



Claims *CMS-1500*

Mastering Claims Submission
and Billing Best Practices

2025 Indiana Health Coverage Programs
(IHCP) Annual Works Seminar

Agenda

- MHS Overview
- Claim Submission Process
- MHS Provider Claims Issue Resolution Process
- Portal Functionality
- Professional Billing
- Web Portal Claim and Payment Review
- Online Claim Reconsiderations on the MHS Secure Provider Portal
- Coordination of Benefits
- Prior Authorization
- MHS Provider Engagement Team
- Questions

MHS Overview

Who Is MHS?

Managed Health Services (MHS) is a health insurance provider that has been proudly serving Indiana residents for 30 years through Hoosier Healthwise (HHW), the Healthy Indiana Plan (HIP), and Hoosier Care Connect (HCC).

MHS is your choice for better healthcare.

Claim Submission Process

Medical Claims Submission

- **Electronic Data Interchange (EDI) Submission:**
 - Preferred method of claims submission.
 - Faster and less expensive than paper submission.
 - MHS Electronic Payor ID **68069**.
- **Online Portal**
 - 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 Claims Submission

- **Electronic Submission:**
 - Payor ID **68068**.
 - MHS accepts Third Party Liability (TPL) information via EDI.
 - It is the responsibility of the provider to review the error reports received from the Clearinghouse (Payor Reject Report).
- **Online Portal**
 - 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
P.O. Box 6800
Farmington, MO 63640-3818

Claims Billing with Ease

- National Provider Identification (NPI), Taxonomy Code, Zip +4.
- This information 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 **Online Secure Portal**

Timely Filing Limits

PROVIDER TYPE	TIMELY FILING LIMIT
In-Network Providers	90 calendar days from DOS or discharge date
Out-of-Network Providers	180 calendar days from DOS or discharge date

Exceptions to The Filig Limit

EXCEPTION TYPE	FILING LIMIT	ADDITIONAL REQUIREMENTS
Newborns (≤ 30 days)	365 calendar days from Date of Service (DOS)	Filed with newborn's MID
TPL - With EOP	365 calendar days from DOS	Include primary insurance Explanation of Payment (EOP)
TPL - Late EOP	60 calendar days from EOP receipt	Filed after 365-day window
TPL - No Response	90 calendar days	Include proof of filing with primary insurer

Paper Claim Corrections

- A corrected claim can be submitted following the Indiana Health Coverage Programs (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*.
 - Remember: A rejection must be submitted as a first-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 rejection code **RE**.

Paper Claim Corrections CMS-1500 Example

- If you must submit via paper – never handwrite “Corrected Claim” on the claim form.
- Complete box 22 (Resubmission Code) to include a 7 (the "Replace" billing code) to notify us of a corrected or replacement claim.

The image shows a CMS-1500 paper claim form with several fields filled in. Key annotations include:

- Original claim number:** An arrow points to box 16, 'DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION', which contains the number '1'.
- Resubmission code is "7":** An arrow points to box 22, 'RESUBMISSION CODE', which contains the number '7'.

Other visible fields include:

- Box 14: DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)
- Box 15: OTHER DATE
- Box 16: DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
- Box 17: HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
- Box 18: ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
- Box 19: OUTSIDE LAB?
- Box 20: PRIOR AUTHORIZATION NUMBER
- Box 21: DIAGNOSIS OR NATURE OF ILLNESS OR INJURY
- Box 22: RESUBMISSION CODE
- Box 23: PROCEDURE, SERVICE, OR SUPPLY
- Box 24: DATE(S) OF SERVICE
- Box 25: FEDERAL TAX ID NUMBER
- Box 26: PATIENT'S ACCOUNT NO.
- Box 27: ACCEPT ASSIGNMENT?
- Box 28: TOTAL CHARGE
- Box 29: AMOUNT PAID
- Box 30: Rptd for NUCC Use
- Box 31: SIGNATURE OF PHYSICIAN OR SUPPLIER
- Box 32: DATE

Laboratory Billing

- All providers that bill laboratory services on a *CMS-1500* form must have a Clinical Laboratory Improvement Amendments (CLIA) certification or a CLIA waiver certification equal to the procedure code being billed and included on the *CMS-1500* form.
- **EXc1 DENIED: INVALID CLIA NUMBER:**
This denial code will appear on the provider's EOP. This verification will ensure that MHS is compliant with the Centers for Medicare & Medicaid Services (CMS) guidelines. Providers will have to submit a corrected claim timely with proper CLIA certificate number entered on their claim submission.

Laboratory Billing Cont.

Physician's Office Lab Testing (POLT)

- MHS Policy CC.PP.055: To ensure laboratory tests are performed in the correct setting, the health plan will limit the performance of in-office laboratory testing to the Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes listed in the Short Turnaround Time (STAT) laboratory (lab) code list.

Laboratory Billing Cont.

- These tests on the POLT list are those needed immediately, in order to manage medical emergencies or urgent conditions. Therefore, specific clinical laboratory tests have been designated as appropriate to be performed in the office setting.
- The health plan's Automated Claims Adjudication System will deny in-office (place of service 11) laboratory procedures that are not included on the STAT lab list.
- Policy and list can be found at: [STAT Lab List](#)

Transportation Claims

- MHS will process all Medicaid emergent and non-emergent ambulance Claims, including air ambulance, which would have previously been processed by our transportation vendor.
- 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 IHCP are eligible for reimbursement. Claims must be filed within:
 - 90 calendar days of the DOS for contracted providers.
 - 180 calendar days of the DOS for non-contracted providers.
- Claims should be submitted to MHS via a *CMS-1500* professional claim form. Claims may be submitted via EDI (preferred), [Online Portal](#) or paper.

Managed Health Services
P.O. Box 531097
Indianapolis, IN 46253

Transportation Claims Cont.

- MHS will follow IHCP billing guidelines for coding and reimbursement.
- For more information on Medicaid ambulance billing guidelines, please visit the [Provider Reference Module](#).
- **Claim Inquiries:**
 - Check status online via the [Online Portal](#)
 - Call Provider Services at 1-877-647-4848
Monday - Friday from 8:00 a.m. – 8:00 p.m. EST.

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.
- Timely filing is not substantiated.
- Rejected claims must be corrected and submitted as a first-time new claim.
- EDI rejections require the provider to contact their clearinghouse and obtain a payer rejection report.

Common Claim Rejections

Medical

- **B5** Missing/incomplete/Invalid Clinical Laboratory (CLIA) Licensing and Certification.
- **01** Invalid Provider ID Billing Physician (Provider State Crosswalk File).
- **02** Invalid Provider ID-Rendering Physician (Provider State Crosswalk File).
- **07** Invalid Subscriber/Member ID.
- **08** Invalid Member Date of Birth.
- **09** Member Invalid on Date of Service.
- **40** Diagnosis code is missing
- **76** Original Claim Number required.
- **90** Invalid or Missing Modifier.

Behavioral Health

- **01** Invalid Provider ID Billing Physician (Provider State Crosswalk File).
- **02** Invalid Provider ID-Rendering Physician (Provider State Crosswalk File).
- **07** Invalid Subscriber/Member ID.
- **08** Invalid Member Date of Birth.
- **09** Member Invalid on Date of Service.
- **40** Diagnosis code is missing.
- **31** Invalid Service Procedure code.
- **76** Original claim number required.

MHS Provider Claims Issue Resolution Process

Provider Claims Issue Resolution

PROCESS

- Level 1: Informal Claims Dispute
- Level 2: Formal Claim Dispute – Administrative Claim Appeal
- 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 Mailing Address

- Medical Claims Address:
Managed Health Services
Attn: Appeals Department
P.O. Box 3002
Farmington, MO 63640-3802
- Behavioral Health Claims Address:
Managed Health Services BH Appeals
Attn: Appeals Department
P.O. Box 6800
Farmington, MO 63640-3818

Informal Claims Dispute or Objection Form

Submit all documentation supporting your Dispute:

- Copies of original MHS EOP showing how the claims in question were processed.
- 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).
- Can be submitted via the Secure Web Portal within 60 calendar days of receipt of the MHS EOP.
- Requests received after the 60 calendar days will not be considered.

Informal Dispute or Objection Form

- Level 1 - Informal Dispute: Upon receipt of the informal claim dispute, MHS will review the claim and the additional information submitted and respond to the provider within 30 calendar days.
- At that time (or upon receipt of our response if sooner), providers will have up to 60 calendar days from date of dispute response to initiate a formal claim appeal, which is (Level 2).

Informal Claims Dispute Objection Form

Helpful Tips

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

After the Informal Claims Dispute (Level 1) has been submitted, the provider can access the Provider Service Phone Line or Web Portal for assistance or questions. The inquiries will be logged and assigned a ticket number. Please keep this ticket number for your reference.

- Phone:
 - 1-877-647-4848 - Provider Contact Center.
 - 8 a.m. to 8 p.m. EST.
- Online Secure Portal
 - Use the Messaging Tool.

Disputing Multiple Claims

Disputing multiple Claim Denials:

- Provide the Provider Services Representative or Web Portal Team member with one claim number as an example of the specific denial.
- Communication is key! Inform the Contact Center that 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 Tax Id Number (TIN)).
- Provide the MHS denial code and description found on the EOP.
- Briefly describe why you are disputing this denial or seeking research.

Formal Claims Dispute - Administrative Claim Appeal

- 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 [Online Portal](#)
- or in writing by using your company letter head with an explanation including any specific details which may justify reconsideration of the disputed claim. The appeal should be clearly marked on the form as Level 2.

Arbitration

- Level 3 is arbitration, 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 must be mailed to:

MHS Arbitration
429 N. Pennsylvania Street, Suite 109
Indianapolis, IN 46204

State Fair Hearing (SFH)

A State Fair Hearing must be initiated in writing by the member, member's authorized representative, member's provider of record, or a healthcare practitioner with knowledge of the member's medical condition. A State Fair Hearing and an external independent review may occur simultaneously.

To request a State Fair Hearing, write to:

Office of Administrative Law Proceedings
100 N. Senate Avenue, Room N802,
Indianapolis, IN 46204

Portal Functionality

Secure Web Portal Login or Registration

The screenshot shows the MHS website's 'For Providers' section. On the left is a navigation menu with links like 'Provider Portal Login', 'Behavioral Health', 'Clinical & Payment Policies', 'Dental Providers', 'Education & Trainings', 'Email Sign Up', 'Enrollment and Updates', 'News', 'Pharmacy', 'Prior Authorization', and 'Quality Improvement'. The main content area is titled 'Provider Portal Login' and features a section 'Create your own online account today!' with a description of MHS tools and a list of benefits: 'Verify member eligibility', 'Submit and check claims', 'Submit and confirm authorizations', and 'View detailed patient list'. Below this is a link for 'Portal Training Guides'. To the right, there are two distinct login options: 'Secure Provider Portal' (noting it excludes Wellcare Complete) and 'Wellcare Complete Provider Portal' (noting it requires a distinct password and login). Both options have a prominent 'Login/Register' button. The MHS logo is in the top left, and navigation links for 'For Members', 'For Providers', and 'Get Insured' are in the top right. A 'Privacy - Terms' link is in the bottom right corner.

mhs

For Members For Providers Get Insured

For Providers

Provider Portal Login

Behavioral Health

Clinical & Payment Policies

Dental Providers

Education & Trainings

Email Sign Up

Enrollment and Updates

News

Pharmacy

Prior Authorization

Quality Improvement

Provider 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

Portal Training Guides

Secure Provider Portal

This login does not include Wellcare Complete.

Login/Register

Wellcare Complete Provider Portal

Wellcare Complete requires a distinct password and login.

Login/Register

Privacy - Terms

Create a login or sign into the Online Portal to get started.

Homepage - MHS (Medicaid)

After logging into the portal this homepage will appear that allows providers to access information

The screenshot shows the MHS (Medicaid) homepage. At the top is a navigation bar with the MHS logo and icons for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below the navigation bar is a section for "Viewing Dashboard For: TIM" with a "Plan Type" dropdown set to "Medicaid" and a "GO" button. There are two notification boxes: "Notification of Pregnancy (NOP)" and "Please Note". Below the notifications is a "Welcome, [Name]" section with a description of the dashboard. At the bottom is an "Admin Settings" section with three buttons: "Add User", "Edit User Access", and "Add a TIN".

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, [Name]
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 Audit Tool

- The Clear Claim Connection screen appears, allowing you to enter the Procedure Code, Modifiers, Quantity, Date and Place of Service, and Diagnosis for a Claim proactively before you submit or retroactively after you submit. This tool helps to prescreen claims prior to submitting.

The screenshot displays the mhs Claims Audit Tool interface. At the top, the mhs logo is on the left, and navigation links for Eligibility, Patients, Authorizations, Claims, Messaging (with 88 notifications), and Help are on the right. Below the navigation bar, a filter section shows 'Viewing Claims For:' with a dropdown set to '3' and a 'Medicaid' dropdown, followed by a 'GO' button. To the right are 'Upload EDI' and 'Create Claim' buttons.

The main section is titled 'Claims' and includes tabs for 'Individual', 'Saved', 'Submitted' (with 11 notifications), 'Batch', 'Payment History', 'My Downloads', and 'Claims Audit Tool'. A 'Filter' button is on the right. Below the tabs is a table with the following data:

CLAIM NO. ↑	CLAIM TYPE ↑	MEMBER NAME ↑	SERVICE DATE(S) ↑	BILLED/ PAID ↑	CLAIM STATUS ↑
1	CMS-1500	f 3	08/22/2017 - 08/22/2017	\$73.00 / \$0.00	⌚

Below the table is the 'Clear Claim Connection' form. It includes a 'Claim Entry' section with 'Gender' (Male/Female), 'Date of Birth' (mm/dd/yyyy), and 'ICD Code Set'. A note states: 'Click grid to enter information. * For quick entry, use your Down Arrow key after you enter a Procedure Code. Date of Service will default to today's date, and Place of Service will default to 11 (Office). Tabbing through Date of Service and Place of Service will give you the same defaults.'

Line	Procedure	Mod 1	Mod 2	Mod 3	Mod 4	Qty.	Date of Service	Place of Service	Line Diag. 1	Line Diag. 2	Line Diag. 3	Line Diag. 4
1								-- select --				
2								-- select --				
3								-- select --				
4								-- select --				
5								-- select --				

At the bottom of the form are buttons for 'Add More Procedures >>', 'Review Claim Audit Results', and 'Clear'.

Claims

- **Web Portal Claims Functionalities:**
 - Submit new Claim.
 - Review Claims information on file for a patient.
 - View payment history
- **Submit a New Claim:**
 - Click **Create Claim** and enter **Member ID** and **Birthdate**.

The screenshot shows the mhs web portal interface. At the top, there is a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, Messaging (with a red notification badge showing '98'), and Help. Below the navigation bar, there is a section for 'Viewing Claims For' with a dropdown menu set to 'Medicaid' and a green 'GO' button. To the right of this section are two buttons: 'Upload EDI' and 'Create Claim'. Below this section, there is a horizontal menu with 'Claims' selected, followed by 'Individual', 'Saved', 'Submitted', 'Batch', 'Payment History', 'My Downloads', and 'Claims Audit Tool'. A 'Filter' button is located on the far right of this menu.

This screenshot shows the same mhs web portal interface as the previous one, but with the search fields expanded. Below the 'Viewing Claims For' section, there are two input fields: 'Member ID or Last Name' and 'Birthdate'. The 'Member ID or Last Name' field contains the text '123456789 or Smith' and has a red 'X' icon to its left. The 'Birthdate' field has a placeholder 'mm/dd/yyyy'. To the right of these fields is an orange 'Find' button. The rest of the interface, including the navigation bar and the horizontal menu, remains the same.

Claims Submission

- Choose the **Claim Type**.
 - **Professional** or **Institutional** claim submission

mhs

Eligibility Patients Authorizations Claims Messaging Help

Viewing Claims For: Tax ID Number Medicaid GO

Upload EDI Create Claim

Choose Claim for

Choose a Claim Type

CMS 1500
Professional Claim →

CMS UB-04
Institutional Claim →

UPDATE: In order to be compliant with ICD-10 regulations, we will require claims with discharge dates or service dates on or after October 1, 2015, be coded with ICD-10 codes. This change applies to the date of service on the claim, not the submission date.

Professional Billing

Professional Claims Submission

- In the **General Info** section, populate the **Patient's Account Number** as assigned to your member account and other information related to the patient's condition by typing into the appropriate fields.
- Click **Next**.

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

THIS SECTION:
General Info [redacted] e dates of the claim.

[redacted] **Next** →

* Required field

Patient's Account Number* [XXXXXXXXXX] 26

Date of current Illness, Injury, Pregnancy (LMP) [Select Type...] [MM/DD/YYYY] 14.

Other Date [Select Type...] [MM/DD/YYYY] 15.

Professional Claims Submission Cont.

- Add the **Diagnosis Codes** for the patient in Box 21. There are some situations that a specific diagnosis is required in position 1 and the claims will deny if it is not listed in primary location.
- Click the **Add** button to save.

Professional Claim for [] Your Progress [] [] [] [] []

THIS SECTION:
Diagnosis Codes
Diagnosis Code and Additional Insurance information.

← Back Next →

* Required field

ICD Version Indicator* ☒ ICD 10

Please note that for the claim statement dates entered, valid ICD-10 codes only are accepted.

Diagnosis Codes* XXXX e.g. V87: Add (Enter diagnosis code and click on Add button)

V837 -- PERS OUTSD INDUST VEH INJ NT ACC Remove X

Add Coordination of Benefits

← Back Next →

Professional Claims Submission Cont.

Click **Add Coordination of Benefits (COB)** to include any payments made by another insurance carrier (if applicable).

Primary Insurance x Remove

Notice: If the Member has more than one primary insurance (Medicaid would be the 3rd payer), the claim cannot be submitted through the Web.

Carrier Type* C50M -- Commercial

Policy Number*

Professional Claims Submission cont.

- **Add Service Lines**, and any applicable COB information at bottom of each line.

The screenshot shows the 'Service Lines' form. A large pink arrow points to the '+ New Service Line' button on the left sidebar. Another pink arrow points to the 'Next' button at the top right. A red box highlights the 'Save / Update' button, with a pink arrow pointing to it from the top right. The form displays 'Now Viewing Line 1: 99213 / \$208.00'. The left sidebar shows a 'Total: \$208.00' and a list of 'PROCEDURE / CHARGES' with '1: 99213 / \$208.00' selected. The main form fields include: 'Dates of Service*' (From: 08/04/2025, To: 08/04/2025), 'Place of Service*' (11 -- PROVIDERS OFFICE), 'Emergency' (Yes/No), 'Procedure Code*' (99213), 'Modifiers' (XX), and 'Diagnosis Code(s)*' (R635 - ABNORMAL WEIGHT GAIN, R0683 - SNORING). The form also includes a 'Delete' button and a 'Save / Update' button. The form is titled 'Service Lines' and has a subtitle 'Enter maximum of 50 service lines.'.

Service Lines
Enter maximum of 50 service lines.

← Back Next →

Total: \$208.00

* Required field

Now Viewing Line 1: 99213 / \$208.00

+ New Service Line

PROCEDURE / CHARGES

1: 99213 / \$208.00

Dates of Service* From: 08/04/2025 To: 08/04/2025 24.a

Place of Service* 11 -- PROVIDERS OFFICE 24.b

Emergency Yes No 24.c EMG

Procedure Code* 99213 24.d

Modifiers XX 24.e

Diagnosis Code(s)* ☒ R635 - ABNORMAL WEIGHT GAIN ☒ R0683 - SNORING

Please enter the modifier and click the Add button.

Delete Save / Update

Professional Claims Submission Cont.

- Enter **Referring, Rendering, and Billing Provider** information.
- **Service Facility Location.**
- Click **Next.**

* Required field

Referring Provider ←

NPI Qualifier

Last Name or Organizational Name First Name

Rendering Provider Only enter rendering provider information if not the same as Billing Provider information.

NPI Tax ID

Taxonomy # Last Name or Organizational Name First Name

Billing Provider ←

Tax ID

Name* NPI Taxonomy *

Address* City* State* Zip*

Service Facility Location ←

Professional Claims Submission Cont.

- In the Attachments section you can **Browse** and **Attach** any documents to the Claim as desired. (Note: If you have no attachments, skip this section.)
- Click **Next**.

The screenshot shows the 'Attachments' section of a professional claim submission interface. At the top, a progress bar indicates the current step. The section title is 'Attachments' with a sub-instruction 'Add attachments to the claim (5MB limit)'. A note states 'Supported types are .jpg, .tif, .pdf and .tiff'. Below this, a yellow banner contains a 'Back' button, the text 'If there are no attachments, click Next.', and a 'Next' button. The main area is titled 'Attachments' and includes a red warning: '*Do NOT send password protected files. You must click ATTACH for each file being submitted.' Below the warning, there are two fields: 'File*' with a 'Choose File' button and the text 'No file chosen', and 'Attachment Type*' with a 'Select Type...' dropdown menu. An 'Attach' button is positioned to the right of these fields. A light blue message box states 'There are no attached files.' At the bottom, another yellow banner contains a 'Back' button, the text 'If there are no attachments, click Next.', and a 'Next' button. Two pink arrows are overlaid on the image: one points to the 'Choose File' button, and the other points to the 'Next' button at the bottom right.

Professional Claims Submission Cont.

Professional Claim for L

THIS SECTION
Review
Please review your claim and submit.

← Back

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

Validate →

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

Claim Id: 8
Member Record Number: 2
Member Claim Amount Paid:
Patient's Account Number: 8

General Info [Edit](#)
Statement From Date: 03/16/2017
Statement To Date: 03/16/2017
Date of current illness, injury, pregnancy (LMP):
Other Date:
Hospitalized From:
Hospitalized To:
Additional Claim Information:
Outside Lab?: No
Outside Lab Amount:
Prior Authorization Number:
CLIA Number:

Diagnosis Codes and Primary Insurance [Edit](#)
Diagnosis Codes
R011 - CARDIAC MURMUR UNSPECIFIED

Service Lines [Edit](#)

Line	From	To	Place	Proc	Diagnosis	Amount	Units/Minutes/Days	Family Plan	EPSDT	MDC	Supplemental Info
1	03/16/2017	03/16/2017	22	93010	R011	\$55.00	1.0	No			

Providers [Edit](#)

Provider Type	Name	Tax ID	NPI	Taxonomy	Address
Referring Provider					
Rendering Provider					
Billing Provider				246W00000X	
Service Facility Location					

Attachments

← Back

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

Validate →

- In the **Review** section, you can see if the Claim is eligible for Real-Time Editing and Pricing (RTEP).
- Click **Validate** for RTEP claims and click **Submit** for regular processed Claims.

RTEP Claim Pricing View

The screenshot displays the 'RTEP Claim Pricing View' interface. At the top, there is a navigation bar with the 'mhs' logo and icons for Eligibility, Patients, Authorizations, Claims, and Messaging. Below this, a header section includes a 'Viewing Claims For:' dropdown, a date range selector, and buttons for 'Upload EDI' and 'Create Claim'.

The main content area features a 'COMPLETE!' message: 'You have successfully submitted your claim.' A green 'Print' button is located to the right. Below this, a 'Web Reference No. 8' and a 'Claim No.' field are visible.

A summary section provides the following details:

- RefAcct No: 1
- DOS Range: [blank]
- Member ID: [blank]
- Billed Amount: \$90.00
- Member Name: [blank]
- Payment Amount: \$46.75
- Servicing Provider: [blank]
- Status: APPROVED

A table with 10 columns (Line, DOS, Proc, Dx, Modifiers, Place of Service, Charged, Payment Amount, Status, Status Description) displays two rows of claim data:

Line	DOS	Proc	Dx	Modifiers	Place of Service	Charged	Payment Amount	Status	Status Description
1	09/21/2015 - 09/21/2015	99212	285.9		11	\$65.00	\$31.75	Approved	92: PAID ACCORDING TO CONTRACT STATE PROCESSING GUIDELINES
2	09/21/2015 - 09/21/2015	99050	285.9		11	\$25.00	\$15.00	Approved	92: PAID ACCORDING TO CONTRACT STATE PROCESSING GUIDELINES

Below the table, a green message states: 'The system has provided a response back to the you indicating amount to be paid on the claim. Any post adjudication processes can change the amount paid.' A green 'Close' button is at the bottom right.

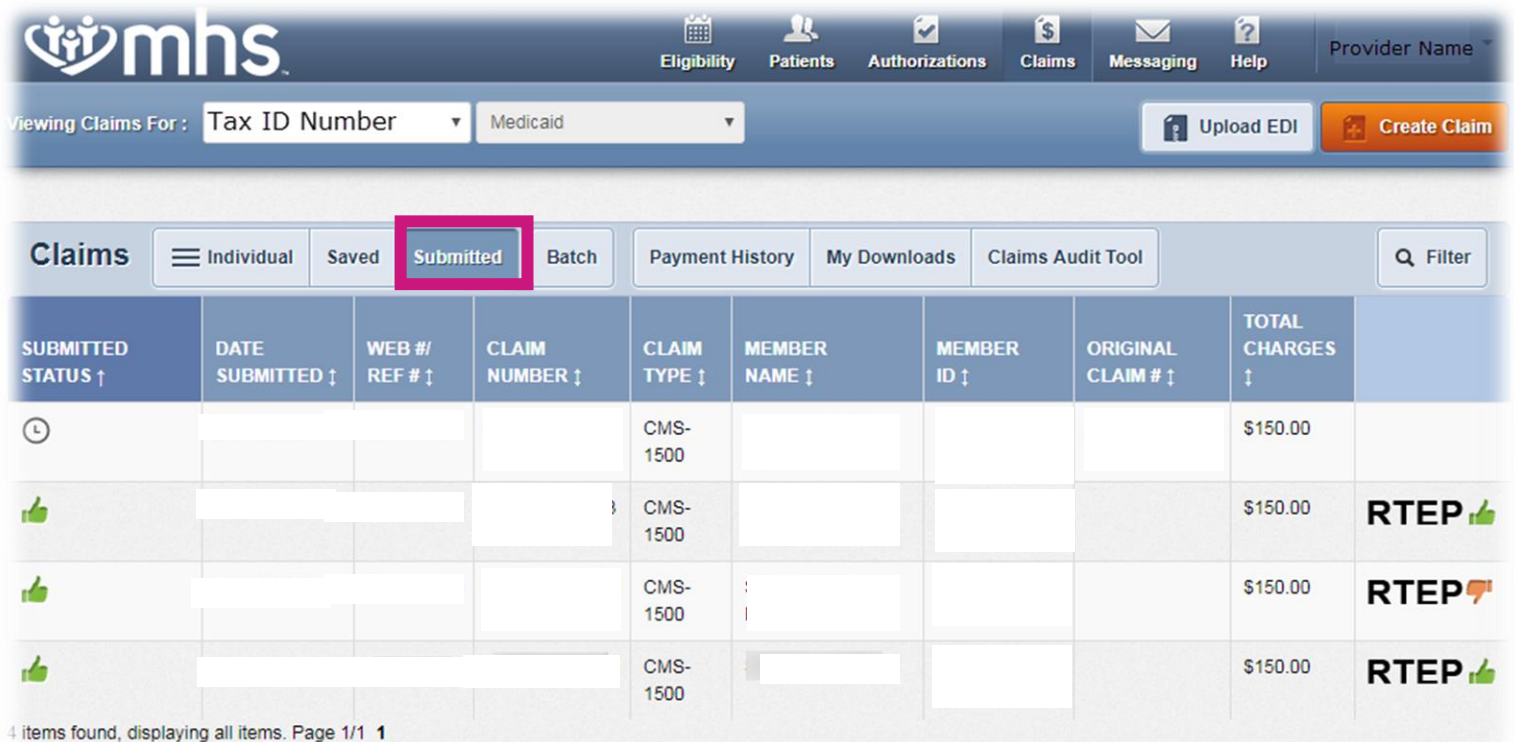
RTEP Overview:

- On the final screen, each procedure code will receive a reimbursement estimate, pending Claim explanation, or Denial reason.
- Claims with a reimbursement estimate or pending explanation may be impacted by final adjudication, including a change to the reimbursement amount or a denial.
- Adjudication status may be affected by code editing or other payment rules.

Web Portal Claim and Payment Review

Submitted Claims

- The **Submitted** tab will only display Claims created via the MHS portal:
 - Accepted** is a **green** thumbs up.
 - Denied** is an **orange** thumbs down.
 - Pending** is a clock.
- RTEP** indicators on the right claims also show if eligible (i.e., line 3 was submitted but was not eligible for RTEP).



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

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

SUBMITTED STATUS ↑	DATE SUBMITTED ↓	WEB #/ REF # ↑	CLAIM NUMBER ↑	CLAIM TYPE ↑	MEMBER NAME ↑	MEMBER ID ↑	ORIGINAL CLAIM # ↑	TOTAL CHARGES ↑	
⌚				CMS-1500				\$150.00	
👍				CMS-1500				\$150.00	RTEP 👍
👍				CMS-1500				\$150.00	RTEP 🚫
👍				CMS-1500				\$150.00	RTEP 👍

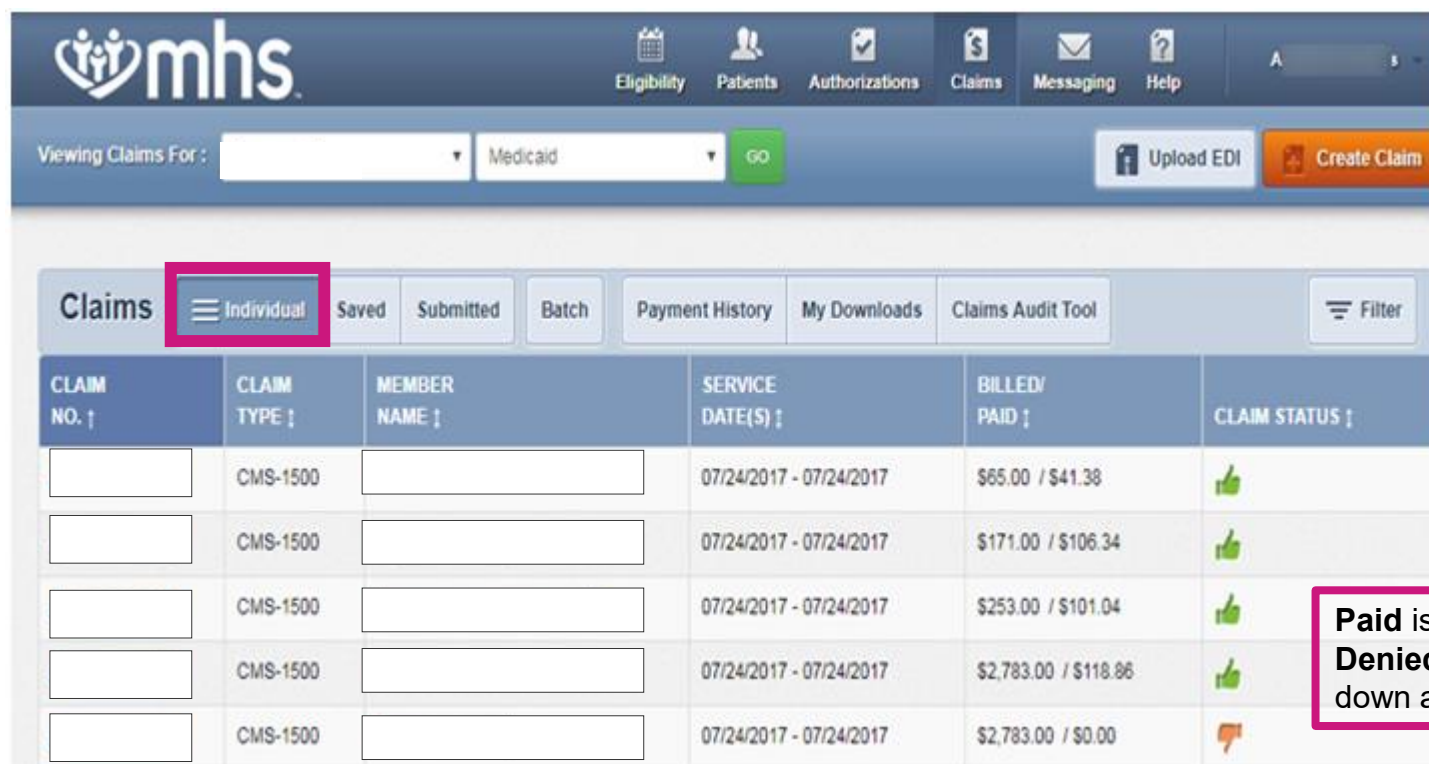
4 items found, displaying all items. Page 1/1 1

Paid is a green thumbs up, **Denied** is an orange thumbs down and a clock is **Pending**.

Individual Claims

On the **Individual** tab, Claims can be reviewed that had been submitted and accepted using paper, portal, or EDI clearinghouse methods.

- View the Claim Number, Claim Type, Member Name, Service Date(s), Billed/Paid, and Claim Status.



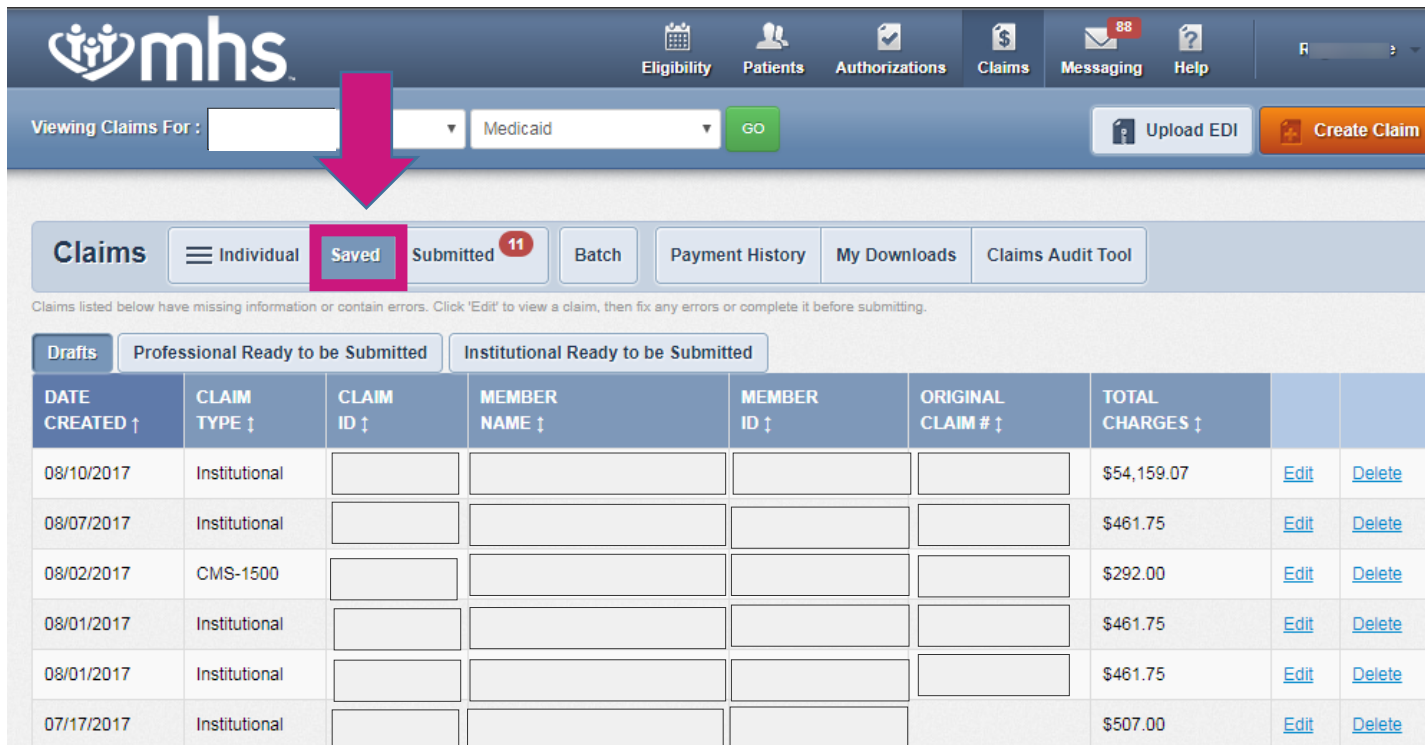
CLAIM NO. ↑	CLAIM TYPE ↑	MEMBER NAME ↑	SERVICE DATE(S) ↑	BILLED/ PAID ↑	CLAIM STATUS ↑
	CMS-1500		07/24/2017 - 07/24/2017	\$65.00 / \$41.38	👍
	CMS-1500		07/24/2017 - 07/24/2017	\$171.00 / \$106.34	👍
	CMS-1500		07/24/2017 - 07/24/2017	\$253.00 / \$101.04	👍
	CMS-1500		07/24/2017 - 07/24/2017	\$2,783.00 / \$118.86	👍
	CMS-1500		07/24/2017 - 07/24/2017	\$2,783.00 / \$0.00	👎

Paid is a green thumbs up,
Denied is an orange thumbs
down and a clock is **Pending**.

Saved Claims

To view **Saved** Claims - Drafts, Professional, or Institutional:

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



Viewing Claims For: Medicaid

Claims

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					\$54,159.07	Edit	Delete
08/07/2017	Institutional					\$461.75	Edit	Delete
08/02/2017	CMS-1500					\$292.00	Edit	Delete
08/01/2017	Institutional					\$461.75	Edit	Delete
08/01/2017	Institutional					\$461.75	Edit	Delete
07/17/2017	Institutional					\$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.
 - Electronic Funds Transfer (EFT) register with [PaySpan](#)

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 .

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

EFT and ERAs

Payspan Health

- Web-based solution for:
 - EFTs.
 - Electronic Remittance Advices (ERAs).
- One-year retrieval of remittance advice.
- Provided at no cost to providers and allows online enrollment.
- Register at: [Payspan](#)
- For questions call Payspan at: 1-877-331-7154 8:00am-8:00pm EST.

Tips to Remember

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

Summary of Online Reconsiderations

Skip the phone call.

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

Email Updates

☐ Check here to receive email status updates for this reconsideration.

Please upload files less than 25 MB each. Supported file formats are PDF, TIFF, TIF, JPEG, and JPG.

Cancel

Submit Reconsideration→

Online Reconsiderations

Providers can:

- Submit informal disputes/reconsiderations on the **Secure Provider Portal.**
- Submit corrected claims.
- Upload/view supporting documents.
- View acknowledgement letters.
- Track real-time updates.
- View denial code information.

Online Reconsiderations Level 1

- 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.

Level 1 Informal Claim on the Secure Provider Portal

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

✖ Claim # Denied

+ Copy Claim

⌂ Void/Recoup Claim

Dispute Claim

✓

Claim Accepted

✓

In Process

✖

Claim Denied

Member

Member Name:

Member ID:

Member DOB:

Provider

Ref/Acct No.:

Servicing Provider:

Servicing NPI:

Claim

DOS Range:
08/04/2025 - 08/04/2025

Received Date:
08/06/2025

Billed Amount:

Most Recent Payment

Payment Date:
08/14/2025

Paid Claim Amount:
\$0.00

Check Dated:
08/13/2025

Service Lines

Line	DOS	Proc	Dx	Modifiers	Place of Service	Charged	Paid Amount	Payment Date	Status	Payment Codes
------	-----	------	----	-----------	------------------	---------	-------------	--------------	--------	---------------

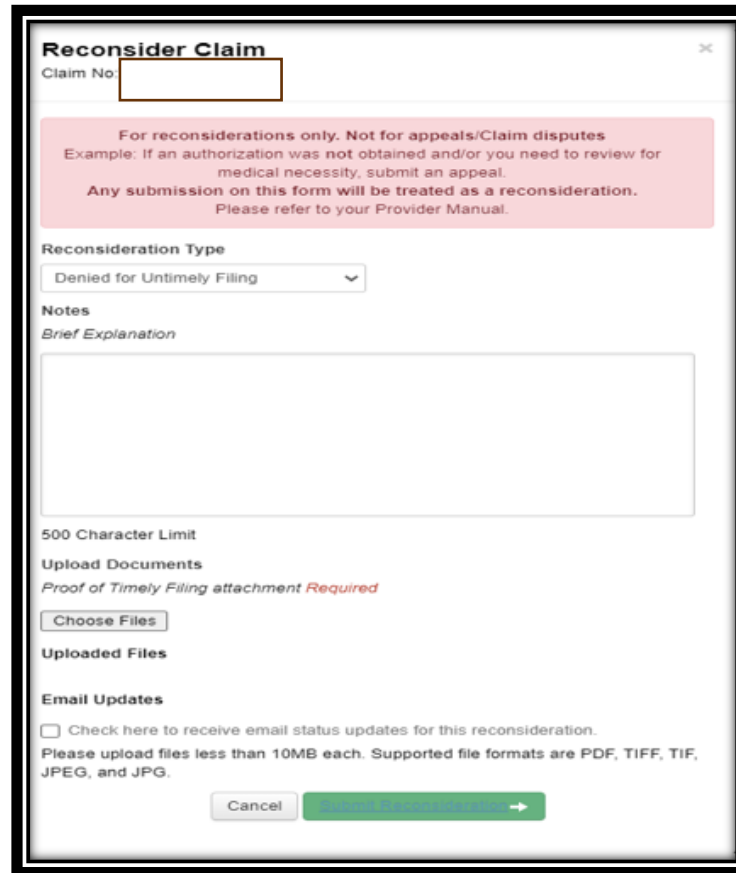
Level 1 Informal Claim Dispute on the Secure Provider Portal Options

The screenshot displays the 'Claims' section of a Secure Provider Portal. At the top, a navigation bar includes links for Eligibility, Patients, Authorizations, Claims, and Messaging, along with a User Name dropdown. Below this, a 'Back to Claims' button is visible next to a text input field for 'Claim #'. The main content area lists three options for dispute resolution, 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 Reconsideration

- 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 2 Claim Appeals on the Secure Provider Portal

Back to Claims **Claim Details**

Claim # : Denied

COPY **DISPUTE**



Dispute/Appeal Details

Created Date	Type	Current Status	Reference No.	Tools
1/26/2021	Dispute - Claim Paid at the Incorrect Amount	Resolved	UD26IA1234565	 

Member	Provider	Claim	Most Recent Payment
Participant Name <input type="text"/>	Ref/Act No. 1234567890	OS Range 08/12/2020 - 08/15/2020	Payment Date ---
Member ID ID123459	Servicing Provider <input type="text"/>	Received Date 09/12/2020	Paid Claim Amount \$0.00
Association Code <input type="text"/>	Servicing NPI 1234567890	Billed Amount \$6,1234.12	Check/EFT No. ---
			Total Check Amount ---
			Check Dated ---

Service Lines

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

Coordination of Benefits

Coordination of Benefits

- This screen is available if a member has other insurance; it is found on the Patient List tab.

[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	<input type="text"/>		AETNA	MEDICAL AND HOSPITAL
Assessments						
Health Record						
Care Plan						
Authorizations						
Coordination of Benefits						
Claims						

Prior Authorization

Prior Authorization Considerations

Learn More About Medicaid Prior Authorization

- **Pre-Authorization Tool.**

How to Obtain Authorization

- **Online**: MHS Secure Provider Portal.
- Fax: 1-866-912-4245.

Authorizations do not guarantee payment.

Prior Authorization



For Members ▾

For Providers ▾

Get Insured

For Providers
Login
Behavioral Health Providers ▾
Clinical & Payment Policies
Dental Providers
Email Sign Up
Enrollment and Updates ▾
Pharmacy ▾
Prior Authorization ^
Medicaid Pre-Auth
Ambetter Pre-Auth ↗
Medicare Pre-Auth
Provider Education & Training ▾
Provider Resources ▾
QI Program ▾
Provider News
Opioid Resources

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 [Evolent](#) [↗](#).
Complex imaging, MRA, MRI, PET, CT scans, PT, ST, OT and Pain Management need to be verified by [Evolent](#) [↗](#).
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 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:

CHECK FOR PRE-AUTH

Y
Yes


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

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

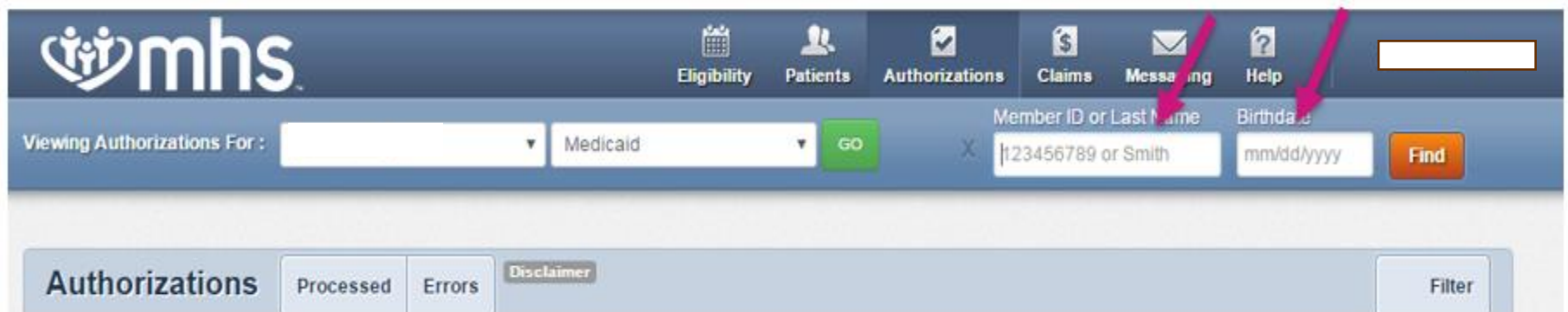


Creating a New Authorization

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



The screenshot shows the top navigation bar of the mhs portal with icons for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below the navigation bar, there is a section for 'Viewing Authorizations For' with a dropdown menu set to 'Medicaid' and a green 'GO' button. To the right, an orange button labeled 'Create Authorization' is highlighted with a red arrow.



The screenshot shows the same mhs portal interface, but with the search fields filled out. The 'Member ID or Last Name' field contains the text '123456789 or Smith' and the 'Birthdate' field contains 'mm/dd/yyyy'. A red arrow points to the 'Member ID or Last Name' input area, and another red arrow points to the 'Birthdate' input area. The 'Find' button is orange and located to the right of the birthdate field.

Creating a New Authorization- Service Type

- Select a Service Type.

The screenshot shows the mhs web application interface. At the top, there is a navigation bar with the mhs logo and several menu items: Eligibility, Patients, Authorizations (highlighted with a mouse cursor), Claims, Messaging (with a notification badge showing 53), and Help. Below the navigation bar, there is a section for "Viewing Authorizations For:" with fields for "TIN" (containing "Tax ID Number") and "Plan Type" (containing "Medicaid"), a "GO" button, and a "Create Authorization" button.

The main content area is divided into two columns. The left column is titled "Authorization For" and contains three informational boxes with close buttons (X). The first box states: "By checking the Urgent Request box, I certify that this is an urgent request for a medically necessary treatment for an injury, illness, or another type of condition (usually not life threatening), which must be treated within 48 hours." The second box states: "After hours emergent and urgent admissions, inpatient notifications or requests will need to be provided telephonically. Electronic requests will not be monitored after hours and will be responded to on the next business day. Please contact our NurseWise line at 877-647-4848 for after-hours urgent admission, inpatient notifications or requests." The third box states: "Please note: Office visit authorization requests will only cover Evaluation and Management (E & M) codes. Other codes may require an additional authorization."

The right column is titled "Enter Authorization" and contains three sections: "1. PROVIDER REQUEST", "2. SERVICE LINE", and "3. FINISH UP". The "1. PROVIDER REQUEST" section includes an "Urgent Request" checkbox and a dropdown menu for "Select a Service Type". The dropdown menu is open, showing a list of service types categorized under "Medical Outpatient" and "Medical Inpatient". The "Vaginal Delivery" option is selected and highlighted in blue. The "2. SERVICE LINE" and "3. FINISH UP" sections are currently empty.

Creating a New Authorization

Select Provider NPI.

Add Primary Diagnosis.

Enter Authorization

1. PROVIDER REQUEST

☐ Urgent Request

Outpatient Medical ▼

Lab Testing?


☐ Yes

☒ No

Requesting Provider

Requesting Provider NPI or Last Name

NEXT >



Enter Authorization

1. PROVIDER REQUEST

Outpatient Medical ▼

Lab Testing?

☐ Yes

☒ No

Requesting Provider

NPI:

TIN:


Name:

Primary Diagnosis

Diagnosis Code

CODE LOOKUP: [ICD-10](#)

+ Add Additional Diagnosis




Creating a New Authorization - Procedures

Add Additional Procedures (if applicable).

Authorization For

DOB: MEDICAID NBR:

PROVIDER REQUEST



Service Type: Outpatient Outpatient Services

SMITH

GENERAL SURGERY

Primary Diagnosis: 5430: HYPERPLASIA OF APPENDIX

Additional Diagnosis: 5379: UNSPEC DISORDER STOMACH&DUODENUM

NPI:

TIN:

Phone:

Enter Authorization

1. PROVIDER REQUEST [EDIT](#)

2. SERVICE LINE

TIN:

Name: SMITH

07/14/2015 - 07/24/2015

1

Primary Procedure

44970

LAPAROSCOPY RUSGICAL
APPENEDECTOMY

[CODE LOOKUP](#)

+

 Add Additional Procedures

Select a Place Of Service

Ambulatory Surgical Center

Outpatient Hospital

Unspecified

+

 Add New Service Line

NEXT >

Creating a New Authorization – Service Lines

Service Line Details:

Enter Authorization

1. PROVIDER REQUEST [EDIT](#)

2. SERVICE LINE

Now adding new service line

Servicing Provider

☐ Same as Requesting Provider

NPI or Last Name

Start Date – End Date

Units/Visits/Days

Select a Place Of Service ▼

Primary Procedure

Procedure Code

- Provider request will appear on the left side of the screen.
- Update Servicing Provider. Check box if same as Requesting Provider.
- Update Servicing Provider if not the same.
- Update Start Date and End Date.
- Update Total Units, Visits, or Days.
- Update Primary Procedure.
- Add any additional procedures.
- Add additional Service Line if applicable: All Service Lines added will appear on the left side of the screen.

Creating a New Authorization - Submission

- Submit a new Authorization:
 - **Confirmation number**

1. PROVIDER REQUEST **EDIT**

2. SERVICE LINE **EDIT**

3. FINISH UP

(123) 456-7890

Fax
(098) 765-4321

Email
jmuliner@centene.com

Questionnaire

Attachment:
Upload any relevant attachments. (5Mb limit)

Browse

Attach

Smart Sheet for Testing.pdf Remove

SUBMIT

Authorization For

DOB: MEDICAID NBR:

Enter Authorization

1. PROVIDER REQUEST

2. SERVICE LINE

Success!

- Your confirmation number
- Member's Name
- Date of Birth
- Medicaid Number

Medical Prior Authorization

- MHS has up to 48 hours to render standard PA decisions and 24 hours to render urgent PA decisions.
- Reasons for a delayed decision may include:
 - Lack of information or incomplete request.
 - Request requiring Medical Director review.
- Medical Management does not verify eligibility or benefit limitations:
 - Provider is responsible for eligibility and benefit verification.

MHS Provider Engagement



MHS Resources

- For additional information, please contact your MHS Provider Engagement Account Manager to schedule an appointment today
- Additional resources available at on the **MHS Website**
- Register online for additional **Monthly Web Sessions**

PEAM Contact Information

NORTHEAST REGION

For claims issues, email:
MHS_ProviderRelations_NE@mhsindiana.com
joy.k.diarra@mhsindiana.com
Joy Diarra, Provider Engagement Account Manager
1-317-864-2378

NORTHWEST REGION

For claims issues, email:
MHS_ProviderRelations_NW@mhsindiana.com
Candace.V.Ervin@mhsindiana.com
Candace Ervin, Provider Engagement Account Manager
1-317-364-7635

NORTH CENTRAL REGION

For claims issues, email:
MHS_ProviderRelations_NC@mhsindiana.com
Natalie.Smith@mhsindiana.com
Natalie Smith, Provider Engagement Account Manager
1-317-379-9035

CENTRAL REGION

For claims issues, email:
MHS_ProviderRelations_C@mhsindiana.com
ldavis@mhsindiana.com
Latisha Davis, Provider Engagement Account Manager
1-317-601-5999

SOUTH CENTRAL REGION

For claims issues, email:
MHS_ProviderRelations_SC@mhsindiana.com
DDENNING@mhsindiana.com
Dalesia Denning, Provider Engagement Account Manager
1-317-951-3800

SOUTHWEST REGION

For claims issues, email:
MHS_ProviderRelations_SW@mhsindiana.com
Dawnalee.A.McCarty@mhsindiana.com
Dawn McCarty, Provider Engagement Account Manager
1-317-556-6171

SOUTHEAST REGION

For claims issues, email:
MHS_ProviderRelations_SE@mhsindiana.com
tiffany.calloway@centene.com
Tiffany Calloway,
Provider Engagement Account Manager
1-812-697-8126

PEAM Manager Map Color Key



Large Provider Groups - Carolyn

CAROLYN VALACHOVIC MONROE

Provider Engagement Account Manager

1-317-443-8243

CMONROE@mhsindiana.com

PROVIDER GROUPS

Eskenazi/The Health and Hospital
Corp.

Baptist Health

Lifespring

Wellcare

Deaconess (including Little Company
of Mary)

Good Samaritan

Norton (including King's Daughters,
Clark & Scott Memorial)

Indiana University Health

Reid Hospital

St. Elizabeth Hospital

Community Health

Large Provider Groups - Mona

MONA GREEN

Provider Engagement Account Manager

1-812-614-1003

mona.green@mhsindiana.com

PROVIDER GROUPS

St. Vincent/Ascension

Wellcare Complete

Lutheran Medical Group

Parkview Health System

Beacon Medical Group

American Senior Care

CarDon & Associates

OrthoIndy

Heart City Health

ONE

Franciscan Health

Behavioral Health Provider Contact

ANGEL JOHNSON

Provider Engagement Account Manager

1-317-468-5184

angel.johnson3@centene.com

PROVIDER GROUPS

Park Center

Otis Bowen

Centerstone

Valley Oaks Health

Grant-Blackford

Four County

Hamilton Center

Community Mental Health
Center (Lawrenceburg)

Oaklawn

Northeastern Center

Edgewater Health

Regional Mental Health

Swanson Center

Porter-Starke Services

Southwestern Behavioral
Community Mental Health
Center (Vevay/Batesville)

Additional Contact Information

MHS Provider Network

NETWORK LEADERSHIP

JILL CLAYPOOL
Senior Vice President, Network Development & Contracting
1-877-647-4848
Jill.E.Claypool@mhsindiana.com

MARK VONDERHEIT
Senior Director, Provider Network
1-877-647-4848
MVONDERHEIT@mhsindiana.com

JENNIFER GARNER
Manager, Provider Relations
1-317-771-5537
jgarner@mhsindiana.com

NETWORK OPERATIONS

KELVIN ORR
Director, Network Operations
1-877-647-4848
Kelvin.D.Orr@mhsindiana.Com

NEW PROVIDER CONTRACTING

TIM BALKO
Director, Network Development & Contracting
1-877-647-4848
TBALKO@mhsindiana.com

MICHAEL FUNK
Manager, Network Development & Contracting
1-877-647-4848
Michael.L.Funk@mhsindiana.com

CENTENE VISION

SIERRA HICKS
sierra.hicks@centene.com
Vision Provider Services: 1-844-820-6523

CENTENE DENTAL

THOMAS "TONY" SMITH
thomas.smith3@centene.com
Dental Provider Services: 1-855-609-5157

Thank You for Attending!

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



Questions?

Thank you for being our partner in care.
