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

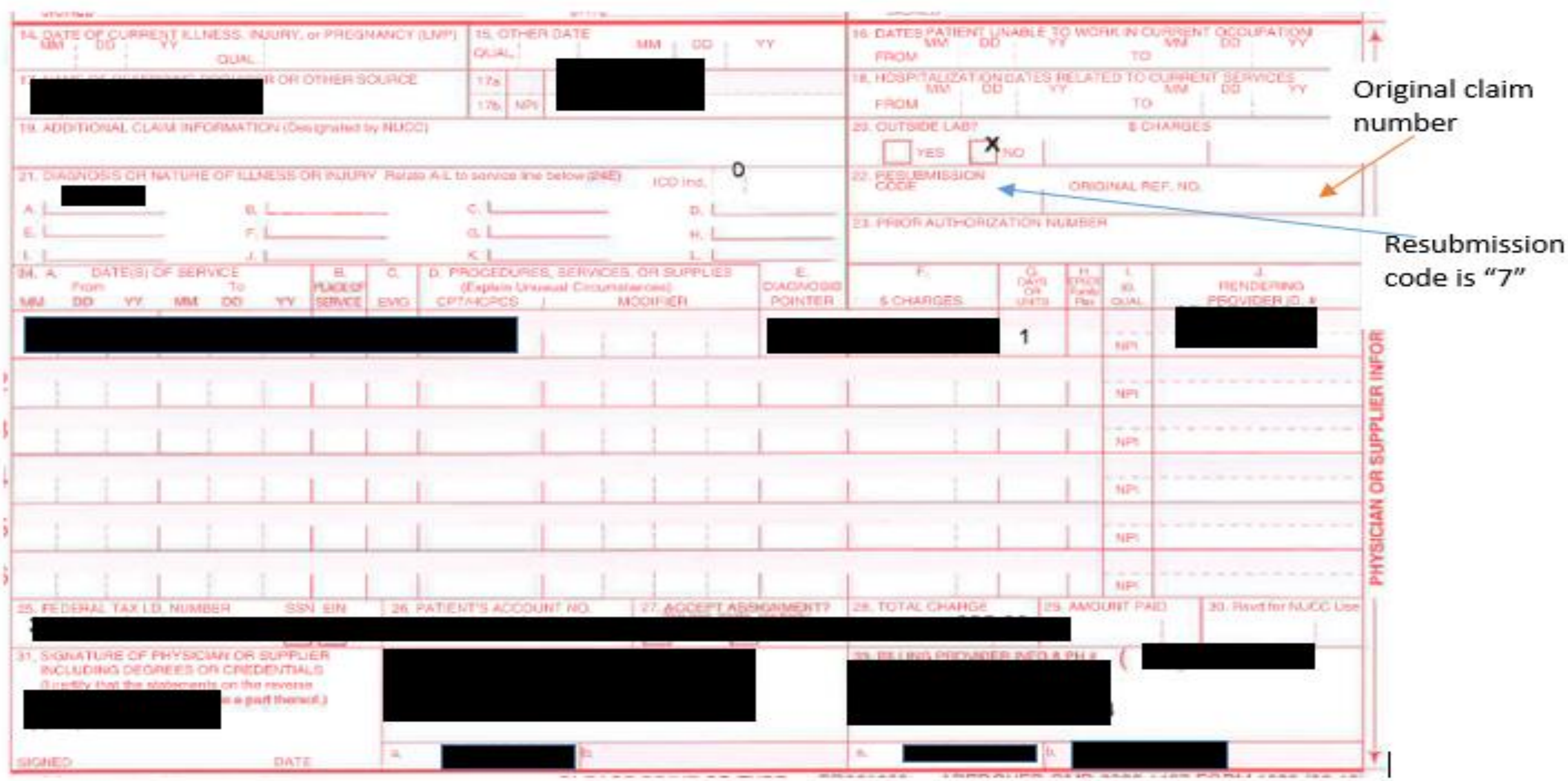
EXCEPTION TYPE	FILING LIMIT	ADDITIONAL REQUIREMENTS
Newborns (≤30 days)	365 calendar days from Date of Service (DOS)	Filed with newborn's MID
TPL - With EOP	365 calendar days from DOS	Include primary insurance Explanation of Payment (EOP)
TPL - Late EOP	60 calendar days from EOP receipt	Filed after 365-day 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.



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 DOSfor 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)

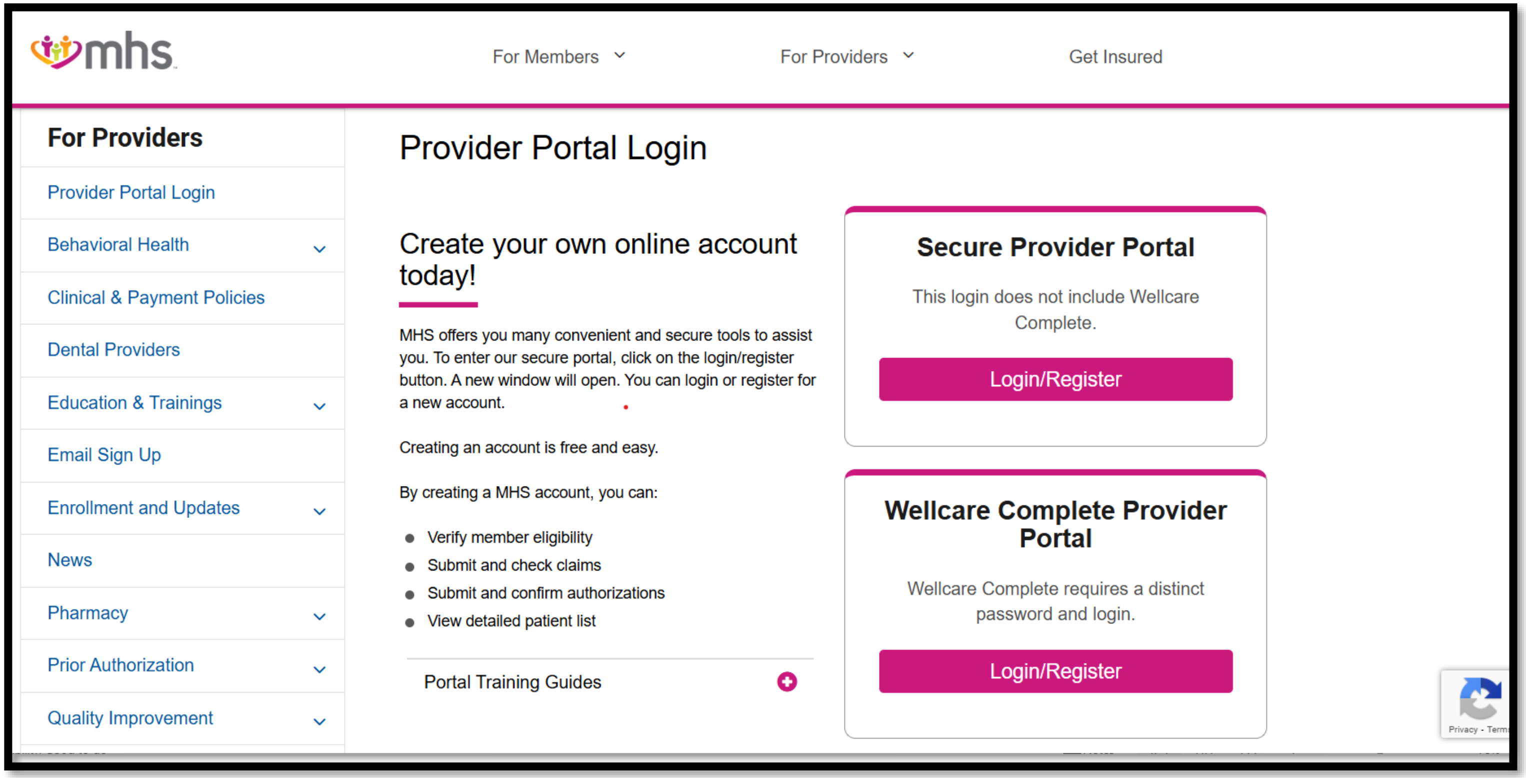
A State Fair Hearing must be initiated in writing by the member, member's authorized representative, member's provider of record, or a healthcare practitioner with knowledge of the member's medical condition. A State Fair Hearing and an external independent review may occur simultaneously.

To request a State Fair Hearing, write to:

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

Portal Functionality

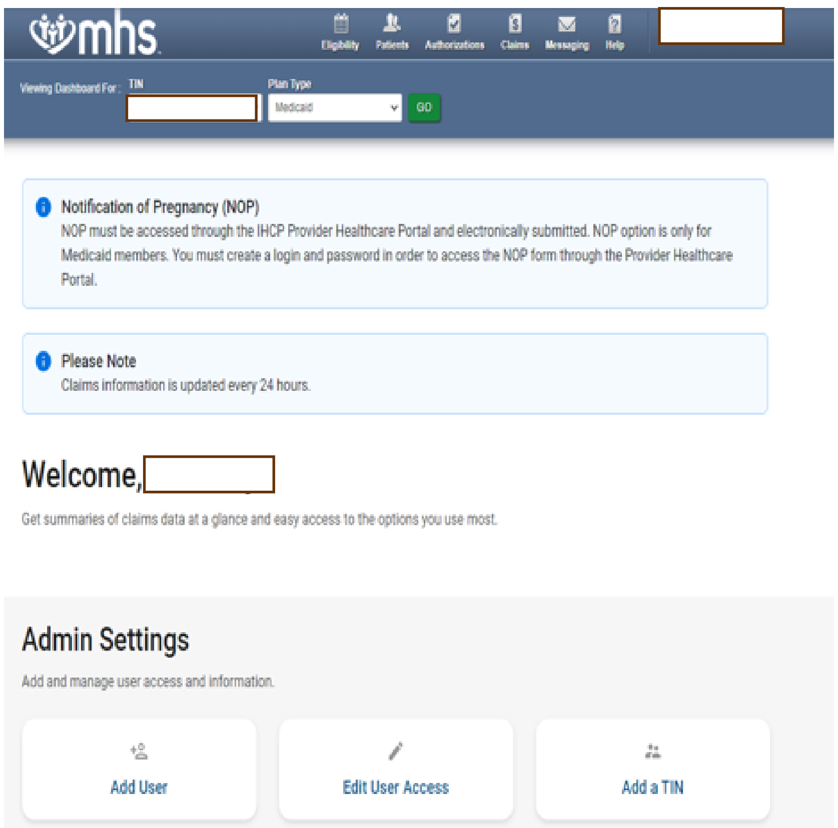
Secure Web Portal Login or Registration

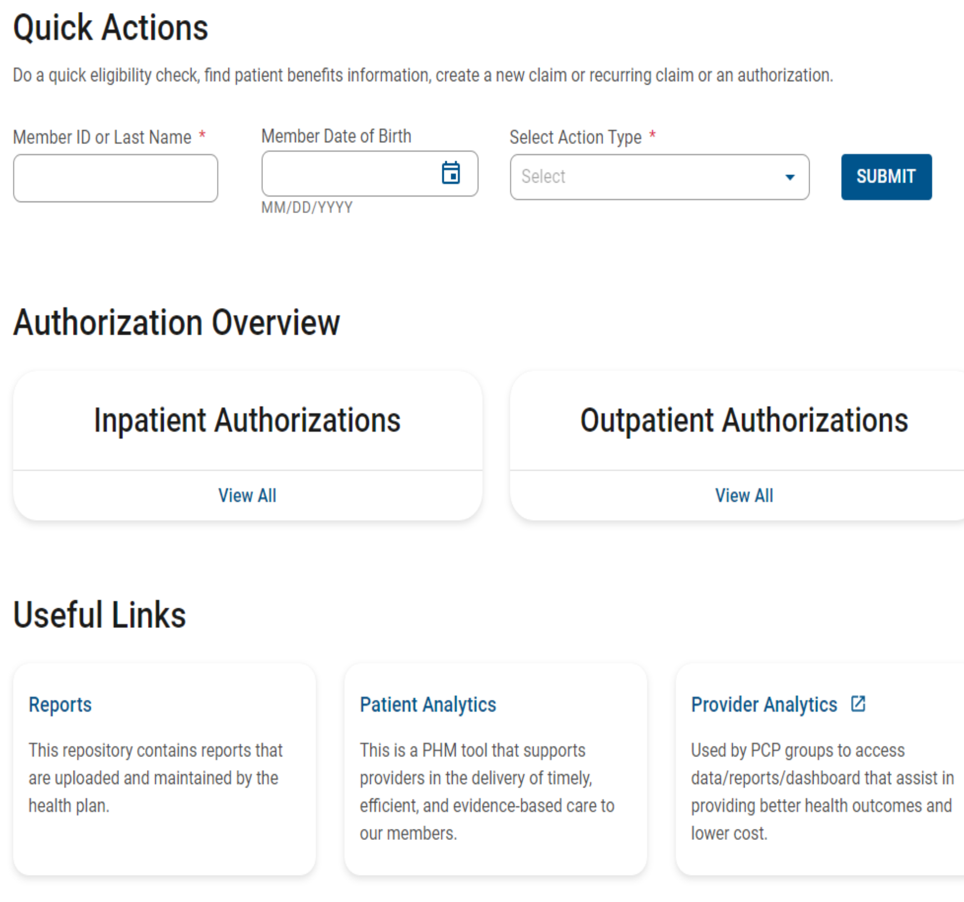


Create a login or sign into the [Online Portal] to get started.

Homepage - MHS (Medicaid)

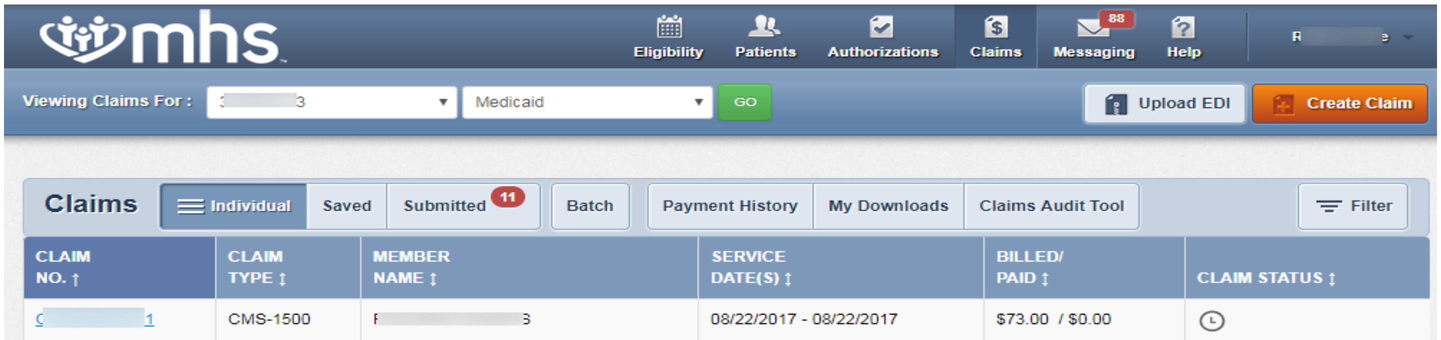
After logging into the portal this homepage will appear that allows providers to access information

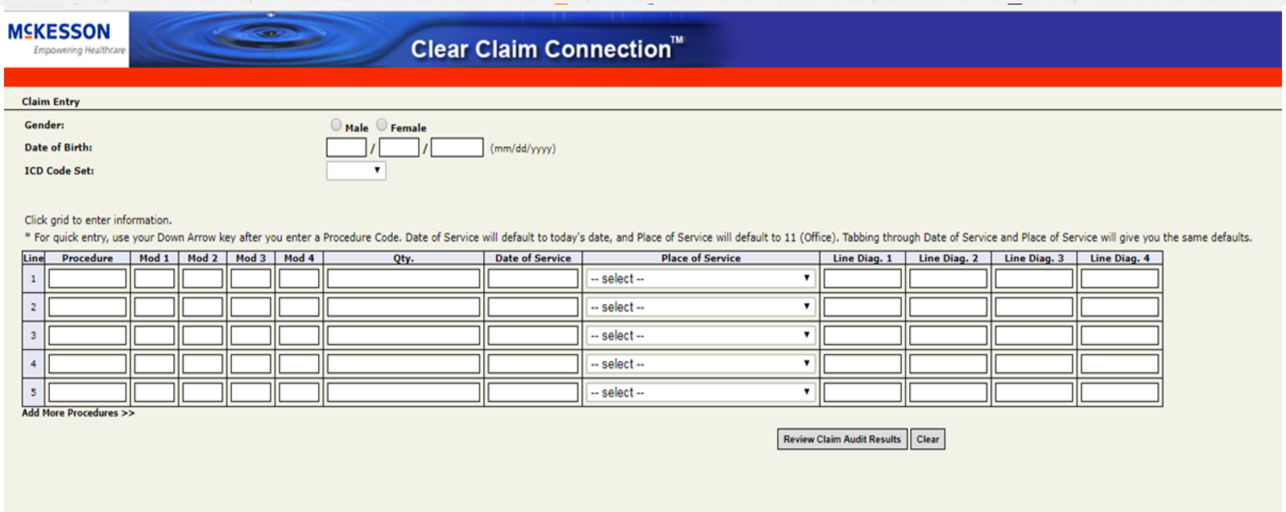




Claims Audit Tool

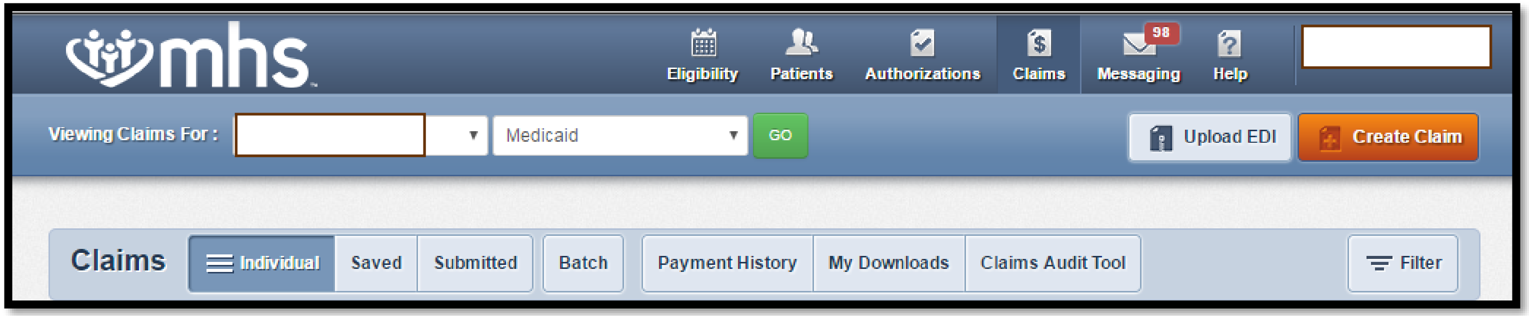
- The Clear Claim Connection screen appears, allowing you to enter the Procedure Code, Modifiers, Quantity, Date and Place of Service, and Diagnosis for a Claim proactively before you submit or retroactively after you submit. This tool helps to prescreen claims prior to submitting.

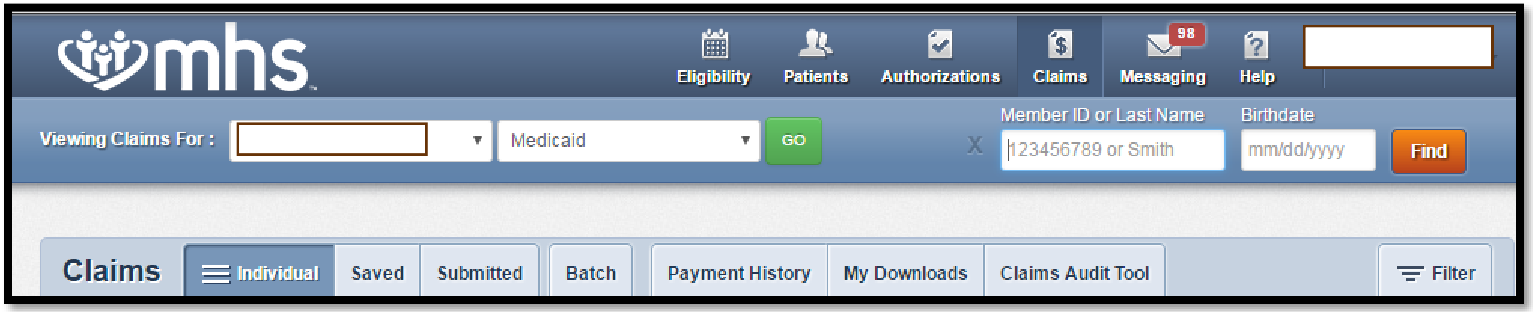




Claims

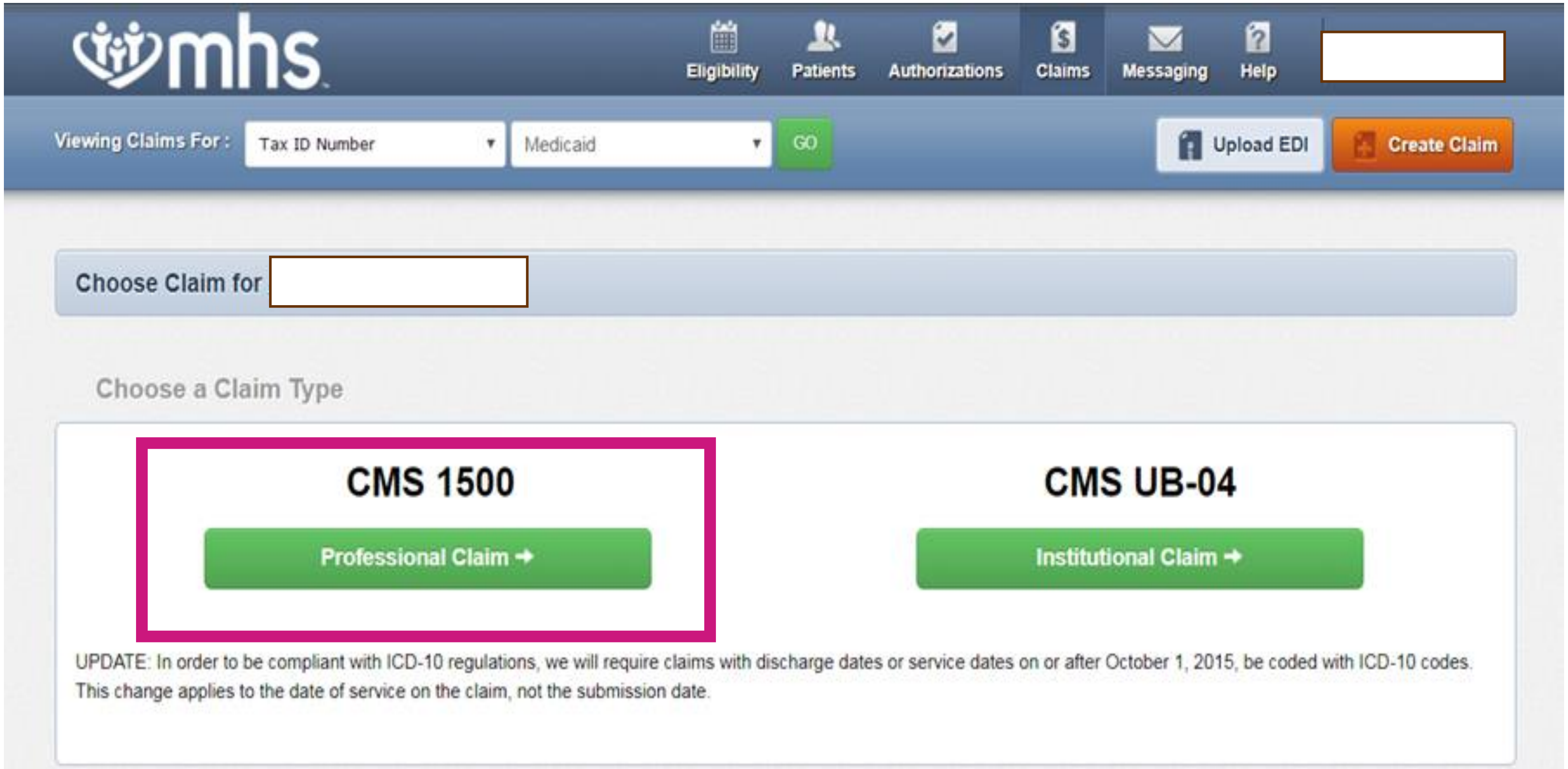
- **Web Portal Claims Functionalities:**
  - Submit new Claim.
  - Review Claims information on file for a patient.
  - View payment history
- **Submit a New Claim:**
  - Click **Create Claim** and enter **Member ID** and **Birthdate.**





Claims Submission

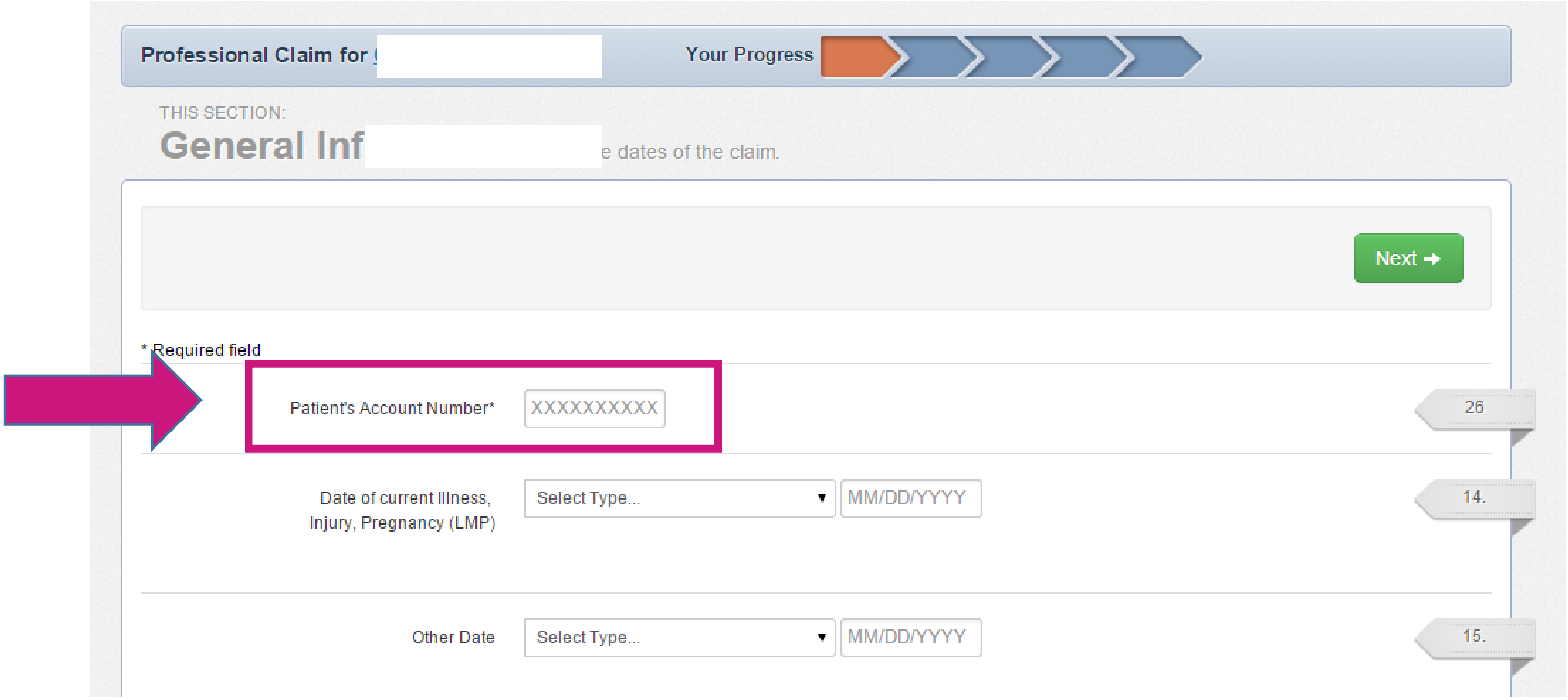
- Choose the **Claim Type.**
  - **Professional** or **Institutional** claim submission



Professional Billing

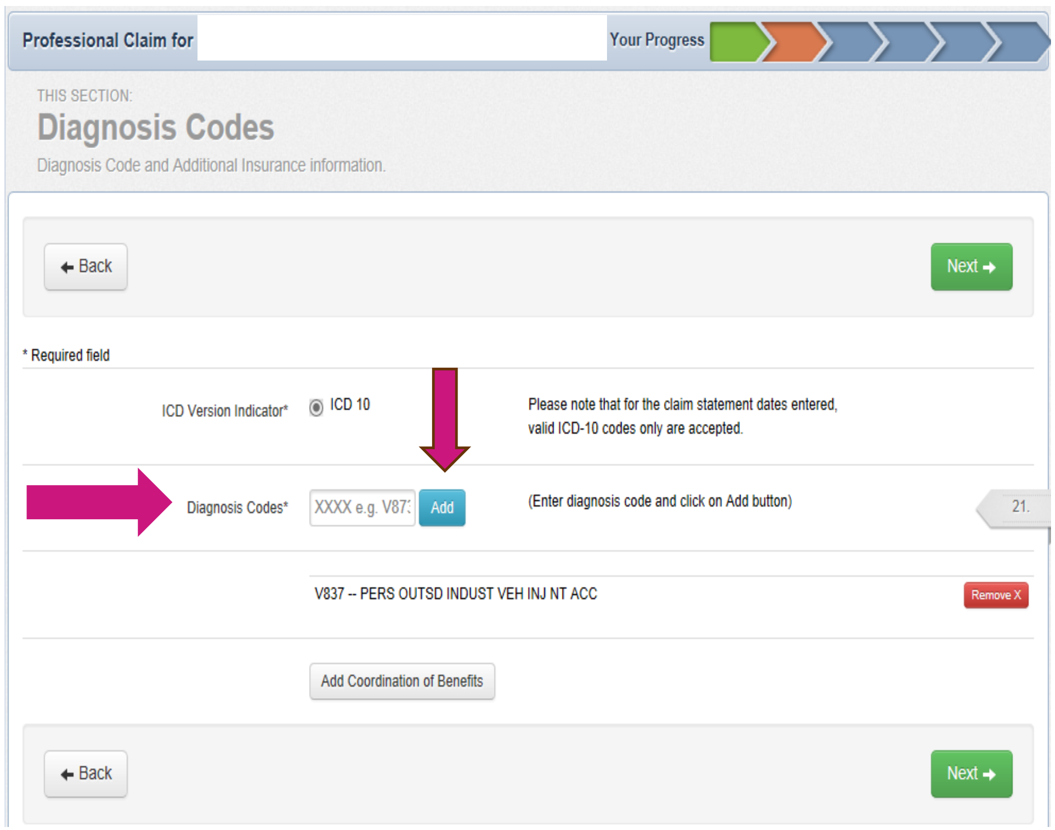
Professional Claims Submission

- 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**.



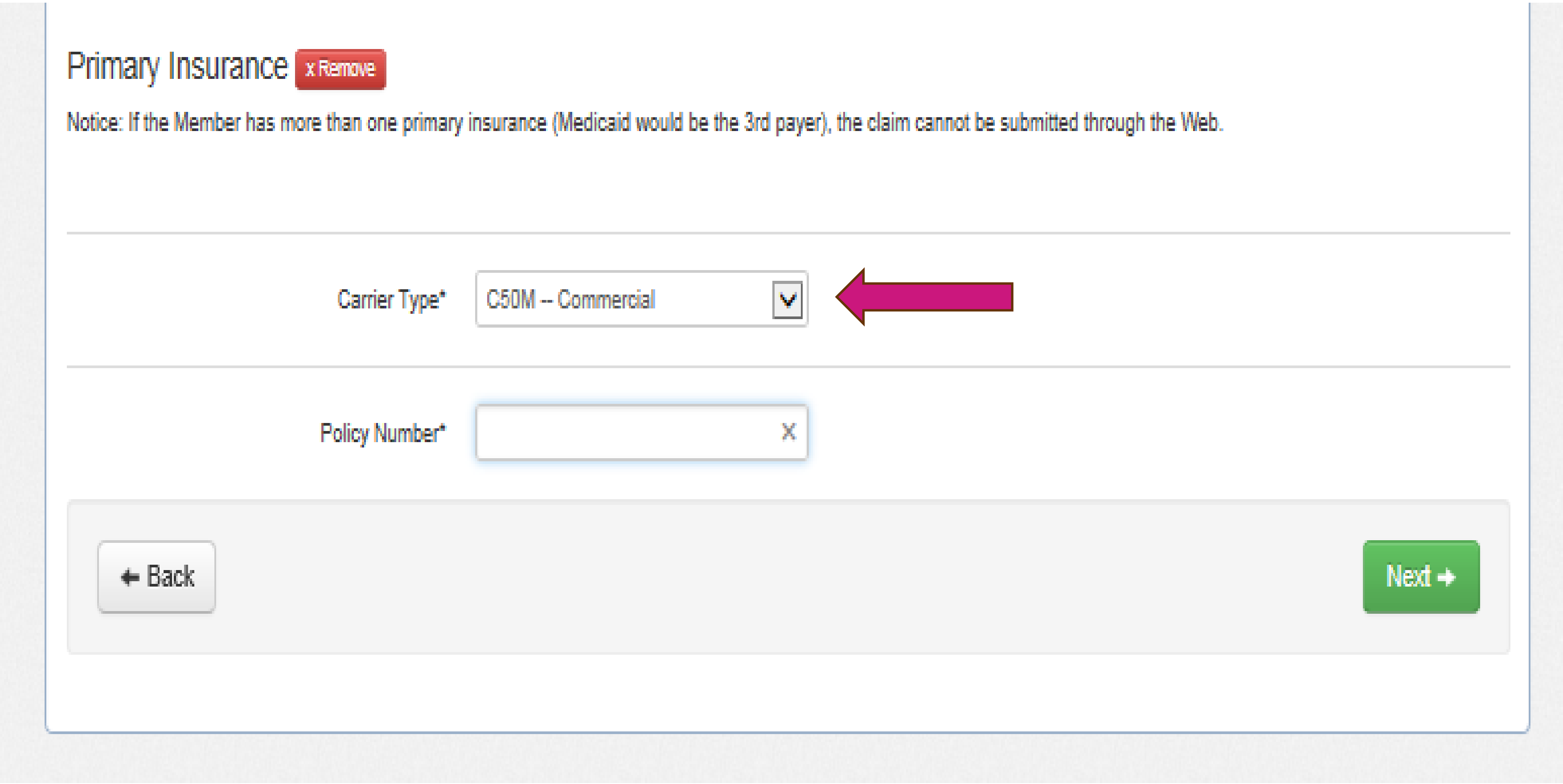
Professional Claims Submission Cont.

- 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.



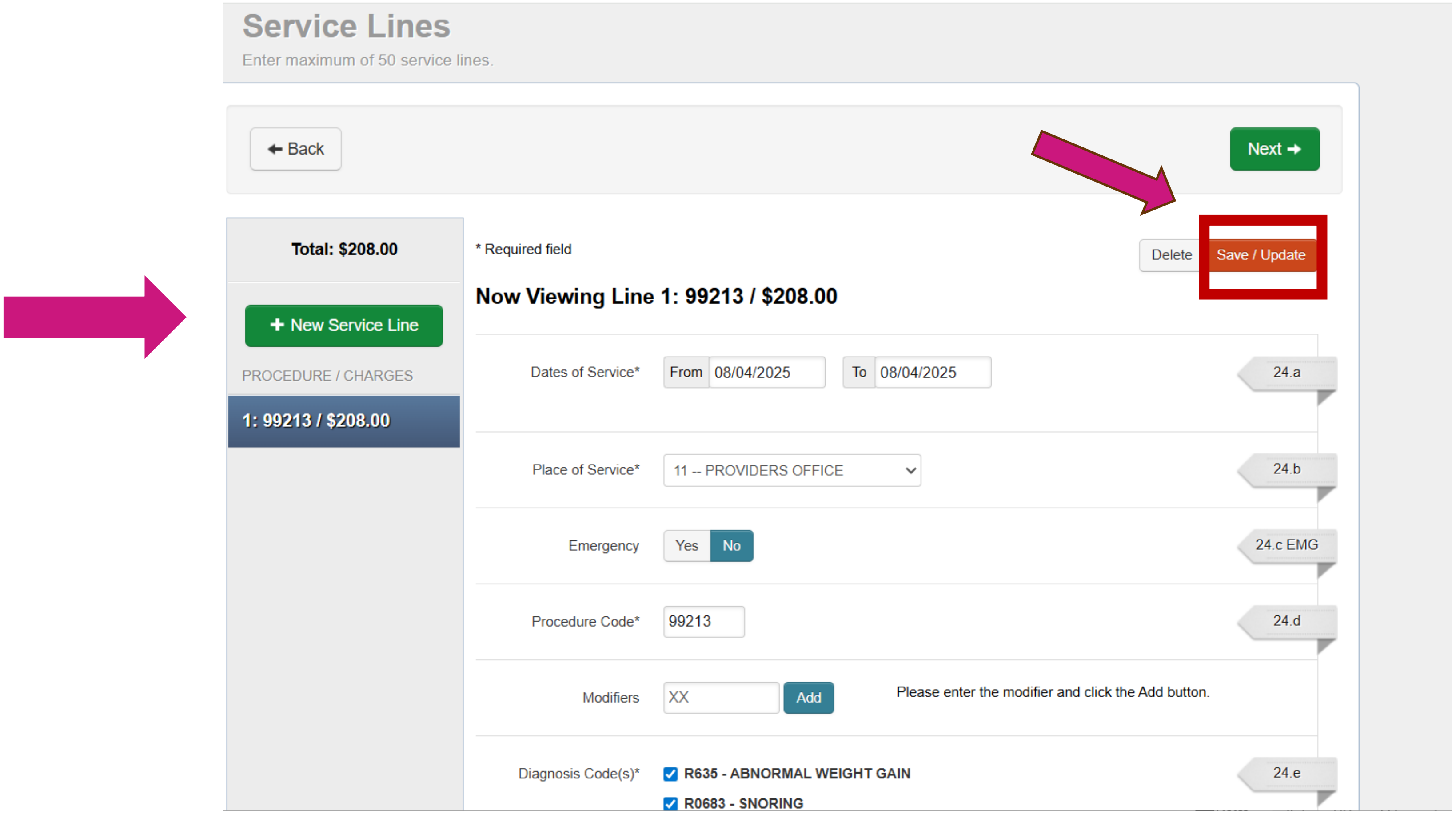
Professional Claims Submission Cont.

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



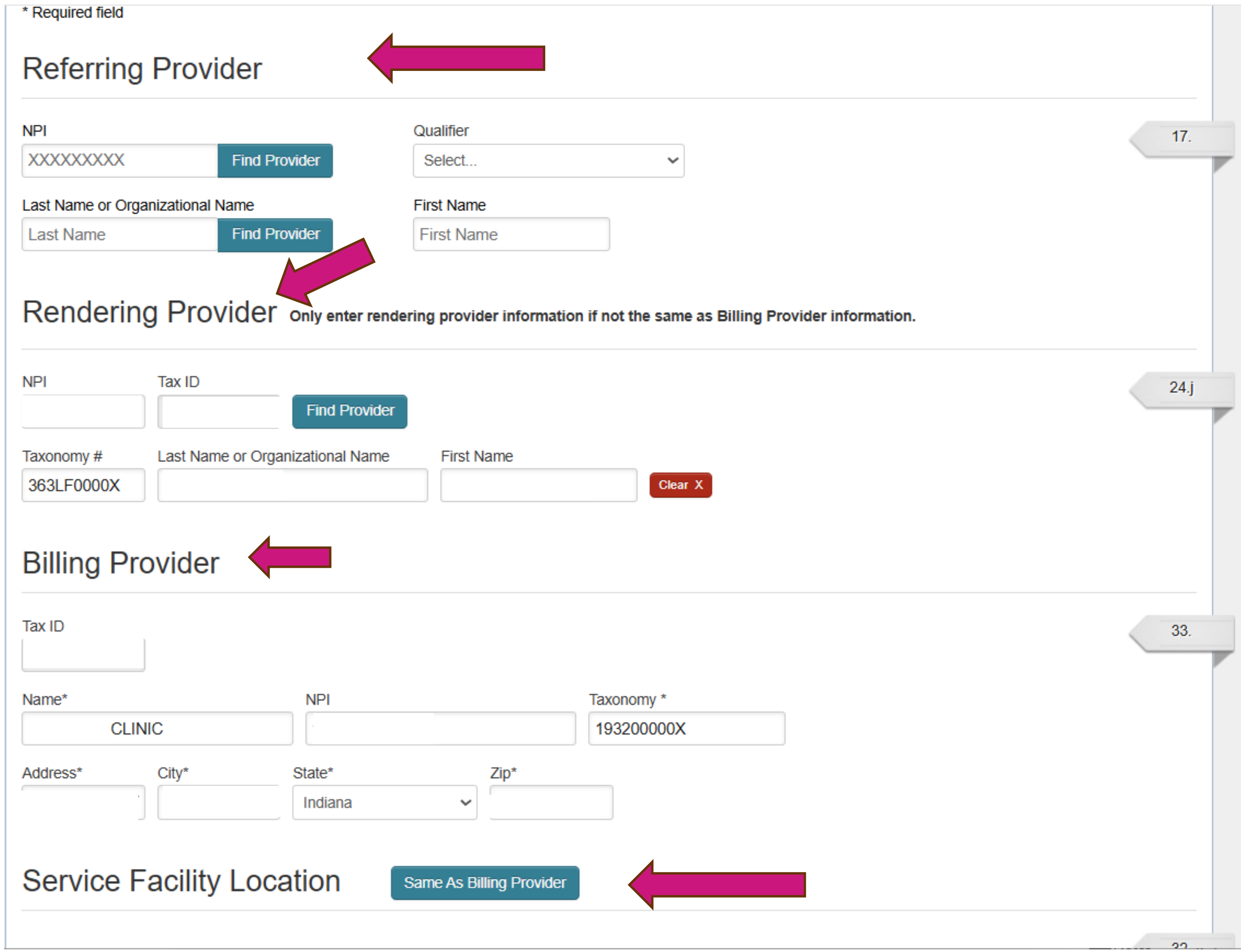
Professional Claims Submission Cont.

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



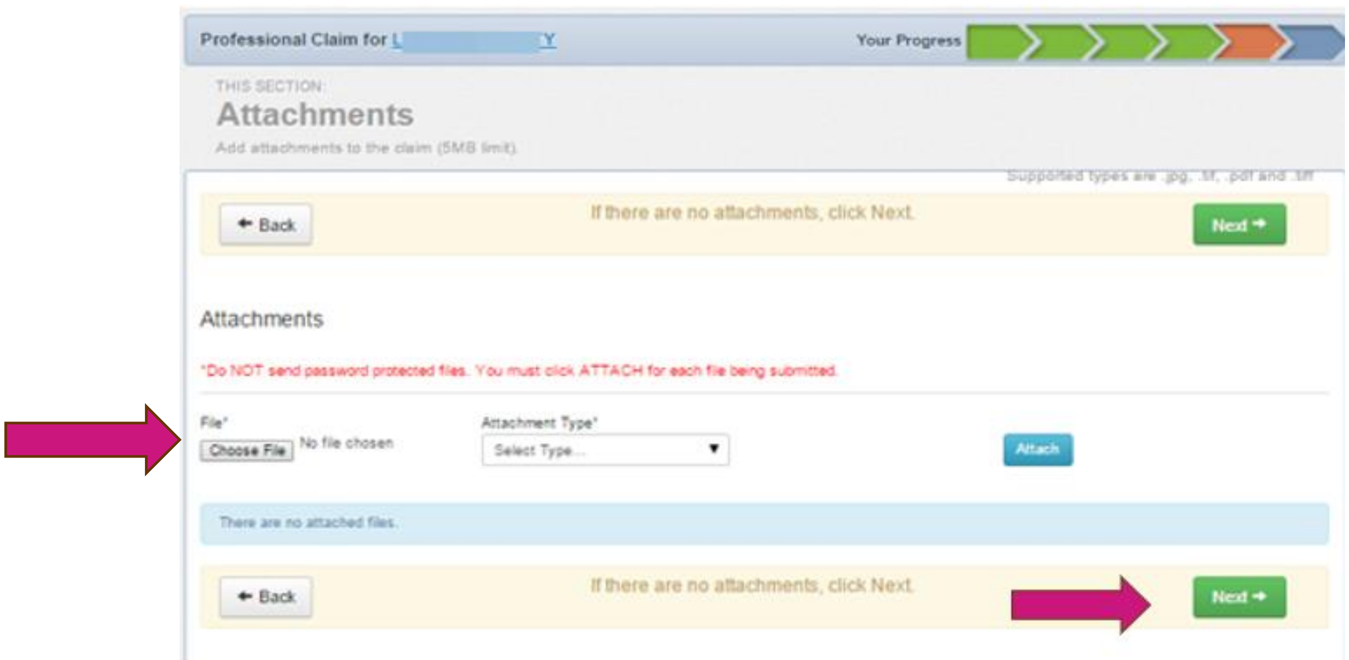
Professional Claims Submission Cont.

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

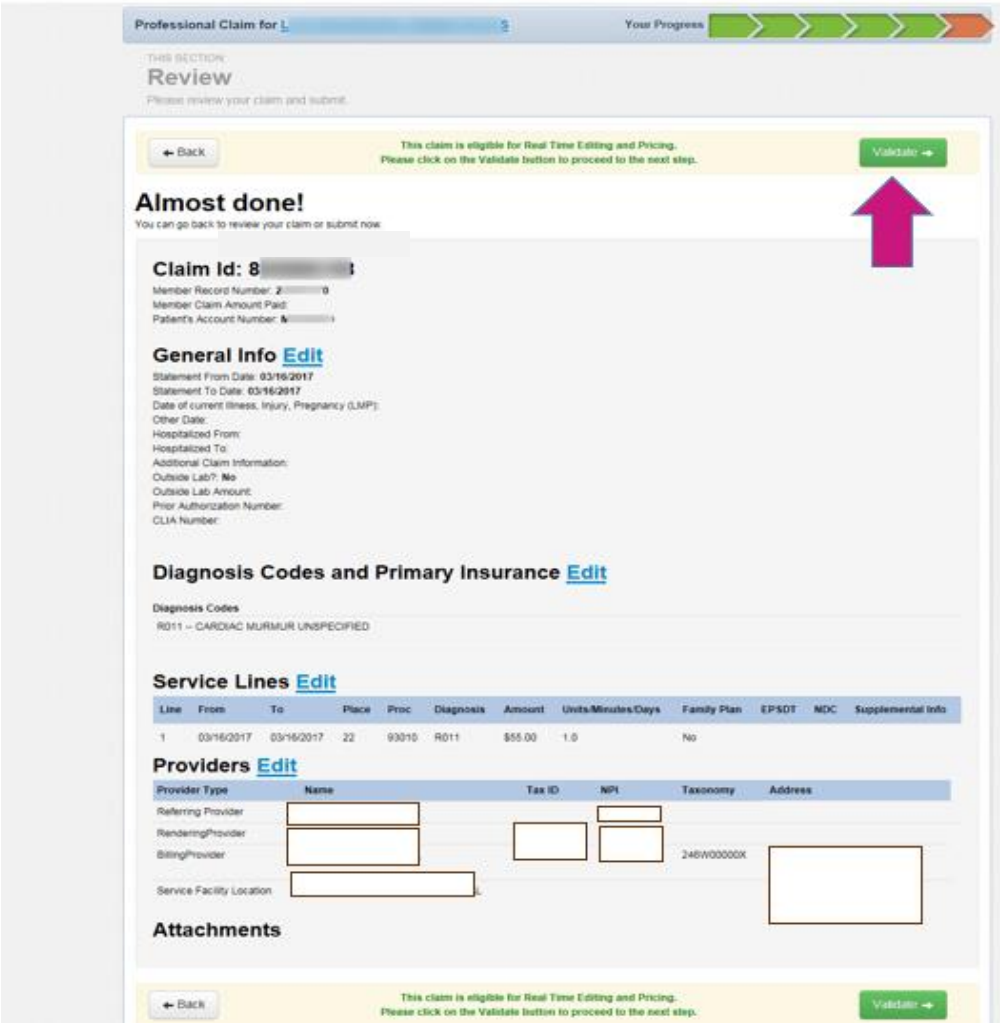


Professional Claims Submission Cont.

- 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**.



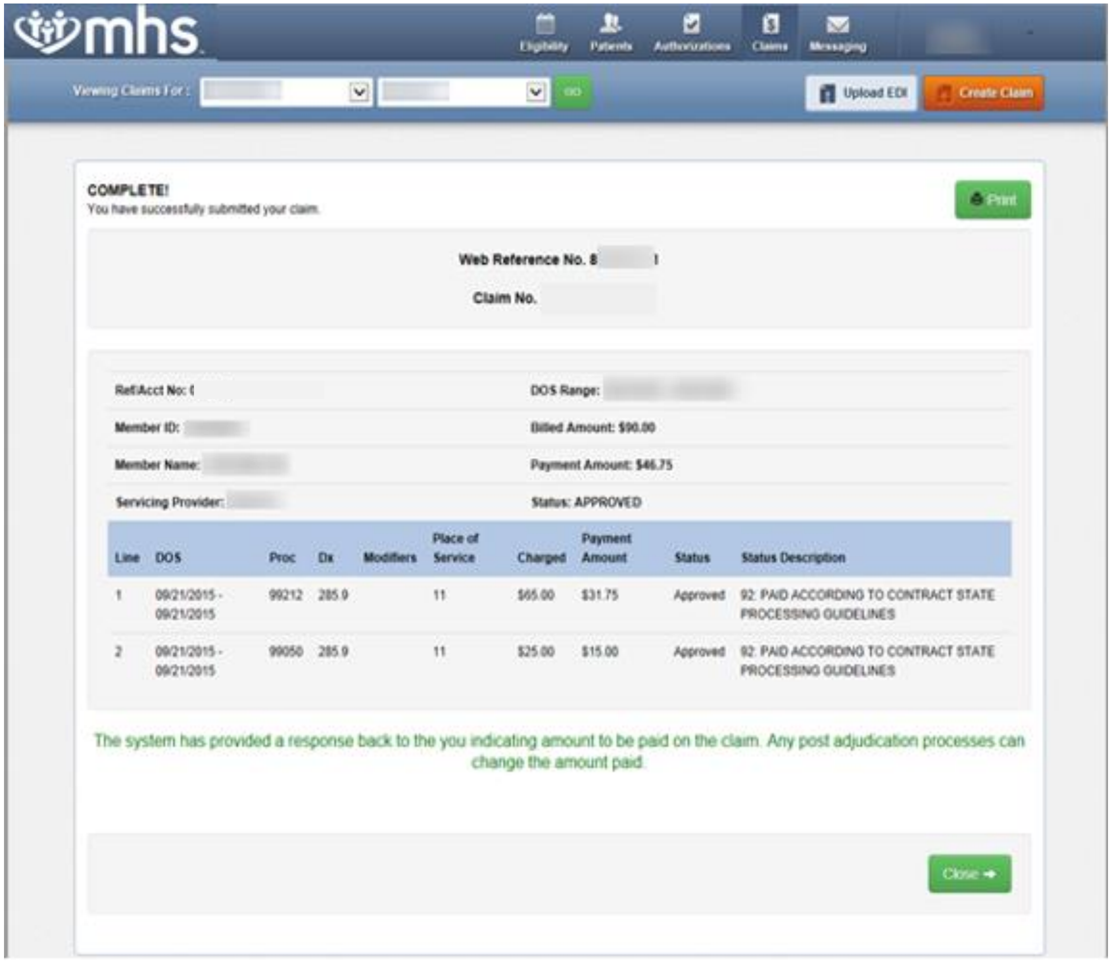
Professional Claims Submission Cont.



- 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



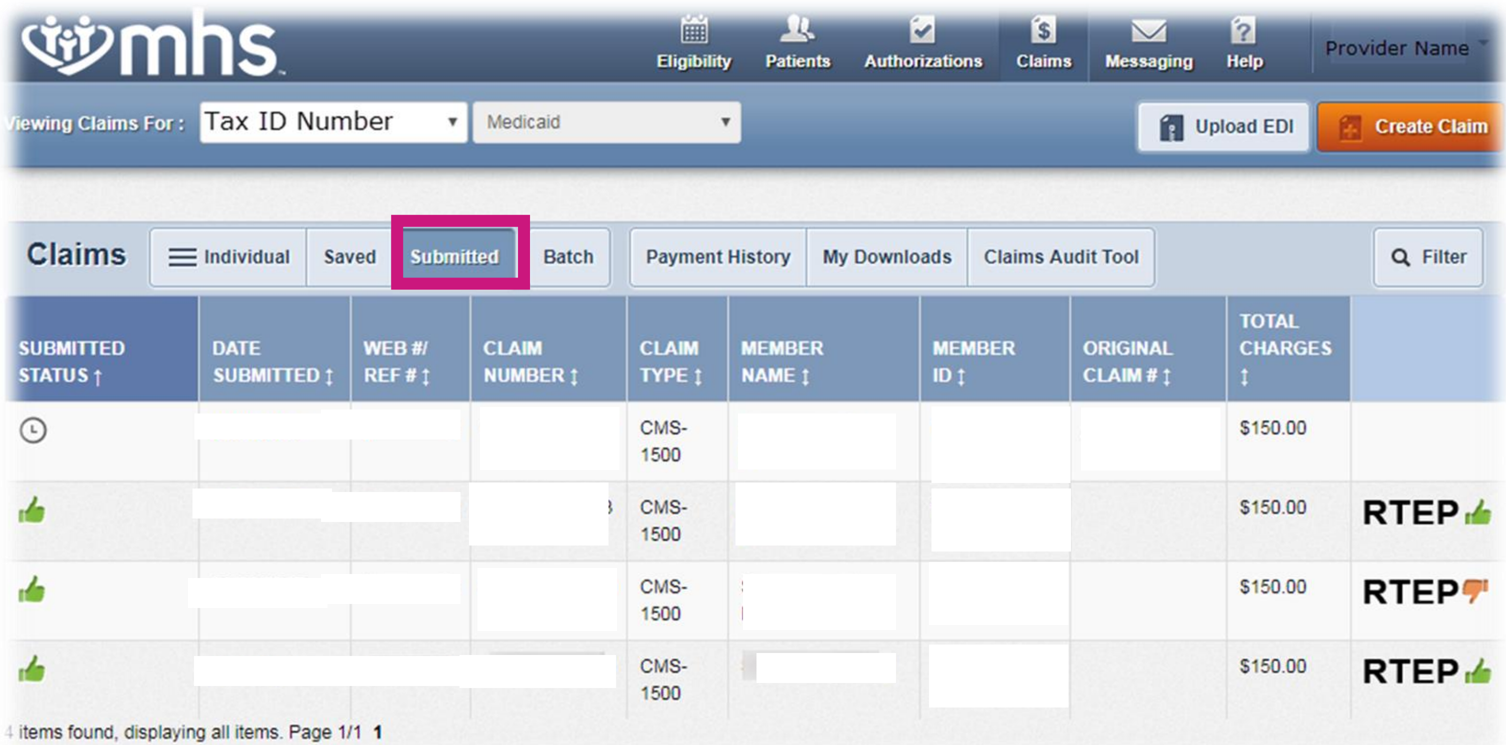
RTEP Overview:

- 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).

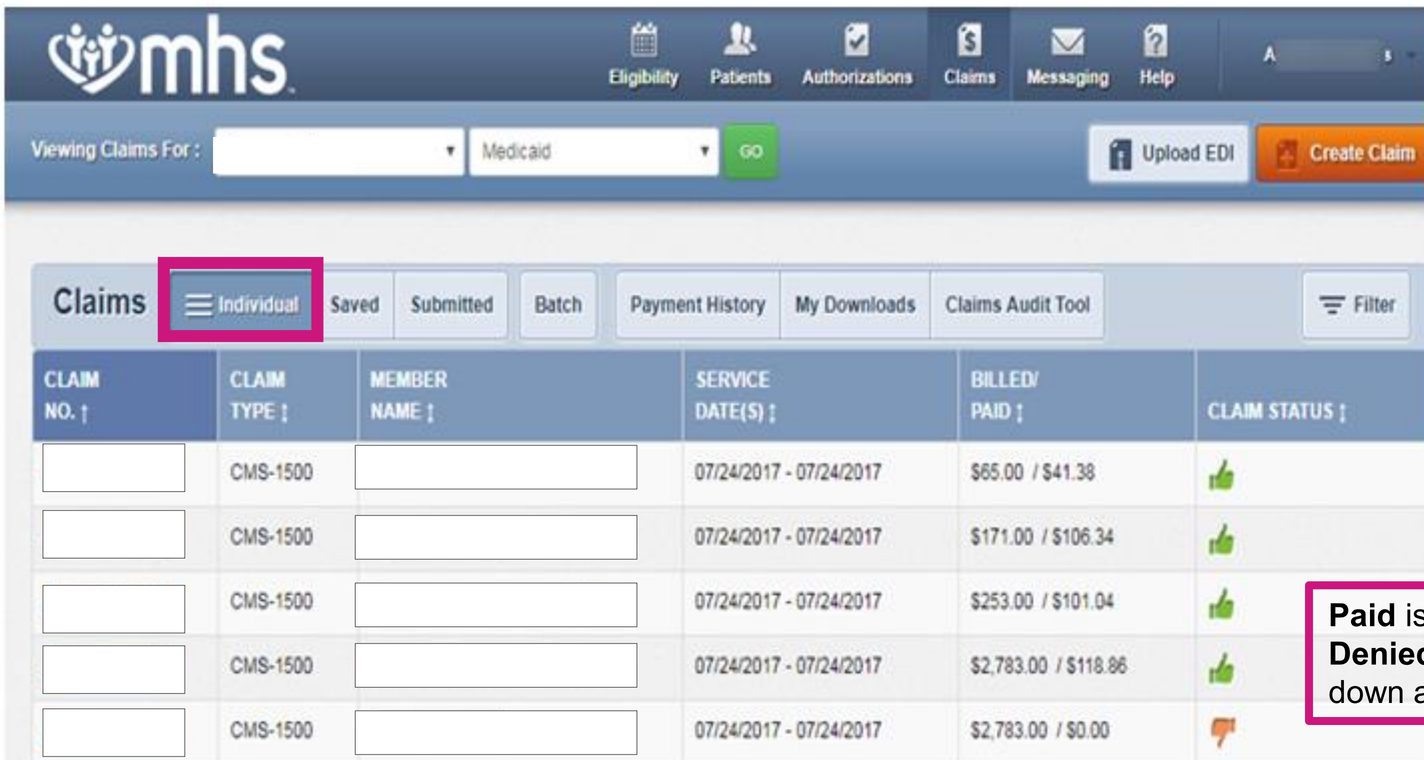


Paid is a green thumbs up, **Denied** is an orange thumbs down and a clock is **Pending.**

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.



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

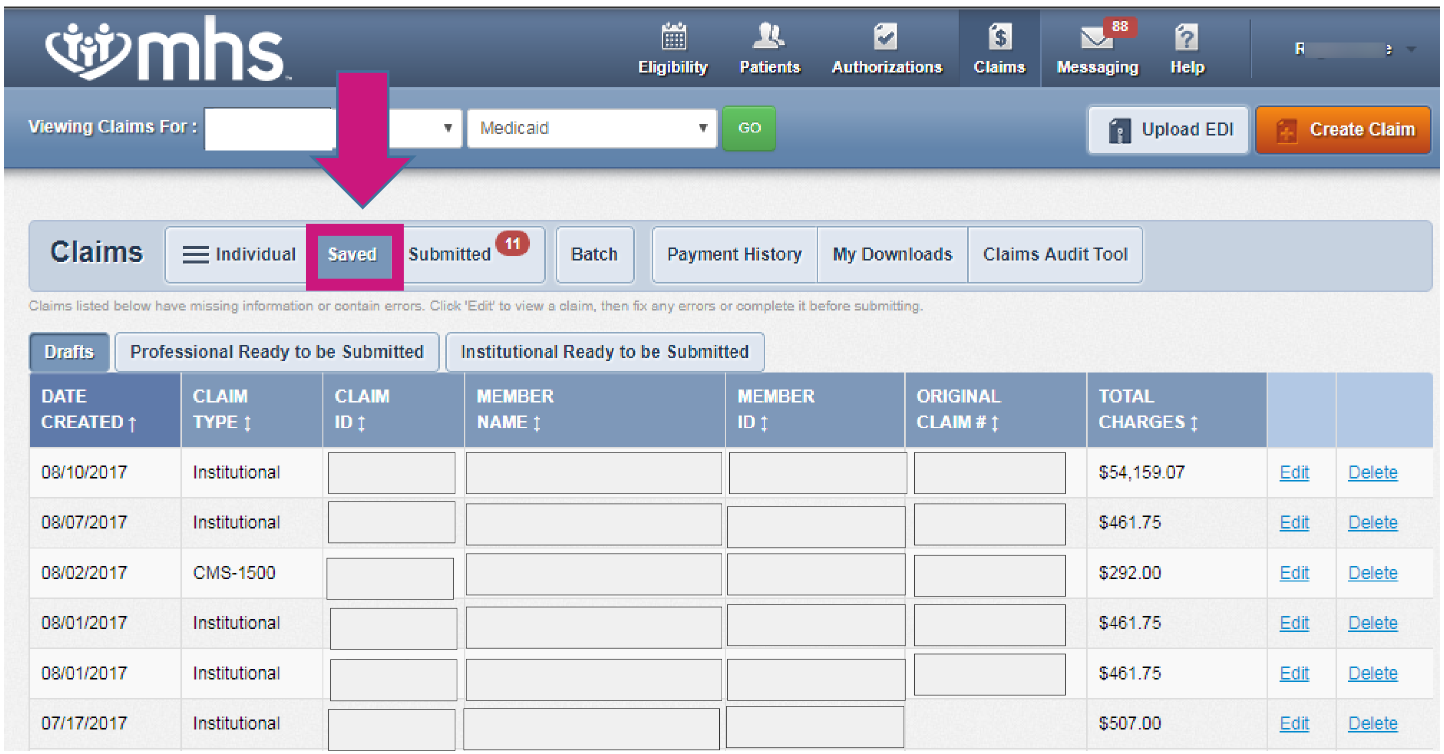
Saved Claims

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.

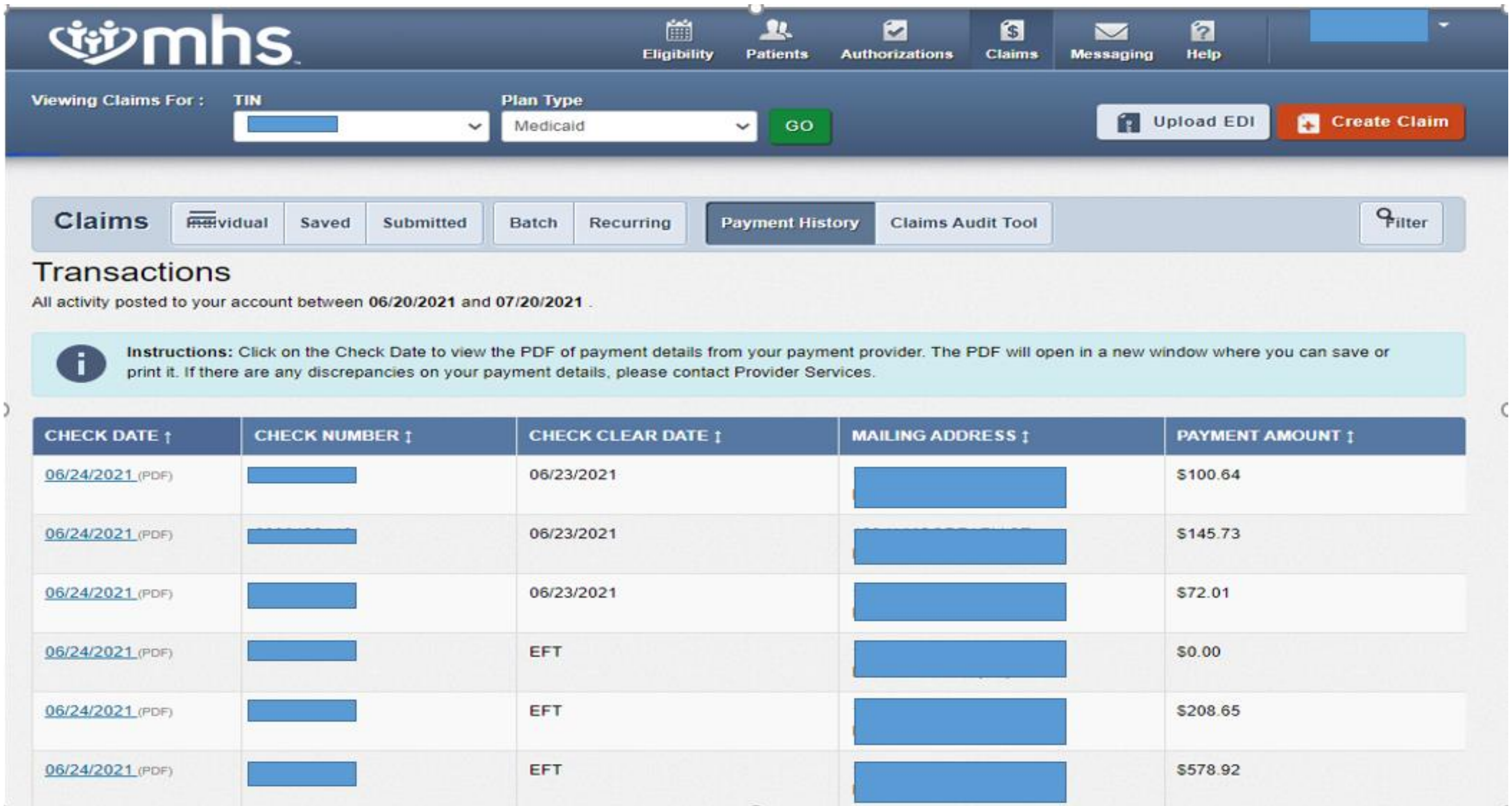
   Or

4. Click **Delete** to delete a saved Claim that is no longer necessary.
5. Click **OK** to confirm the deletion.



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]



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.

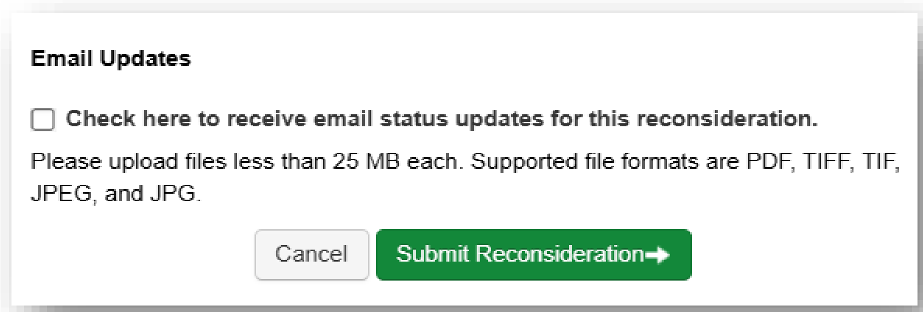
- Providers can submit informal Dispute/Reconsideration comments using expanded text fields.

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

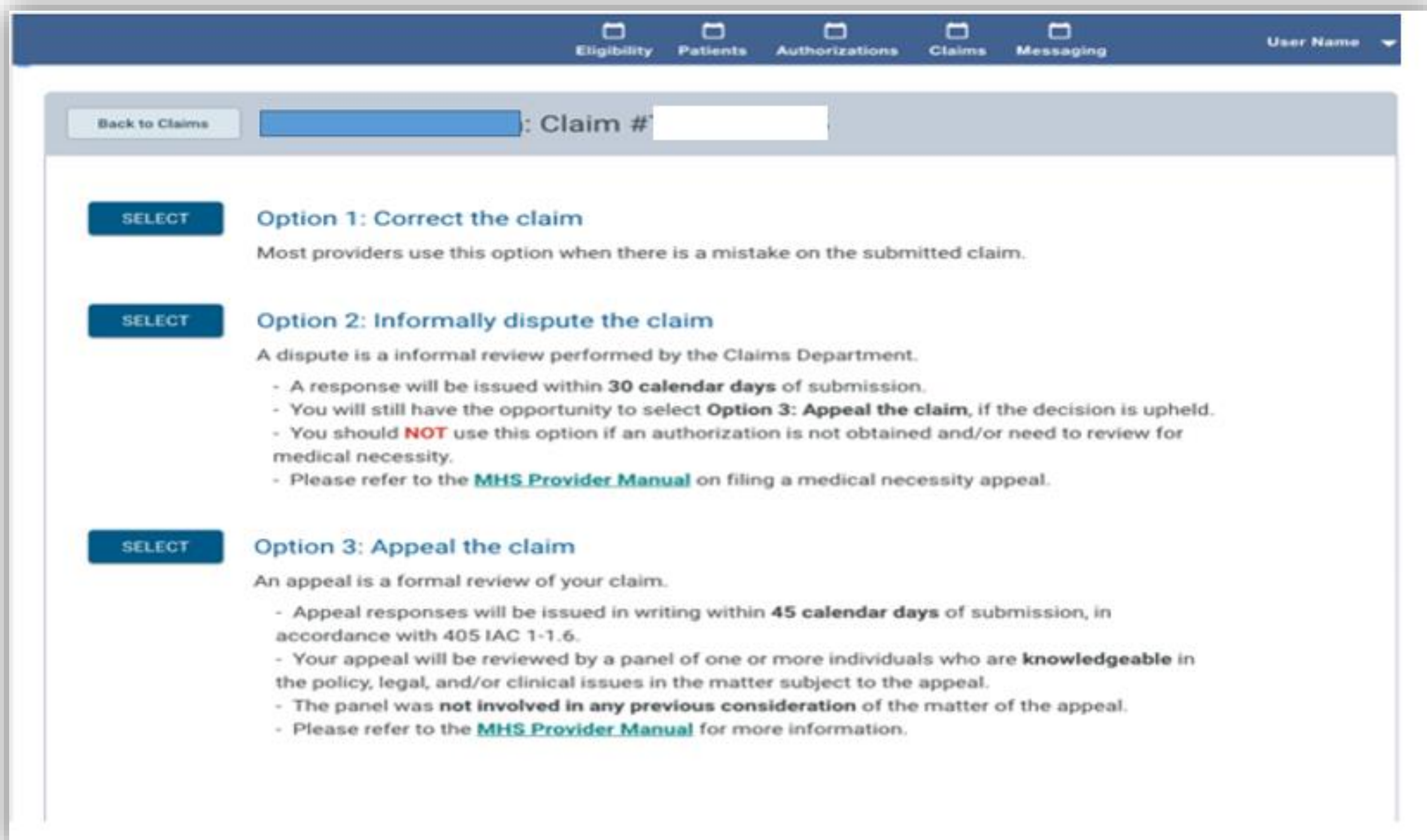
Paid Claim Amount:
$0.00

Check Dated:
08/13/2025

Service Lines

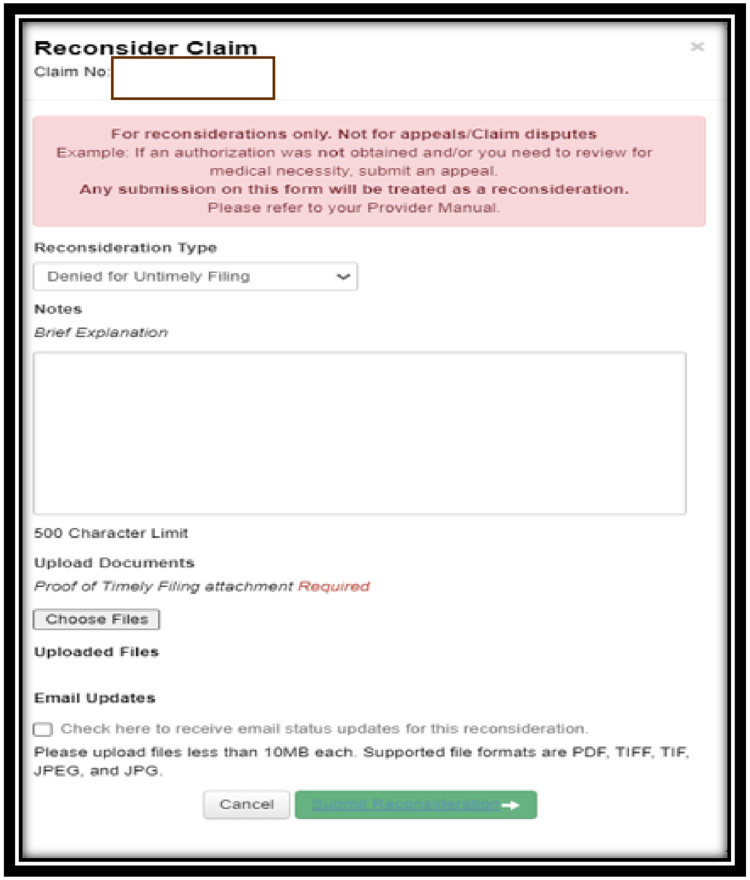
Line	DOS	Proc	Dx	Modifiers	Place of Service	Charged	Paid Amount	Payment Date	Status	Payment Codes

Level 1 Informal Claim Dispute on the Secure Provider Portal Options

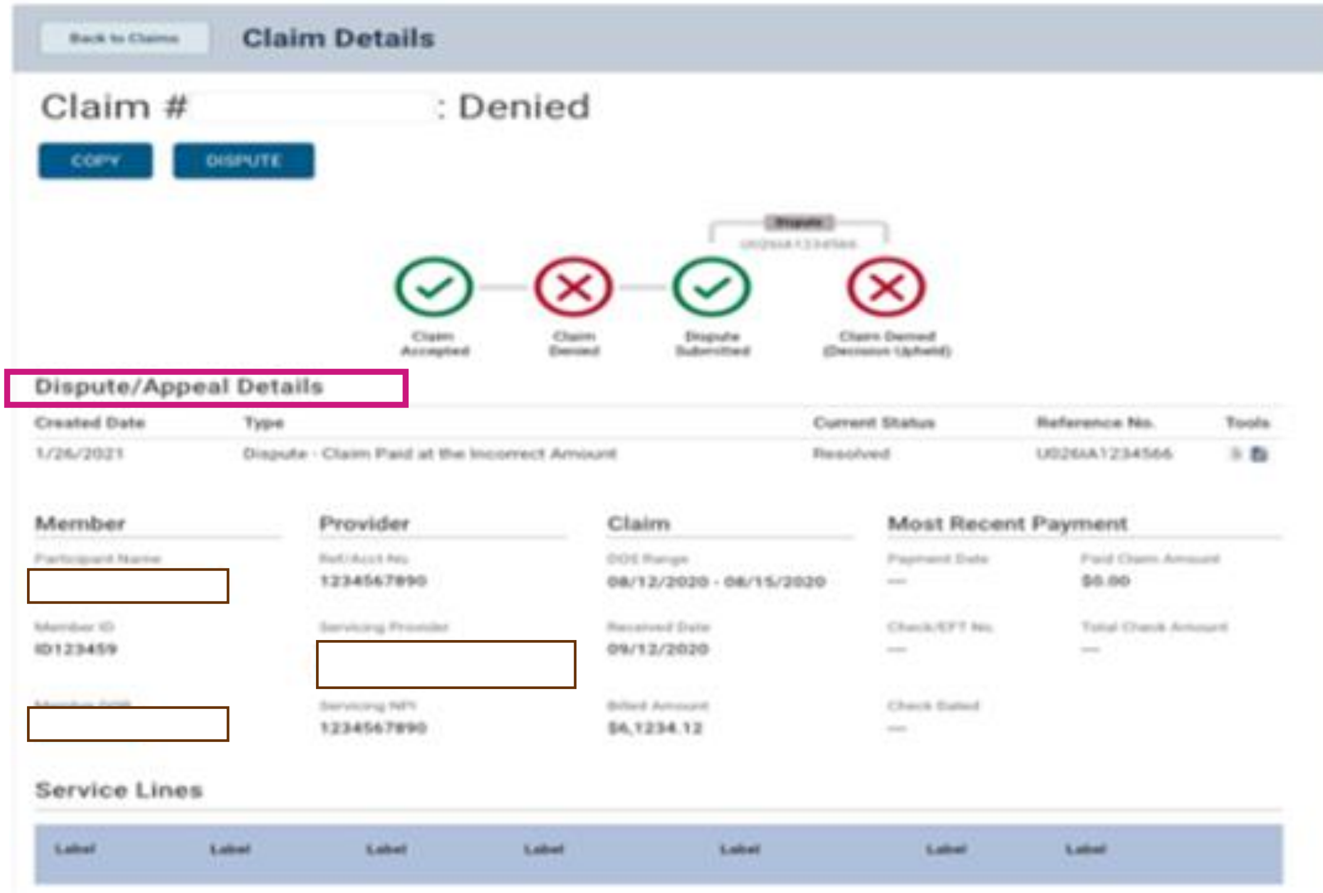


Claim Reconsideration

- Enter your explanation for reconsideration and check email updates.



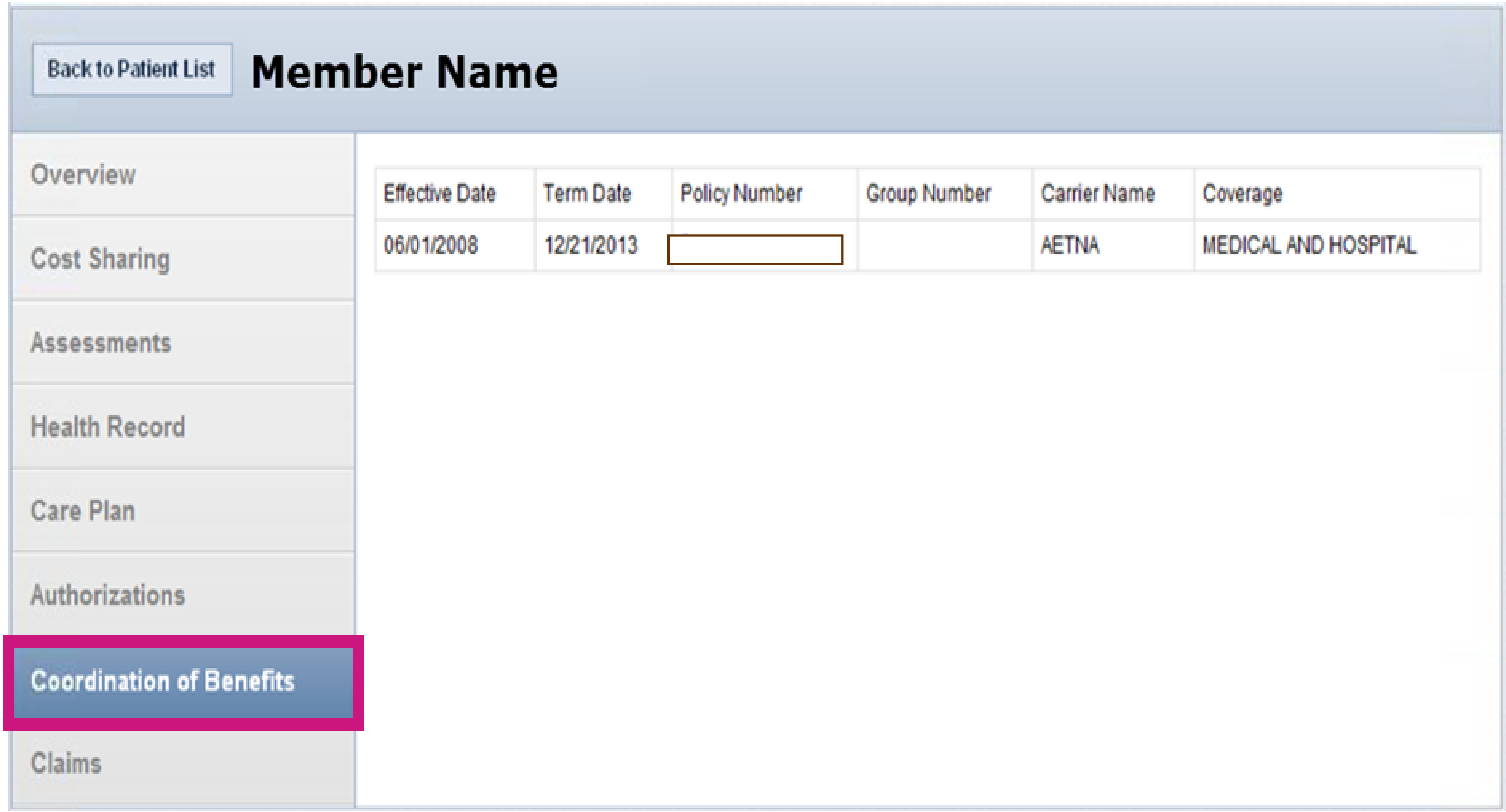
Level 2 Claim Appeals on the Secure Provider Portal



Coordination of Benefits

Coordination of Benefits

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



Prior Authorization

Prior Authorization Considerations

Learn More About Medicaid Prior Authorization

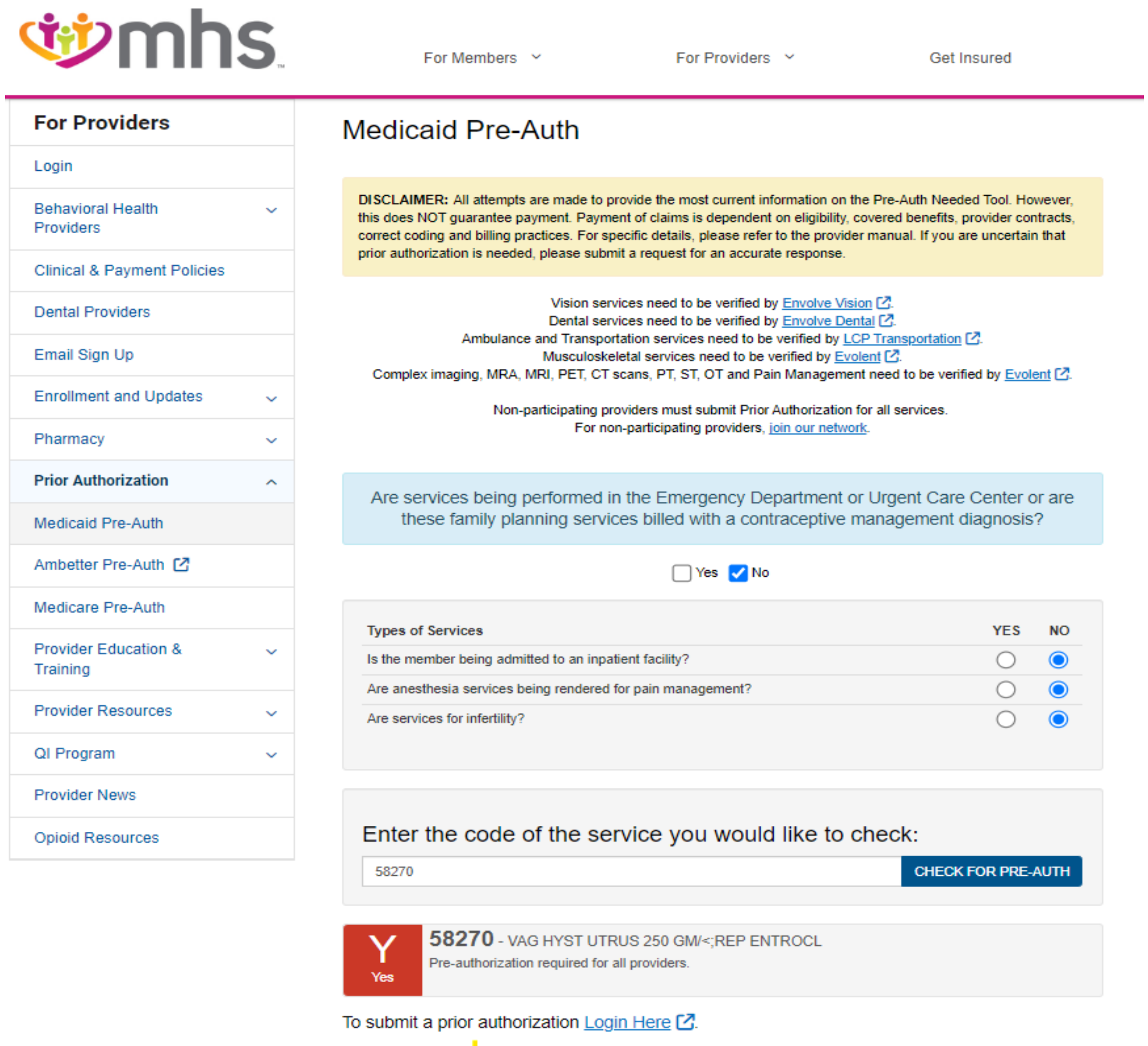
- **Pre-Authorization Tool.**

How to Obtain Authorization

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

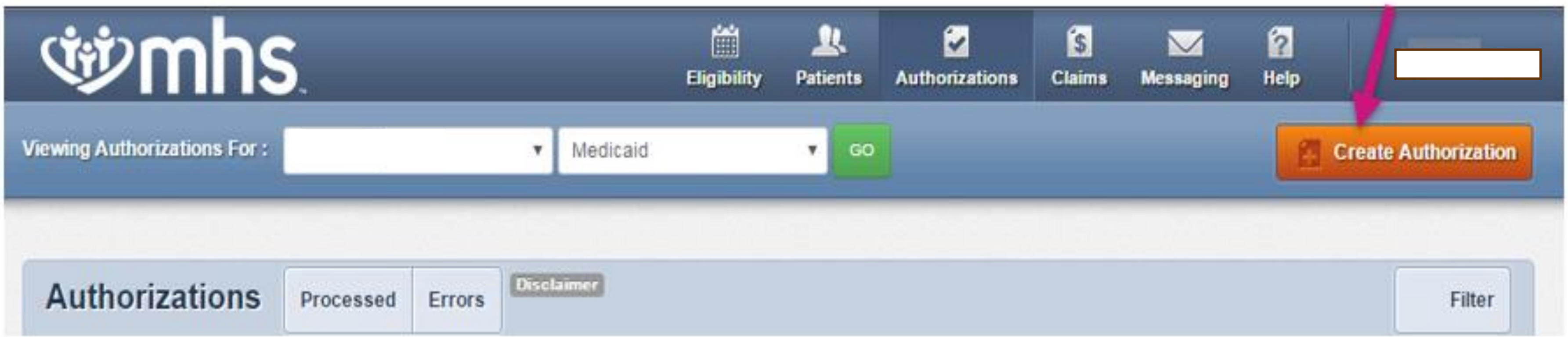
Authorizations do not guarantee payment.

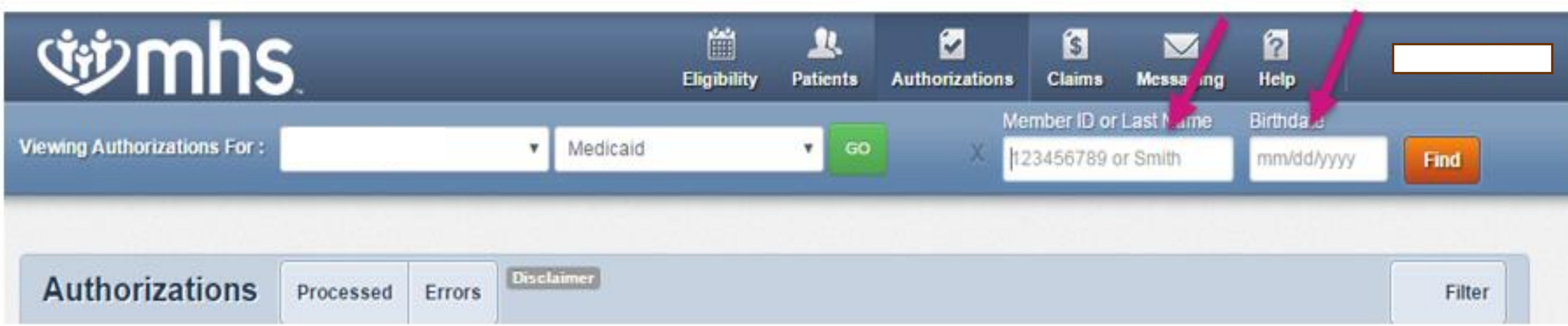
Prior Authorization



Creating a New Authorization

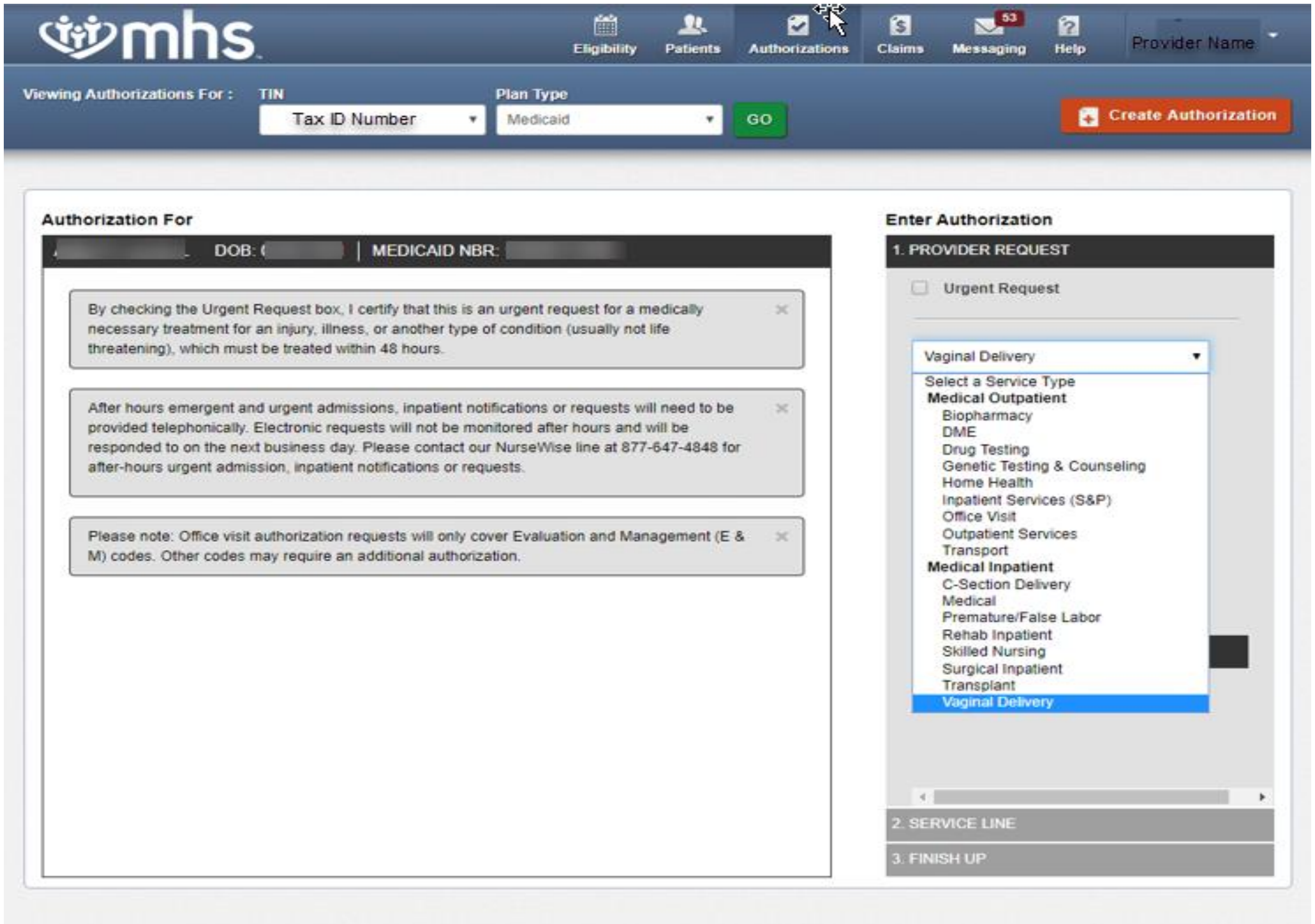
- Click **Create Authorization.**
- Enter **Member ID** or **Last Name** and **Birthdate.**





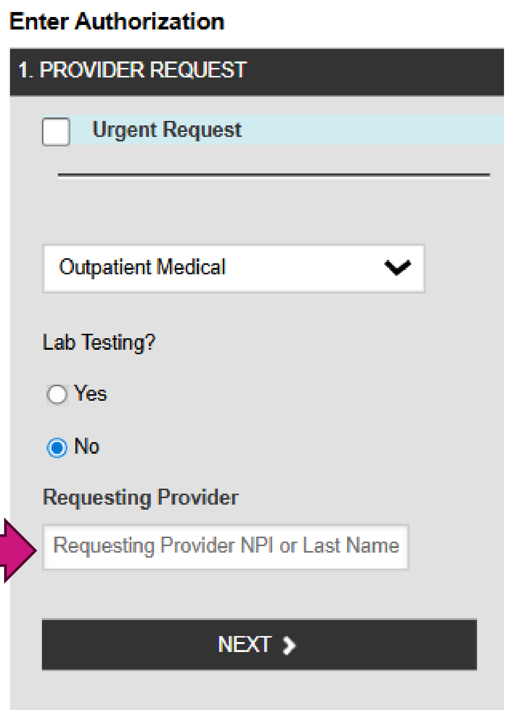
Creating a New Authorization- Service Type

- Select a Service Type.

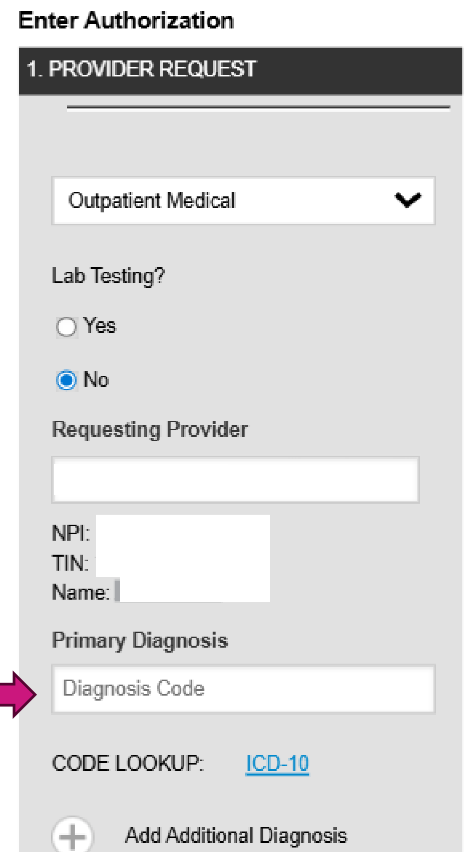


Creating a New Authorization

Select Provider NPI.

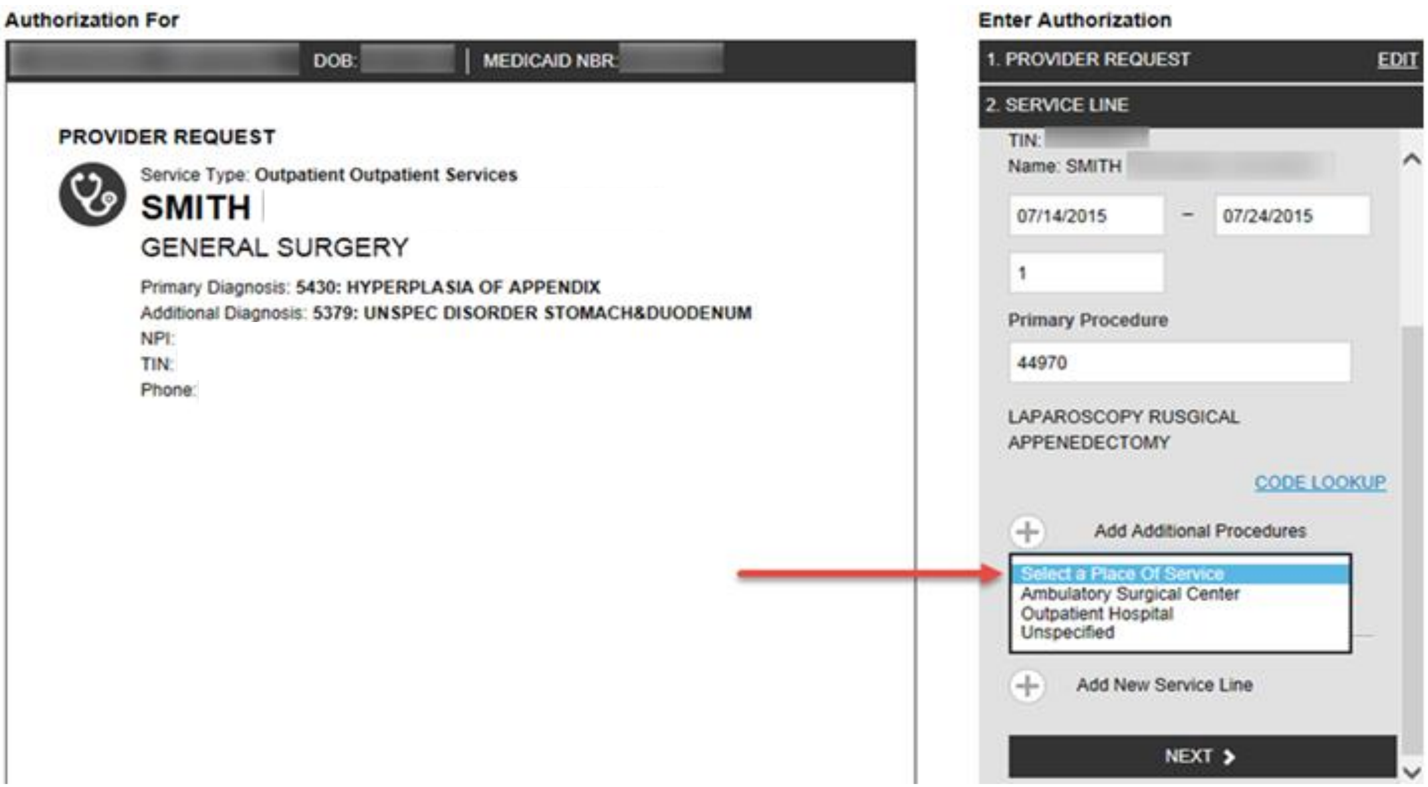


Add Primary Diagnosis.



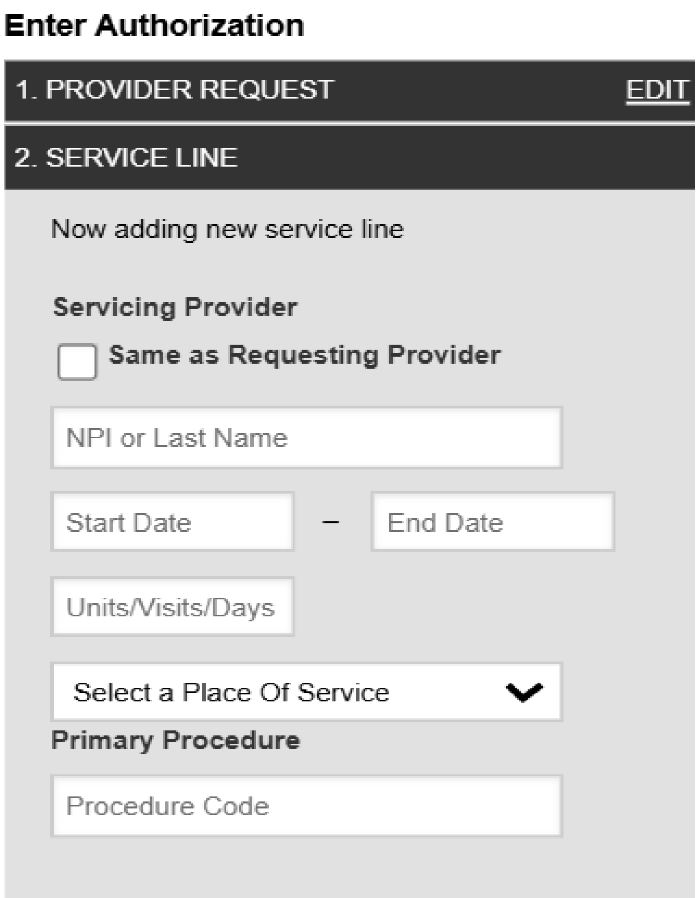
Creating a New Authorization - Procedures

Add Additional Procedures (if applicable).



Creating a New Authorization – Service Lines

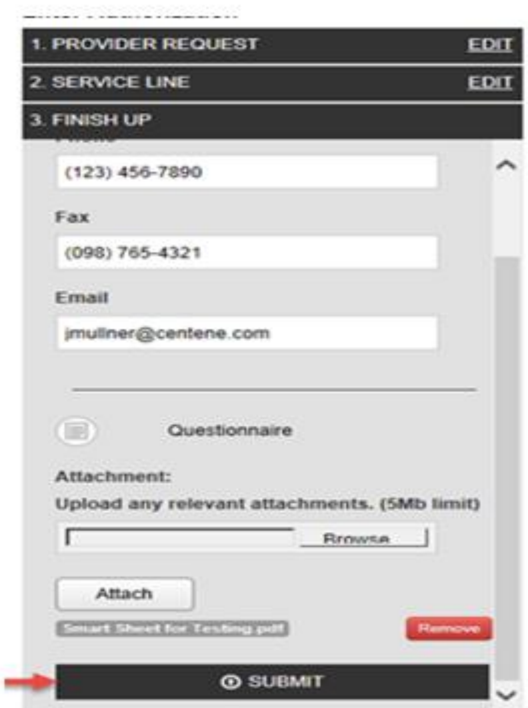
Service Line Details:



- 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**



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 GROUPS
Provider Engagement Account Manager	St. Vincent/Ascension
1-812-614-1003	Wellcare Complete
mona.green@mhsindiana.com	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

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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.J.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.

TQRCG

mhs

Questions?

Thank you for being our partner in care.