a red square next to the radio button. A red arrow points from the text on the left towards this selected option. At the bottom of the form are two buttons: 'Select' and 'Cancel'.

Create Message to Update TPL



Providers should forward copies of any documentation, including:

- Explanation of benefits (EOB)
- Remittance advice (RA)
- Member's third-party insurance card
- Letter from the carrier
- Start and Termination dates, if applicable
- Claim Date of Service

Please allow up to 10 business days for the TPL to be updated.

Once it is updated, you will need to resubmit your claim.

Secure Correspondence - Create Message [Back to Select Category](#) ?

Enter your correspondence information below and click the **Send** button to send the correspondence or click **Cancel** to return to Secure Correspondence - Select Category page. Ensure that all pertinent information is in the Message box or other fields. The Subject box is NOT submitted with the correspondence. The Subject box is only for your tracking and organization

* Indicates a required field.

*Subject

*Message Category

Instructions This is for submitting a request to add/remove/update "other insurance" information on a member. Please do not submit duplicate requests and allow up to 10 days for processing previous requests.

*Email Address

Provider/Facility

*Member ID

Claim Number

Date of Service To

Medicaid Paid Amount

Paid Date

*Type of TPL Request

Instructions

*Message

The following types of files are allowed to be uploaded: pdf, bmp, gif, jpg, jpeg, tiff, tif, png
Size limit for attachments is 5MB.

Attachments

Click the **Remove** link to remove the entire row.

#	Transmission Method	File	Control #	Attachment Type	Action
Click to add attachment.					

Send **Cancel**



Denial Reason Example #3

Denial EOB Codes 2006, 2033 and Claim Adjustment Reason Code 40:

Claim EOB Information				
Claim / Service #	Disposition	EOB Code	Description	
Svc # 1	Deny	2006	DIAGNOSIS CODE BILLED IS NOT COVERED FOR THE MEMBER'S BENEFIT PLAN.	
Svc # 1	Deny	2033	INVALID CLAIM TYPE FOR THE PROGRAM BILLED	
Claim Adjustment Reason Code Information				
Claim / Service #	ARC Code	Adjustment Amount	System	Description
Svc # 1	40	\$1,621.00	System	Charges do not meet qualifications for emergent/urgent care. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

When you receive a denial like this, check eligibility and review the Coverage Details section on the [IHCP Portal](#).

Package E – Emergency Services Only



Denial Reason Example #3:

The claim denied because this member has Package E – Emergency Services Only and the claim was not billed as emergent.

Benefit Details 			
Coverage	Description	Effective Date	End Date
Package E - Emergency Services Only	Package E - Emergency Services Only	07/21/2025	07/21/2025
Coverage	Description and Copayment Message		Copay Amount
Package E - Emergency Services Only	Hospital - Inpatient - Copay is not applicable to an emergency services only member.		\$0.00

Review the next 2 slides to show how you might bill for claims that are emergent and see the [Emergency Services](#) and [Claim Submission and Processing](#) provider reference modules for additional information.

Emergency Services Only – Package E Billing Instructions for Professional and Dental Claims on the IHCP Portal



Package E Billing Instructions for your claim type IF Emergent:

Professional Claim Type on the [IHCP Portal](#):

- In the Service Details panel in Step 3, select the EMG box for each applicable detail to indicate that it was an emergency service.

Dental Claim Type on the [IHCP Portal](#):

- In the Claim Information panel in Step 1, select the Emergency box to indicate that the claim is for an emergency situation, and if the treatment is a result of an occupational illness or injury, auto accident, or other accident, select the appropriate option from the drop-down menu in the Accident Related field.
- In the Service Details panel in Step 3, enter only appropriate procedure codes that have been designated by the IHCP as emergency dental services in the Procedure Code field.

See [Dental Services Codes](#) for Dental Procedure Codes Allowed for Emergency Services Only.

Emergency Services Only – Package E Billing Instructions Outpatient and Inpatient Claims on the IHCP Portal



Package E Billing Instructions for your claim type IF Emergent:

Outpatient Claim Type on the [IHCP Portal](#):

- In the Diagnosis Codes panel in Step 2, enter the appropriate emergency diagnosis code in the first (primary) position.

Inpatient Claim Type on the [IHCP Portal](#):

- In the Claim Information panel in Step 1, enter 1 – Emergency in the Admission Type field.

See the [Emergency Services](#) provider reference module for more details, including billing for emergency department screenings.

Denial Example #4

Prior Authorization Units Exceeded



**Denial EOB Code 3006 - Units Exceed PA Master
Claim Adjustment Reason Code 198**

Claim EOB Information					
Claim / Service #	Disposition	EOB Code	Description		
Svc # 1	Deny	3006	PAYMENT FOR THIS SERVICE HAS BEEN DENIED OR CUTBACK DUE TO DOLLARS BILLED EXCEEDING THE DOLLARS PRIOR AUTHORIZED.		
Claim Adjustment Reason Code Information					
Claim / Service #	ARC Code	Adjustment Amount	System	Description	
Svc # 1	198		System	Precertification/notification/authorization/pre-treatment exceeded.	

The claim denied due to the number of units billed for an authorized service/procedure code exceeds the unused number of units authorized for the date of service.

OR

The claim cuts back and pays up to the remaining number of units.

Denial Example #4 Resolution

Prior Authorization Units Exceed PA Master



Denal EOB Code 3006 - Units Exceed PA Master
Claim Adjustment Reason Code 198

Resolution: For a non-waiver claim, please review your prior authorization (PA) via Acentra Health's [Atrezzo](#) system. Verify what you were approved for versus what you billed, including dates, units, and modifiers.

For waiver claims, please review your Notice of Action (NOA) / Service Authorization. If the member needs additional authorization, please reach out to the member's care manager.

See the [Prior Authorization](#) provider reference module for additional details.

Denial Example #5

Prior Authorization Not Found



**Denial EOB Code 3001 – Date of Service Not on PA Master File/
Claim Adjustment Reason Code 197**

Claim EOB Information					
Claim / Service #	Disposition	EOB Code	Description		
Svc # 1	Deny	3001	DATES OF SERVICE NOT ON THE P.A. MASTER FILE.		

Claim Adjustment Reason Code Information						
Claim / Service #	ARC Code	Adjustment Amount	System	Description		
Svc # 1	197	\$300.00	System	Precertification/authorization/notification/pre-treatment absent.		

When you receive a denial like this, the code billed requires prior authorization (PA) for that program, and the date(s) of service indicated on the claim do not fall within the start/stop dates prior authorized for the service rendered.

OR

If the modifier usage on the claim does not match the usage on the PA.

Denial Example #5 Resolution

Prior Authorization Not Found

**Denial EOB Code 3001 – Date of Service Not on PA Master File/
Claim Adjustment Reason Code 197**

Resolution: For a non-waiver claim, contact the PA vendor Acentra Health via their [Atrezzo](#) system to follow up on the status of the request and review your claim dates and modifier usage versus authorization approved. If there is no prior authorization (PA) on file, the claim will remain denied unless you are able to obtain retro authorization. Medical records cannot bypass this requirement.

For waiver claims, please review your NOA and make sure that you billed with the correct service and modifiers. If you did, please reach out to the member's care manager for assistance.





IHCP Portal Claim Submission Tips for Secondary Claims

Electronic Claim Submission



Submitting claims electronically through a Health Insurance Portability and Accountability Act (HIPAA)-compliant 837 transaction or through the [IHCP Portal](#) reduces paperwork, increases accuracy, and claims are processed more quickly, resulting in faster payment.

Resources available on the [Indiana Medicaid for Providers](#) website include:

Provider Reference Modules:

- [Claim Submission and Processing](#)
- [Electronic Data Interchange](#)
- [Provider Healthcare Portal](#)
- [Third-Party Liability](#)

[Electronic Data Interchange \(EDI\) Solutions](#)

[IHCP Provider Healthcare Portal Training](#)

For assistance and training, providers should contact their [Provider Relations Consultant](#).

IHCP Portal Claim Submission

While logged into the [IHCP Portal](#) under the correct Service Location, you will click on the **Claims** Menu and select the appropriate Submit Claim type for your specialty

The screenshot displays the 'INDIANA MEDICAID for Providers' portal. At the top, there is a navigation bar with links for 'My Home', 'Eligibility', 'Claims', 'Care Management', and 'Resources'. The 'Claims' menu is highlighted with a red box, and a dropdown list is visible, containing the following options: 'Search Claims', 'Submit Claim Dental', 'Submit Claim Inst', 'Submit Claim Prof', 'Search Payment History', 'Request FQHC/RHC Wrap Report', and 'Retrieve FQHC/RHC Wrap Report'. The 'Submit Claim Dental', 'Submit Claim Inst', and 'Submit Claim Prof' options are also highlighted with a red box. On the left side, there are sections for 'User Details' (Welcome, My Profile, Manage Accounts) and 'Provider' (Name, Provider ID, Disenroll, Provider Profile, Provider Maintenance, Enrollment / Revalidation Status). On the right side, there are links for 'Contact Us', 'Notify Me', and 'Secure Correspondence'. A maintenance notice is visible in the center-right area, stating: 'CP will be performing system maintenance on Sunday, July 27th, from 10 pm - 10 pm ET. The system may be unavailable during this period.'

Secondary Professional Claim Submission on the IHCP Portal When Primary Paid

Everything with an * needs to be completed

Patient Number is your identification number for this claim - not specific to the IHCP

If there is a primary insurance that **covers** the service, check the box

Submit Professional Claim: Step 1

* Indicates a required field.

Provider Information

Requesting Provider Information

Billing Provider ID	ID Type	NPI	Name
Rendering Provider ID	ID Type		Name
Rendering Taxonomy			
Referring Provider ID	ID Type		Name
Service Facility Location ID	ID Type		Name

Patient Information

Enter Member ID, Date of Birth and at least one character of First and Last Name

*Member ID		*First Name	
*Last Name		Other Claim ID	
Birth Date			

Claim Information

Claim Header Instructions

Hospital From Date		Hospital To Date	
Date Type		Date of Current	
Accident Related		Authorization Number	
*Patient Number		Special Program	
Medical Record Number			

*Does the provider have a signature on file? ☒ Yes ☐ No

*Does the provider accept assignment for claim processing? ☒ Yes ☐ No ☐ Clinical Lab Services Only

Are benefits assigned to the provider by the patient or their authorized representative? ☒ Yes ☐ No ☐ N/A

Does the provider have a signed statement from the patient releasing their medical information? ☒ Yes ☐ No

Include Other Insurance ☐

Total Charged Amount \$0.00

Continue **Cancel**

Click on the Magnifying Glass Icon – use NPI or Medicaid Provider ID to choose and add **Rendering Provider ID or Referring ID** (If Needed)

Click continue to go to Step 2

Diagnosis Codes Section

Add each diagnosis by entering the description or diagnosis code without any punctuation and selecting the add button.

Submit Professional Claim: Step 2 ?

* Indicates a required field.

Provider Information

Billing Provider ID	ID Type	NPI	Name
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Patient and Claim Information

Member ID	Other Claim ID
Member	Gender
Birth Date	Total Charged Amount

[Expand All](#) | [Collapse All](#)

Diagnosis Codes +

Select the row number to edit the row. Click the **Remove** link to remove the entire row.
Please note that the 1st diagnosis entered is considered to be the principal (primary) Diagnosis Code.

#	Diagnosis Type	Diagnosis Code	Action
1	ICD-10-CM	H5213-MYOPIA, BILATERAL	Remove
2			

2 *Diagnosis Type *Diagnosis Code

[Add](#) [Reset](#)

Other Insurance Details +

Enter the carrier and policy holder information below.

Enter other carrier Remittance Advice details here for the claim or with each service line. Enter adjusted payment details, such as reason codes, in the Claim Adjustment Details section.

Click the **Remove** link to remove the entire row.

[Refresh Other Insurance](#)

#	Carrier Name	Carrier ID	Group ID	TPL/Medicare Paid Amount	Paid Date	Action
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[+](#) Click to add a new other insurance.

Claim Codes +

Click the **Remove** link to remove the entire row.

#	Claim Code	Action
1		

1 *Claim Code

[Add](#) [Reset](#)





Other Insurance Details

Review the primary insurance information under Other Insurance Details – the **Header** Level – which is Step 2 of the claim

Other Insurance Details

Enter the carrier and policy holder information below.

Enter other carrier Remittance Advice details here for the claim or with each service line. Enter adjusted payment details, such as reason codes, in the Claim Adjustment Details section.

Click the **Remove** link to remove the entire row.

[Refresh Other Insurance](#)

#	Carrier Name	Carrier ID	Group ID	TPL/Medicare Paid Amount	Paid Date	Action
1					–	Remove

[+](#) Click to add a new other insurance.

- Verify that the Carrier Name shows the correct insurance
- Remove any insurance that should not be listed
- Click the [1](#) by the **Carrier Name** to complete the information
- **Click** the [+](#) to add the correct primary/secondary insurances if not listed



Completing Other Insurance Details

Enter Primary Insurance Information/TPL at the **Header** Level in Step 2

Other Insurance Details

Enter the carrier and policy holder information below.

Enter other carrier Remittance Advice details here for the claim or with each service line. Enter adjusted payment details, such as reason codes, in the Claim Adjustment Details section.

Click the **Remove** link to remove the entire row.

[Refresh Other Insurance](#)

#	Carrier Name	Carrier ID	Group ID	TPL/Medicare Paid Amount	Paid Date	Action
<input type="checkbox"/> Click to collapse.						
	*Carrier Name	*Carrier ID				
	*Policy Holder Last Name		*First Name		MI <input type="checkbox"/>	
	Policy Holder Address					
	City					
	State <input type="text"/> ZIP Code <input type="text"/> Country <input type="text"/>					
	*Policy ID		SSN <input type="text"/>			
	*Relationship to Patient		*Claim Filing Code			
	Group ID		Policy Name			
	TPL/Medicare Paid Amount \$0.00					
	Claim ID		Paid Date <input type="text"/>			
	Referral Number					
	<input type="button" value="Add"/>		<input type="button" value="Cancel"/>			

Enter name of the Primary Insurance in both **Carrier Name** and **Carrier ID** boxes

Everything with an * needs to be completed

Paid amount for the **ENTIRE** claim goes here. It does not have an * but is required for processing.

Final Step - Select Add

How the member is related to the person who holds the insurance

Claim Filing Codes:

CI – Commercial Insurance
16 – Medicare Replacement Plan
MB – Medicare B

Claim Adjustment Details

Enter Patient Responsibility (PR) Information at the **Header** Level in Step 2

The screenshot shows the 'Claim Adjustment Details' form. At the top, it states: 'You can enter up to five unique group codes. You can repeat six combinations of reason code and adjustment amount with each group code.' Below this is a table with columns: '#', 'Claim Adjustment Group Code', and 'Reason Code'. A 'Click to collapse' link is present. Below the table is a form with fields: '*Claim Adjustment Group Code' (a dropdown menu), '*Reason Code' (a text field), and '*Adjustment Amount' (a text field). There are 'Add' and 'Cancel' buttons below the form fields. At the bottom, there are 'Save' and 'Cancel' buttons. Annotations include: a red box on the left stating 'Most Common Claim Adjustment Group Code: PR - patient responsibility' with an arrow pointing to the '*Claim Adjustment Group Code' field; a red box on the right titled 'Most Common Reason Codes:' listing '1 - Deductible amount', '2 - Coinsurance amount', and '3 - Co-payment amount', with an arrow pointing to the '*Reason Code' field; a red box at the bottom center stating 'Adjustment amount is the responsibility amount for the ENTIRE claim per primary EOB' with an arrow pointing to the '*Adjustment Amount' field; and a red box at the bottom left stating 'Add and Save each time' with arrows pointing to the 'Add' and 'Save' buttons.

Most Common Claim Adjustment Group Code:
PR - patient responsibility

Most Common Reason Codes:
1 – Deductible amount
2 – Coinsurance amount
3 – Co-payment amount
Or CO (contractual obligation) with the valid TPL Claim Adjustment Reason Code explanation

Adjustment amount is the responsibility amount for the **ENTIRE** claim per primary EOB

Add and Save each time

- The claim adjustment details are **NOT** completed for TPL, unless there is an acceptable denial adjustment reason code (ARC).
- The claim adjustment details **ARE** completed for Medicare and Medicare Replacement Plans.

Claim Codes Section



IMPORTANT

No claim code is needed on most claims.

Leave blank!

Diagnosis Codes

Select the row number to edit the row. Click the **Remove** link to remove the entire row.
Please note that the 1st diagnosis entered is considered to be the principal (primary) Diagnosis Code.

#	Diagnosis Type	Diagnosis Code	Action
1	ICD-10-CM	M7981-NONTRAUMATIC HEMATOMA OF SOFT TISSUE	Remove
2	ICD-10-CM	S92502D-DISPL UNSP FX LEFT LESSER TOE(S), SUBS FOR FX W ROUTH HEAL	Remove
3			

3 *Diagnosis Type *Diagnosis Code

[Add](#) [Reset](#)

Other Insurance Details

Enter the carrier and policy holder information below.

Enter other carrier Remittance Advice details here for the claim or with each service line. Enter adjusted payment details, such as reason codes, in the Claim Adjustment Details section.

Click the **Remove** link to remove the entire row.

[Refresh Other Insurance](#)

#	Carrier Name	Carrier ID	Group ID	TPL/Medicare Paid Amount	Paid Date	Action
1	ANTHEM MEDICARE DUAL ADVANTAGE	000079	INMCRWPO	\$104.17	-	Remove

☐ Click to add a new other insurance.

Claim Codes

Click the **Remove** link to remove the entire row.

#	Claim Code	Action
1		

*Claim Code

[Add](#) [Reset](#)

[Back to Step 1](#) [Continue](#) [Cancel](#)

Service Detail Level

Adding Secondary Insurance Information at the **Service Detail** Level of the claim in Step 3

All * need to be completed

The screenshot shows the 'Service Details' form. At the top, a header bar contains the title 'Service Details' and a collapse icon. Below this is a instruction: 'Select the row number to edit the row. Click the Remove link to remove the entire row.' A table with columns: '#', 'From Date', 'To Date', 'Place of Service', 'Procedure Code', 'Charge Amount', 'Units', and 'Action' is visible. Below the table is a 'Click to collapse' link. The main form area contains several fields: '*From Date' (calendar icon), 'To Date' (calendar icon), '*Place of Service' (dropdown), '*Procedure Code' (text), '*Diagnosis Pointers' (four dropdowns), 'Modifiers' (text), 'Charge Amount' (text, highlighted with a red box and containing '\$0.00'), '*Units' (text), '*Unit Type' (dropdown), 'EPSDT' (checkbox), 'Family Plan' (checkbox), 'EMG' (checkbox), 'Rendering Provider ID' (text with search icon), 'Type' (dropdown), and 'Rendering Taxonomy' (text). At the bottom are 'NDC for Service Detail' and 'Note for Service Detail' sections, each with a '+' icon. At the very bottom are 'Add' and 'Cancel' buttons. A red arrow points from the 'Add' button to a text box at the bottom left. Another red arrow points from the 'Charge Amount' field to a text box at the bottom right.

#	From Date	To Date	Place of Service	Procedure Code	Charge Amount	Units	Action
---	-----------	---------	------------------	----------------	---------------	-------	--------

Click to collapse.

*From Date To Date *Place of Service

*Procedure Code *Diagnosis Pointers

Modifiers

Charge Amount *Units *Unit Type EPSDT ☐ Family Plan ☐ EMG ☐

Rendering Provider ID Type Rendering Taxonomy

Line Item Control#

NDC for Service Detail

Note for Service Detail

Enter the charge amount and **TAB** to the Units field. Charge Amount does not have an *, but is required for processing.

Add and Save each time

Other Insurance at the Service Detail

Adding information at the **Service Detail** Level of the claim in Step 3

Once you input your service detail/each charge and hit add button, click on the **# 1** to open the **Other Insurance for Service Detail** row.

Other Carrier
Choose the Primary /TPL Insurance you added on Step 2 (header level) of the Claim.

Service Details

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

#	From Date	To Date	Place of Service	Procedure Code	Charge Amount	Units	Action
1	02/26/2025	02/26/2025	11-Office	99213-OFFICE O/P EST LOW 20 MIN	\$90.00	1.00 Unit	Remove

*From Date: 02/26/2025 To Date: 02/26/2025 *Place of Service: 11-Office

*Procedure Code: 99213-OFFICE O/P EST LOW 20 MIN *Diagnosis Pointers: 1 2 3

Modifiers:

Charge Amount: \$90.00 *Units: 1.00 *Unit Type: Unit EPSDT ☐ Family Plan ☐ EMG ☐

Rendering Provider ID: ID Type: Rendering Taxonomy:

Line Item Control#:

Other Insurance for Service Detail

Click the row number to edit the row. Click the **Remove** link to remove the entire row.

#	Carrier ID	TPL/Medicare Paid Amount	Paid Date
<input type="checkbox"/> Click to collapse.			
*Other Carrier:			
*TPL/Medicare Paid Amount:		*Paid Date:	

Add **Click Add**

Enter primary paid amount for **this service detail only in the TPL/Medicare Paid Amount** and **Paid Date** of Primary EOB.

If you have more than one charge, you will enter the primary paid and responsibility for **each of them separately**.

Claim Adjustment Details at the Service

Adding information at the **Service Detail** Level of the claim in Step 3

Claim Adjustment Group Code:
PR - Patient Responsibility

Add and Save each time

The screenshot shows the 'Claim Adjustment Details' form. At the top, it says 'You can enter up to five unique group codes. You can repeat six combinations of reason code and adjustment amount with each group code.' Below this is a table with columns: '#', 'Claim Adjustment Group Code', 'Reason Code', and 'Adjustment Amount'. A 'Click to collapse' link is visible. Below the table are input fields for '*Claim Adjustment Group Code', '*Reason Code', and '*Adjustment Amount', along with an 'Adjusted Units' field. There are 'Add' and 'Cancel' buttons below the input fields, and a 'Save' and 'Cancel' button at the bottom. Red arrows point from the text boxes to the corresponding fields: from 'PR - Patient Responsibility' to the Group Code field, from 'Add and Save each time' to the 'Add' button, from 'Adjustment Amount: The responsibility or ARC amount on this DETAIL only' to the Adjustment Amount field, and from 'Reason Code: 1 - Deductible amount, 2 - Coinsurance amount, 3 - Co-payment amount Or CO (contractual obligation) with a Valid TPL adjustment reason code' to the Reason Code field.

#	Claim Adjustment Group Code	Reason Code	Adjustment Amount
Click to collapse.			
	*Claim Adjustment Group Code	*Reason Code	*Adjustment Amount

Adjusted Units

Add Cancel

Save Cancel

Reason Code:

- 1 – Deductible amount
 - 2 – Coinsurance amount
 - 3 – Co-payment amount
- Or
- CO (contractual obligation) with a Valid TPL adjustment reason code

Adjustment Amount:
The responsibility or ARC amount on this **DETAIL** only

- Claim adjustment details are **NOT** completed for TPL, unless there is an acceptable denial adjustment reason code (ARC)
- Claim adjustment details **ARE** completed for Medicare and Medicare Replacement Plans

Submitting Attachments



When a primary EOB or other documentation to support your claim is needed, use the Attachments feature on Step 3

Click on **Choose File** to find your document on your system to upload

Your file must be one of the following types: .bmp, .gif, .jpg, .jpeg, .pdf, .png, .tif and .tiff
PDF files work best!

Add and Save each time

Clicking on the drop-down arrow to select the correct item that identifies what you are attaching.
For example: EB for Explanation of Benefits

A screenshot of the 'Attachments' form interface. The form has a table with columns: #, Transmission Method, File, Control #, Attachment Type, and Action. Below the table, there are fields for '*Transmission Method' (set to 'FT-File Transfer'), '*Upload File' (with a 'Choose File' button and 'No file chosen' text), and '*Attachment Type' (with a drop-down menu). A list of attachment types is shown below the drop-down, including 'CK-Consent Form(s)', 'CT-Certification', 'D2-Drug Profile Document', 'DA-Dental Models', 'DB-Durable Medical Equipment Prescription', 'DG-Diagnostic Report', 'DJ-Discharge Monitoring Report', 'DS-Discharge summary', 'EB-Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer)', and 'HC-Health Certificate'. The 'EB' option is highlighted. Red arrows point from the text boxes to the 'Choose File' button, the 'Add' button, and the 'Attachment Type' drop-down arrow.

Claim Note Information



The Indiana Health Coverage Programs accepts claim notes as documentation for certain situations, and Claim Note Information is entered in Step 3

Note Reference

Code: select the drop-down menu to identify the functional area or purpose to which the note applies.

Note Text: type your claim note here.

A screenshot of the 'Claim Note Information' form. The form has a title bar 'Claim Note Information' with a minus icon. Below the title bar is a instruction: 'Click the Remove link to remove the entire row.' The main table has columns: '#', 'Note Reference Code', 'Note Text', and 'Action'. Below the table is a 'Click to collapse.' link. There are input fields for 'Note Reference Code' and 'Note Text'. Below these fields are 'Add' and 'Cancel' buttons. To the right of the input fields is a box titled 'Additional Information' containing 'Certification Narrative', 'Goals, Rehabilitation Potential, or Discharge Plans', 'Diagnosis Description', and 'Third Party Organization Notes'. At the bottom of the form are 'Back to Step 1', 'Back to Step 2', 'Submit', and 'Cancel' buttons. Red boxes and arrows highlight the 'Add' button, the 'Submit' button, and the 'Additional Information' box. A red box also highlights the 'Note Reference Code' input field.

Click **Submit** to proceed to final preview

Click **Add** to add the claim note

Please refer to the [Claim Submission and Processing](#) provider reference module for acceptable claim notes, or your [Provider Relations Consultant](#).

Claim notes cause the claim to go in pending status to allow a claim analyst time to review.

Claim Status

The screenshot shows the 'INDIANA MEDICAID for Providers' portal. At the top, there's a navigation bar with links: 'My Home', 'Eligibility', 'Claims', 'Care Management', 'Resources', and 'Switch Provider'. Below this, a breadcrumb trail reads 'Claims > Claim Receipt'. A green bar contains a 'Delegate for' section with 'Role IDs' set to 'Provider - In Network -'. The main content area has a dark blue header 'Submit Professional Claim: Confirmation' and a light blue sub-header 'Professional Claim Receipt'. The text states: 'Your Professional Claim was successfully submitted. The claim status is FinalizedPayment. The Claim ID is CLAIM NUMBER HERE'. Below this, instructions are provided: 'Click **Print Preview** to view the claim details as they have been saved on the payer's system.', 'Click **Copy** to copy member or claim data.', 'Click **Edit** to resubmit the claim.', and 'Click **New** to submit a new claim.' At the bottom, there are four buttons: 'Print Preview', 'Copy', 'Edit', and 'New'.

- If a claim denies, you can make corrections and rebill the claim again. There is no need to wait.
- Submitting claims online via the [IHCP Portal](#) provides immediate status- Paid, Denied or Pending in Process.

An attachment or Claim Note may cause the claim to go into Pending in Process status for a claim analyst to review.



Claim Adjustments on the IHCP Portal

Claim Adjustments on the IHCP Portal



Edit, Copy and Void Functions



- **Edit** a **paid** claim that needs to be adjusted.
- Leave the correct information on the claim that was previously paid, correct what is wrong.
- **Never** edit a paid claim if the date of service is past timely filing, unless it meets specific guidelines.
- **Copy** a **denied** claim - you **cannot** adjust a denied claim.
- Do not use **Void** unless the **entire** paid amount on the claim needs to be refunded.



Editing Claims



1. Search claims by the Member ID and date of service.
2. Choose the most recent ***paid*** claim for your date of service and select the Edit button.



A claim adjustment must be done within **180** calendar days from the **date of service or the date on a primary EOB** to file on the [IHCP Portal](#).



For questions regarding the filing limit, or if you need claim adjustment help, please refer to your [Provider Relations Consultant](#).



Claim Adjustments

Additional Information

Exceptions for the 180-calendar day filing limit examples for claim adjustment:

- Crossover claims *
- Retro eligibility *
- Retro prior authorization or Notice of Action *
- Retro provider enrollment *
- Change in policy/coverage *
- Primary payment (adjustment must be within 180 days of the date on the primary EOB)
- Overpayment*

*Claim Note may be required to bypass timely filing

For additional information on claim adjustments, please see the [Claim Adjustments](#) provider reference module.



Remittance Advice Basics

Remittance Advice Overview

Financial cycle runs
each Friday

Electronic funds transfer
(EFT) deposited each
Wednesday

Check payments are
dated each Wednesday
following the financial
cycle

Payments are calculated
based on paid claims,
less payments for
outstanding accounts
receivable and liens

Sections of the
Remittance Advice
include Claims Paid,
Claims Denied, Claims
In Process, Claim
Adjustments, Payment
Holds, Financial
Transactions and
Refunds

Remittance Advice
statements are available
via the IHCP secure
website weekly

Locating Your Remittance Advice on the IHCP Portal



Once logged into the [IHCP Portal](#) under the specific service location, click on the Claims menu, then choose **Search Payment History**.

The screenshot shows the 'INDIANA MEDICAID for Providers' web portal. At the top, there's a navigation bar with 'My Home', 'Eligibility', 'Claims', 'Care Management', and 'Resources'. The 'Claims' menu is expanded, showing options like 'Search Claims', 'Submit Claim Dental', 'Submit Claim Inst', 'Submit Claim Prof', 'Search Payment History', 'Request FQHC/RHC Wrap Report', and 'Retrieve FQHC/RHC Wrap Report'. A red arrow points from the text 'Search Payment History' in the left-hand instruction to the 'Search Payment History' option in the expanded Claims menu. On the left sidebar, there are sections for 'User Details' (with 'My Profile' and 'Manage Accounts' links), 'Provider' (with 'Name', 'Provider ID', 'Disenroll', 'Provider Profile', 'Provider Maintenance', and 'Enrollment / Revalidation Status' links), and 'Provider Services' (with 'Member Focused Viewing' and 'Search Payment History' links). The main content area includes a 'Last Messages' section with a maintenance notice, a 'Contact Us' link, a 'Notify Me' link, and a 'Secure Correspondence' link. At the bottom, there's a banner for 'WE HEALTH CARE PROFESSIONAL!' with a photo of two healthcare professionals and a paragraph about the portal's commitment to providers.

Search Payment History

My Home Eligibility Claims Care Management Resources

Claims > Search Payment History Wednesday 07/16/2025 10:08 PM

Search Payment History

Provider Information

Provider ID	ID Type	NPI	Name
-------------	---------	-----	------

* Indicates a required field.

Enter a From and To Issue Date that does not span more than 90 days. To further refine the search, select a Payment Method and/or enter a Payment ID.

Payment Method All **Payment ID**

Issue Date *From 04/17/2025 *To 07/16/2025

Search Reset

Search Results

To see payment details, click on the Payment ID link.
To access a copy of the Remittance Advice, select the RA icon. Access to the RA will require Adobe Acrobat Reader.

Total Records: 13

Issue Date	Payment Method	Payment ID	Total Paid Amount	RA Copy (PDF)
07/16/2025	EFT		\$123.24	RA
07/09/2025	EFT		\$971.39	RA
07/02/2025	EFT		\$732.46	RA

The **Payment Method** will default to All - leave as is.

To search for previous dates, change the date range.
Can be no greater than a 90 calendar-day span.

Payment ID will be blank. Leave blank to search for all RAs in that time frame. If searching for a specific RA, enter the **Payment ID**.

Click on the RA icon to download the PDF to see the complete RA information.

RA Date

Payment Method

Payment ID

Payment Amount

Remittance Advice Copy

View Payment Details



View Payment Details [Back to Search Payment History](#) ?

Provider Information

Provider ID

ID Type NPI

Name

To access a copy of the Remittance Advice, select the 'RA Copy' button. Access to the RA will require Adobe Acrobat Reader.

To filter the results shown in the Claim Payment Details grid, click on the Show Filter Options link, enter the information on which you would like to filter the results, and click the Filter button.

Payment Summary for Payment ID

Claim Payments

Additions \$0.00

Deductions \$0.00

Total Paid Amount \$6,151.11

[RA Copy \(PDF\)](#)

[Show Filter Options](#)

To see details of an individual claim, click on the Claim ID link.

Claim Payment Details

Total Records: 3

<u>Claim ID</u>	<u>Member Name</u>	<u>Service Dates</u>	<u>Total Charges</u>	<u>Payment Amount</u>
2225		06/07/2025 - 06/09/2025	\$2,600.00	\$2,743.40

Claim ID-can click on hyperlink to open claim and review.

Payment Amount of claim

Click on **RA Copy (PDF)** to open a full copy of your Remittance Advice

Provider Remittance Advice Claim Paid Example



REPORT: INDIANA CORE MMIS DATE: 05/16/2025
 RA#: INDIANA TITLE XIX PAGE: 1
 PAYER: PROVIDER REMITTANCE ADVICE
 PROFESSIONAL SERVICES CLAIMS PAID

PAYEE ID
 NPI
 PAYMENT NUMBER
 PAYMENT DATE 05/21/2025

--ICN--	PATIENT NUMBER	MRN	SERVICE DATES FROM TO	BILLED AMT ALLOWED AMT	OTH INS AMT SPENDDOWN AMT	COPAY AMT CO-INS CB	PAID AMT OUTPAT DED
MEMBER NAME:			MEMBER NO.:				
			031325 031325	186.35 141.44	0.00 0.00	0.00 0.00	141.44 0.00

PROC CD	MODIFIERS	SERVICE DATES FROM TO	ALLW UNITS COPAY AMT	RENDERING PROVIDER BILLED AMT	PA NUMBER ALLOWED AMT	PAID AMT
H0015		031325 031325	1.00 0.00	MCD 186.35	141.44	141.44

Allowed Amount \$141.44
Claim Paid \$141.44

Provider Remittance Advice Claim Denied Example



REPORT:
RA#:
PAYER: TXIX

INDIANA CORE MMIS
INDIANA TITLE XIX
PROVIDER REMITTANCE ADVICE
PROFESSIONAL SERVICES CLAIMS DENIED

DATE: 05/16/2025
PAGE: 6

PAYEE ID
NPI
PAYMENT NUMBER
PAYMENT DATE 05/21/2025

ICN	PATIENT NO.	MRN	SERVICE DATES FROM TO	BILLED AMOUNT	OTH INS AMOUNT	SPENDDOWN AMOUNT
MEMBER NAME:			MEMBER NO.: 050125 050525	372.70	0.00	0.00

**Denied Claim
No Units Allowed**

ADJUSTERS	ALLW UNITS	SERVICE DATES FROM TO	RENDERING PROVIDER	PA NUMBER BILLED AMT
	0.00	050125 050125	MCD	186.35
	0.00	050525 050525	MCD	186.35

EOBS	001	2033	3000	9806	9918
	002	2033	3000	9806	9918
ARCS	001	198		186.35	
	002	198		186.35	
REMARKS	001	N34			
	002	N34			

EOB Code, ADJ Reason Code and Remark Code Descriptions

Each claim listed on your Remittance Advice lists EOB, ARCS and Remarks Codes.

Find these descriptions near the end of the RA to see the description of how a claim processed.

REPORT:	INDIANA CORE MMIS	DATE:	05/16/2025
RA#:	INDIANA TITLE XIX	PAGE:	12
PAYER:	PROVIDER REMITTANCE ADVICE		
	EOB CODE DESCRIPTIONS		
		PAYEE ID	MCD
		NPI	
		PAYMENT NUMBER	
		PAYMENT DATE	05/21/2025
EOB CODE DESCRIPTIONS			
CLM EOB CODE	DESCRIPTION		
1121	THE RENDERING PROVIDER NPI SUBMITTED IS REPORTED TO MULTIPLE LPIS. RESUBMIT THE CLAIM WITH THE TAXONOMY OF THE RENDERING PROVIDER IN ADDITION TO THE RENDERING NPI.		
2033	INVALID CLAIM TYPE FOR THE PROGRAM BILLED		
3000	PAYMENT FOR THIS SERVICE HAS BEEN DENIED OR CUTBACK DUE TO UNITS BILLED EXCEEDING THE UNITS PRIOR AUTHORIZED.		
9070	THE AMOUNT BILLED IS LESS THAN THE IHCP ALLOWED AMOUNT.		
9806	PRICING ADJUSTMENT - PAYMENT REDUCED DUE TO BENEFIT PLAN LIMITATIONS.		

REPORT:	INDIANA CORE MMIS	DATE:	05/16/2025
RA#:	INDIANA TITLE XIX	PAGE:	13
PAYER:	PROVIDER REMITTANCE ADVICE		
	ADJ REASON CODE DESCRIPTIONS		
		PAYEE ID	
		NPI	
		PAYMENT NUMBER	
		PAYMENT DATE	05/21/2025
ARC CODE	DESCRIPTION		
198	Precertification/notification/authorization/pre-treatment exceeded.		

REPORT:	INDIANA CORE MMIS		
RA#:	INDIANA TITLE XIX		
PAYER:	PROVIDER REMITTANCE ADVICE		
	REMARK CODE DESCRIPTIONS		
REMARK CODE	DESCRIPTION		
N34	Incorrect claim form/format for this service.		

RA Summary

REPORT: CRA-SUMM-R
RA#: TXIX
PAYER: TXIX

INDIANA CORE MMIS
INDIANA TITLE XIX
PROVIDER REMITTANCE ADVICE
SUMMARY

DATE: 06/13/2025
PAGE: 7

PAYEE ID MCD
NPI
PAYMENT NUMBER
PAYMENT DATE 06/18/2025

-----CLAIMS DATA-----						
	CURRENT NUMBER	CURRENT AMOUNT	MONTH-TO-DATE NUMBER	MONTH-TO-DATE AMOUNT	YEAR-TO-DATE NUMBER	YEAR-TO-DATE AMOUNT
CLAIMS PAID	2	161.58	4	206.62	47	3,672.02
CLAIM ADJUSTMENTS	0	0.00	0	0.00	0	0.00
CLAIM INTEREST		0.00		0.00		0.00
TOTAL CLAIMS PAYMENTS	2	161.58	4	206.62	47	3,672.02
CLAIMS DENIED	4		9		84	
CLAIMS IN PROCESS	0	0.00				
-----EARNINGS DATA-----						
PAYMENTS:						
CLAIMS PAYMENTS		161.58		206.62		3,672.02
MANAGED CARE ADMINISTRATIVE PAYMENT*		0.00		0.00		0.00
HOOSIER HEALTHWISE CAPITATION PAYMENT*		0.00		0.00		0.00
PATHWAYS CAPITATION PAYMENT*		0.00		0.00		0.00
HEALTHY INDIANA PLAN POWER ACCOUNT*		0.00		0.00		0.00
HEALTHY INDIANA PLAN CAPITATION PAYMENT*		0.00		0.00		0.00
NON EMERG MED TRANSP CAPITATION PAYMENT*		0.00		0.00		0.00
PAYOUTS		0.00		0.00		0.00
ACCOUNTS RECEIVABLE:						
CLAIM SPECIFIC:						
CURRENT CYCLE		(0.00)		(0.00)		(0.00)
OUTSTANDING FROM PREVIOUS CYCLES		(0.00)		(0.00)		(0.00)
NON-CLAIM SPECIFIC		(0.00)		(0.00)		(0.00)
REFUNDS:						
CLAIM SPECIFIC ADJUSTMENT REFUNDS		(0.00)		(0.00)		(0.00)
NON CLAIM SPECIFIC REFUNDS		(0.00)		(0.00)		(0.00)
OTHER FINANCIAL:						
MANUAL PAYOUTS		(0.00)		(0.00)		(0.00)
VOIDS		(0.00)		(0.00)		(0.00)
MEMBER CONTRIBUTION (POWER)		(0.00)		(0.00)		(0.00)
NET PAYMENT		161.58		206.62		3,672.02
NET EARNINGS		161.58		206.62		3,672.02

Financial Transactions



REPORT: CRA-TRAN-R
RA#: TXIX
PAYER: TXIX

INDIANA CORE MMIS
INDIANA TITLE XIX
PROVIDER REMITTANCE ADVICE
FINANCIAL TRANSACTIONS

DATE: 06/13/2025
PAGE: 6

Name of Provider and
Address

PAYEE ID MCD
NPI
PAYMENT NUMBER
PAYMENT DATE 06/18/2025

```

-----NON-CLAIM SPECIFIC PAYOUTS TO PAYEE-----
TRANSACTION    PAYOUT    REASON    FIN    SERVICE DATE    RELATED
NUMBER          AMOUNT    CODE      ARC    FROM    THRU    PROVIDER ID

NO NON-CLAIM SPECIFIC PAYOUTS TO PAYEE

-----NON-CLAIM SPECIFIC REFUNDS FROM PAYEE-----
TRANSACTION    REFUND    REASON    FIN    PAYMENT    RECEIPT    MEMBER NAME    MEMBER NO.
NUMBER          AMOUNT    CODE      ARC    NUMBER    DATE

NO NON-CLAIM SPECIFIC REFUNDS FROM PAYEE

-----ACCOUNTS RECEIVABLE-----
A/R NUMBER    SETUP    ORIGINAL    RECOUPMENT    REASON FIN    MEMBER NAME    MEMBER NO.    ADJUSTMENT    PREVIOUS    AMOUNT RECOUPEI
NUMBER        DATE      AMOUNT      AMOUNT TO DATE  CODE  ARC          MEMBER NO.    --ICN--      --ICN--      CURRENT CYCLE

NO OUTSTANDING ACCOUNTS RECEIVABLE
    
```

- Accounts receivables are set up when claims are adjusted.
- Adjusted ICN, new ICN, and AR numbers are displayed.
- Accounts Receivables may be recouped in current cycle or future cycles.

Remittance Advice and Financial Transaction Resources



The [Financial Transactions and Remittance Advice](#) provider reference module



Call the Customer Assistance Unit toll-free line at 800-457-4584 for requests such as asking Finance to reissue a lost check. Live assistance is available 8 a.m. to 6 p.m. Eastern Time, Monday through Friday, excluding holidays. Providers should allow two weeks (14 calendar days) before submitting a reissue request to allow for delivery delays from the U.S. Postal Service.



Your [Provider Relations Consultant](#) if needing instructions on updating your address to report correct information on your W-9 and service location, need help with EFT enrollment or updates, questions on claim denials, remittance advice, accounts receivables and much more.



Send a Secure Correspondence message while logged on through the [IHCP Portal](#) if you have questions on a finance letter, check, payment or remittance advice.





Submitting Medicare Exhaust Inpatient Claims on the IHCP Portal



Medicare Part A Benefits Exhaust IHCP Portal Instructions Without Medicare Part B Benefits

[IHCP Portal](#) claim transactions for inpatient acute services must be submitted with the following information, as applicable:

Medicare Part A benefits exhausted without Medicare Part B benefits:

- Adjustment reason code (ARC) 119 – Benefit maximum for this time period or occurrence has been reached
- Claim filing code indicator of MA
- Medicare Part A paid amount = \$0

Please see [BT2025125](#) for more information, including the (837I) electronic claim transactions.

Medicare Part A Benefits Exhaust IHCP Portal Step 2 Example Without Medicare Part B Benefits



Add Medicare
Part A to
**Carrier
Name/
Carrier ID**

Other Insurance Details

Enter the carrier and policy holder information below.

Enter other carrier Remittance Advice details here for the claim or with each service line. Enter adjusted payment details, such as reason codes, in the Claim Adjustment Details section.

Click the **Remove** link to remove the entire row.

[Refresh Other Insurance](#)

#	Carrier Name	Carrier ID	Group ID	TPL/Medicare Paid Amount	Paid Date	Action
1	MEDICARE PART A	MEDICARE PART A		\$0.00	10/01/2025	Remove

**Claim
Filing Code
MA –
Medicare
Part A**

**TPL/Medicare
Paid Amount**
enter \$0 or
amount paid

*Relationship to Patient: 18-Self
Group ID:

*Claim Filing Code: MA-Medicare Part A
Policy Name: MEDICARE

TPL/Medicare Paid Amount: \$0.00
Claim ID:

Paid Date: 10/01/2025
Referral Number:

Authorization Number:

**Claim Adjustment
Group and
Reason Codes
PR 119 and
amount**

Claim Adjustment Details

You can enter up to five unique group codes. You can repeat six combinations of reason code and adjustment amount with each group code.

Click the **Remove** link to remove the entire row.

#	Claim Adjustment Group Code	Reason Code	Adjustment Amount	Units	Action
1	PR-Patient Responsibility	119-Benefit maximum for this time period or occurrence has been reached.	\$31,625.27		Remove



Medicare Part A Benefits Exhaust With Medicare Part B Benefits IHCP Portal Instructions

[IHCP Portal](#) claim transactions for inpatient acute services must be submitted with the following information, as applicable:

Medicare Part A benefits exhausted with Medicare Part B benefits:

- Adjustment Reason Code (ARC) 119
- Claim filing code indicator of MA
- Medicare Part A paid amount = \$0

AND

- Claim filing indicator of MB
- Medicare Part B paid amount

Please see [BT2025125](#) for more information, including the (837I) electronic claim transactions.

Medicare Part A Benefits Exhaust With Medicare Part B Benefits

IHCP Portal Step 2 Example Part 1



Add Medicare Part A to
Carrier Name/
Carrier ID

Claim Filing
Code
MA –
Medicare
Part A

TPL/Medicare
Paid Amount
enter \$0 or
amount paid

Claim
Adjustment
Group and
Reason Codes
PR 119 and
amount

Other Insurance Details

Enter the carrier and policy holder information below.

Enter other carrier Remittance Advice details here for the claim or with each service line. Enter adjusted payment details, such as reason codes, in the Claim Adjustment Details section.

Click the **Remove** link to remove the entire row.

[Refresh Other Insurance](#)

#	Carrier Name	Carrier ID	Group ID	TPL/Medicare Paid Amount	Paid Date	
1	MEDICARE PART A	MEDICARE PART A		\$0.00	10/01/2025	Remove
2	MEDICARE PART B	MEDICARE PART B		\$1,086.66	10/01/2025	Remove

*Relationship to Patient: Group ID:

*Claim Filing Code: Policy Name:

TPL/Medicare Paid Amount: Paid Date:

Claim ID: Authorization Number:

Referral Number:

Claim Adjustment Details

You can enter up to five unique group codes. You can repeat six combinations of reason code and adjustment amount with each group code.

Click the **Remove** link to remove the entire row.

#	Claim Adjustment Group Code	Reason Code	Adjustment Amount	Units	
1	PR-Patient Responsibility	119-Benefit maximum for this time period or occurrence has been reached.	\$31,625.27		Remove

Medicare Part A Benefits Exhaust With Medicare Part B Benefits IHCP Portal Step 2 Example Part 2



Add Medicare
Part B to
**Carrier
Name/Carrier
ID** below
Medicare Part
A

**Claim Filing
Code**
MB -
Medicare Part B

**TPL/Medicare
Paid Amount**
enter Medicare
Part B paid
Amount

**Claim Adjustment
Group and Reason
Codes PR and
reason code per
Medicare EOB
and amount**

Other Insurance Details

Enter the carrier and policy holder information below.

Enter other carrier Remittance Advice details here for the claim or with each service line. Enter adjusted payment details, such as reason codes, in the Claim Adjustment Details section.

Click the **Remove** link to remove the entire row.

[Refresh Other Insurance](#)

#	Carrier Name	Carrier ID	Group ID	TPL/Medicare Paid Amount	Paid Date	Action
1	MEDICARE PART A	MEDICARE PART A		\$0.00	10/01/2025	Remove
2	MEDICARE PART B	MEDICARE PART B		\$1,086.66	10/01/2025	Remove

*Relationship to Patient: 18-Self
Group ID:

*Claim Filing Code: MB-Medicare Part B
Policy Name:

TPL/Medicare Paid Amount: \$1,086.66
Paid Date: 10/01/2025

Claim ID:
Referral Number:
Authorization Number:

Claim Adjustment Details

You can enter up to five unique group codes. You can repeat six combinations of reason code and adjustment amount with each group code.

Click the **Remove** link to remove the entire row.

#	Claim Adjustment Group Code	Reason Code	Adjustment Amount	Units	Action
1	PR-Patient Responsibility	2-Coinsurance Amount	\$232.00		Remove

No Medicare Part A Benefits IHCP Portal Instructions



[IHCP Portal](#) claim transactions for inpatient acute services must be submitted with the following information, as applicable:

No Medicare Part A benefits with Medicare Part B benefits:

- Claim filing code indicator of MB
- Medicare Part B paid amount

Please see [BT2025125](#) for more information, including the (837I) electronic claim transactions.

No Medicare Part A Benefits IHCP Portal Step 2 Example

Add Medicare
Part B to
**Carrier
Name/Carrier
ID**

**Claim Filing
Code**
MB-
Medicare Part B

**TPL/Medicare
Paid Amount**
enter Medicare
Part B paid
amount

**Claim
Adjustment
Group and
Reason Codes**
PR and reason
code per
Medicare EOB
and amount

Other Insurance Details

Enter the carrier and policy holder information below.

Enter other carrier Remittance Advice details here for the claim or with each service line. Enter adjusted payment details, such as reason codes, in the Claim Adjustment Details section.

Click the **Remove** link to remove the entire row.

[Refresh Other Insurance](#)

#	Carrier Name	Carrier ID	Group ID	TPL/Medicare Paid Amount	Paid Date	Action
1	MEDICARE PART B	MEDICARE PART B		\$1,086.66	10/01/2025	Remove

***Relationship to Patient** 18-Self ***Claim Filing Code** MB-Medicare Part B

Group ID Policy Name

TPL/Medicare Paid Amount Paid Date

Claim ID Authorization Number

Referral Number

Claim Adjustment Details

You can enter up to five unique group codes. You can repeat six combinations of reason code and adjustment amount with each group code.

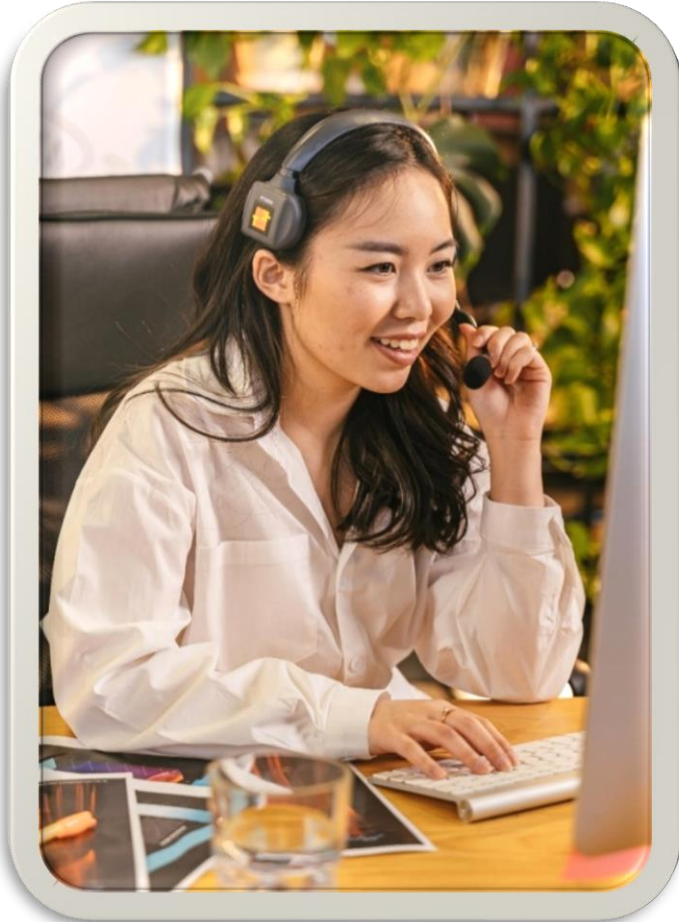
Click the **Remove** link to remove the entire row.

#	Claim Adjustment Group Code	Reason Code	Adjustment Amount	Units	Action
1	PR-Patient Responsibility	2-Coinsurance Amount	\$232.00		Remove



Helpful Tools

Useful Information



[Indiana Medicaid for Providers website](#)

[IHCP Provider Reference Modules](#)

[IHCP Bulletins](#)

Sign up for [email notifications](#) to receive weekly summaries of new and updated bulletins, modules and other publications.

Customer Assistance

800-457-4584

8 a.m. - 6 p.m. Eastern Time Monday – Friday

[Provider Relations Consultants](#) by region

Secure Correspondence via the [IHCP Provider Healthcare Portal](#)

*(After logging in to the IHCP Portal, click the **Secure Correspondence** link to submit a request.)*

Provider Relations Consultants



Areas Covered	Consultant	Email	Telephone
Region 1 plus Chicago/Watseka, IL, and Sturgis, MI	Michelle Walls	INXIXRegion1@gainwelltechnologies.com	317-488-5071
Region 2 plus Danville, IL	Jill Harris	INXIXRegion2@gainwelltechnologies.com	317-488-5080
Region 3	Gabrielle Anderson	INXIXRegion3@gainwelltechnologies.com	317-488-5324
Region 4 plus Cincinnati/Harrison and Hamilton/Oxford, OH	Kassandra Johnson	INXIXRegion4@gainwelltechnologies.com	317-488-5153
Region 5	Jeannette Moore	INXIXRegion5@gainwelltechnologies.com	317-488-5186
Region 6	Emily Redman	INXIXRegion6@gainwelltechnologies.com	317-210-2618
Region 7 plus Louisville and Owensboro, KY	Tami Lott	INXIXRegion7@gainwelltechnologies.com	317-286-6894
All out-of-state providers except those in the previously listed cities	Judy Green	INXIX_OOS@gainwelltechnologies.com	317-488-5026



Questions

Thank you for attending!

By taking a few moments to complete the event and session evaluations, you help us understand your experience and shape the future of our programs.



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