



UB-04: Mastering Claims Submission and Billing Best Practices

2025 Indiana Health Coverage Programs (IHCP) Annual Works Seminar

Agenda

- MHS Overview
- Claim Submission Process
- Claim Rejections
- MHS Provider Claims Issue Resolution Process
- Additional Claims Assistance
- MHS Secure Provider Portal Functionality
- Facility Billing
- Provider Portal Claim and Payment Review
- Online Claim Reconsiderations on the MHS Secure Provider Portal
- Prior Authorization
- MHS Provider Engagement
- 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 Claim Submission

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

- **Electronic Submission:**

- Payer ID **68068**.
- MHS accepts Third Party Liability (TPL) information via Electronic Data Interchange (EDI).
- It is the responsibility of the provider to review the error reports received from the clearinghouse (Payer Reject Report).

- **Online through the MHS Secure 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

Claim Billing with Ease

Tips to help you bill with ease

- The National Provider Identifier (NPI), Taxonomy Code, and Zip +4 is necessary for the system to make a one-to-one match based on the information provided on the claim and the information on file with Indiana Medicaid.
- Secondary Claims Third Party Liability (TPL):
 - Accepted electronically from vendors or via the **MHS Secure Portal**

Claim Submission

In-Network providers: 90 calendar days from the date of service or discharge date.

Out-of-Network providers: 180 calendar days from the date of service or discharge date.

Exceptions:

- Newborns (30 days of life or less) – Claims must be received within 365 calendar days from the date of service. Claim must be filed with the newborn's Medicaid Identification number.
- TPL – Claims with primary insurance must be received within 365 calendar days of the date of service with a copy of the primary Explanation of Payment (EOP).
 - If the EOP is received after the 365 calendars days, providers have 60 days from date of primary EOP to file claim to MHS. If the third party does not respond within 90 calendar days, claims may be submitted to MHS for consideration. Claims submitted must be accompanied by proof of filing with the patient's primary.

Claim Submission and Acceptance

Claim Acceptance and Adjudication

- System reviews claim for errors and critical fields (i.e., dates of service, billing/rendering provider, etc.) prior to acceptance.
- Regulatory requirements (federal and state) mandate certain information to be present to accept and pay a claim.
- Common rejection/denial; provider information on claim must match record at Indiana Health Coverage Programs (IHCP) enrollment – a state requirement.

Paper Claim Correction

A corrected claim can be submitted following IHCP claim adjustment processes.

- Corrections should be submitted with the correct resubmission code in the 3rd digit of the bill type located in box 4. (Corrected claim will be 7.)
- The original claim number must also be listed in box 64 on the corrected claim.
- A rejection must be submitted as a 1st time claim, not as a corrected claim.
- Handwriting or stamping on a claim will not be accepted as submission of a corrected claim, and will be rejected with code RE.

Claim Rejections

Claim Rejections

- A rejected claim contains invalid, or missing data elements requires for acceptance of the claim in the claim processing system.
- Rejected claims need corrected and submitted as a first-time new claim.
- Timely filing is not substantiated when a claim is rejected.

Claims EDI Rejections

- EDI rejections require the provider to contact their clearinghouse and obtain a Payer Rejection Report.
- MHS website tools :
 - **MHS Resources**
 - Refer to Rejection Code Help Aid.
 - Scroll down to Claims/Billing:
 - Top 10 Rejections Codes Help AID.
 - Reject Reason Codes and Descriptions..
 - Paper to electronic mapping.

Reason for Claim Rejections

Medical

07 Invalid Subscriber/Member ID
09 Member Invalid on Date of Service
01 Invalid Provider ID Billing Physician
08 Invalid Member Date of Birth
76 Original Claim Number Required
40 Diagnosis Code Is Missing
90 Invalid or Missing Modifier
B5 Missing/Incomplete/Invalid Clinical
77 Invalid Claim Type
A3 Claim Exceeded the Maximum 97 line

Behavioral Health

09 Member Invalid on Date of Service
07 Invalid Subscriber/Member ID
08 Invalid Member Date of Birth
01 Invalid Provider ID Billing Physician
76 Original Claim Number Required
40 Diagnosis Code Is Missing
31 Invalid Service Procedure Code
A3 Claim Exceeded the Maximum 97line

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 – Medical and Behavioral Health

Medical Claims Address:

Managed Health Services
P.O. Box 3000
Attn: Appeals Department
Farmington, MO 63640-3800

Behavioral Health Claims Address:

Managed Health Services BH Appeals
P.O. Box 6000
Attn: Appeals Department
Farmington, MO 63640-3809

Informal Claims Dispute or Objection Form

Level 1:

- Submit all documentation supporting your objection.
 - Copies of any subsequent MHS EOPs or other determinations on the claim(s) in question.
 - Documentation of any previous attempt you have made to resolve the issue with MHS.
 - Other documentation that supports your request for reprocessing or reconsideration of the claim(s).
- Must be submitted via the MHS Secure Provider Portal or in writing within **60 calendar days** of receipt of the MHS Explanation of Payment by using the Medical Claim Dispute/Appeal Form.
 - Requests received after day 60 will not be considered.

Informal Claims Dispute or Objection Form

Level 1:

- MHS will make all reasonable efforts to review your documentation and respond to you within **30 calendar days**.
- At that time (or upon receipt of our response if sooner), you will have up to **60 calendar days** from date of dispute response to initiate a Formal Claim Appeal (Level 2).

Informal Claims Dispute and Helpful Tips

Level 1: Helpful Tips

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

- After the Informal Claims Dispute (Level 1) has been submitted, for assistance or questions, the provider can access the Provider Service Phone Line or Provider Portal. The inquiries will be logged and assigned a ticket number. Please keep this ticket number for your reference.
- Phone: 1-877-647-4848; Provider Services 8:00 a.m. to 8:00 p.m. EST.
- Provider Web Portal: [MHS Secure Portal](#)
 - Use the Messaging Tool.

Provider Services Phone Requests & Provider Portal Inquiries Helpful Tips

Helpful Tips:

Disputing multiple Claim Denials:

- Provide the Provider Services Representative or Provider Portal Team Member with one claim number as an example of the specific denial. Communication is key!
- Inform the representative 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 Taxpayer Identification 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 Claim Dispute

Level 2:

- Level 2 is a Formal Claim Dispute, Administrative Claim Appeal.
- In the event the provider is not satisfied with the Informal Claim Dispute/Objection Resolution, the provider may file an Administrative Claim Appeal. The appeal must be filed within 60 calendar days from receipt of the Informal Dispute Resolution Notice.

Formal Claim Dispute - Administrative Claim Appeal

Level 2:

- An Administrative Claim Appeal must be submitted via the **MHS Secure Portal** or in writing by using the Medical Claim Dispute/Appeal Form with an explanation including any specific details which may justify reconsideration of the disputed claim. The appeal should be clearly marked on the form as Level 2.
- In the comment box clearly state your reason for the dispute.

Arbitration

Level 3:

- Level 3 is a part of the formal MHS Provider Claims Dispute Process.
- In the event a provider is not satisfied with the outcome of the Administrative Claim Appeal Process (Level 2), the provider may request arbitration. Claims with similar issues from the same provider may be grouped together for the purpose of requesting arbitration.
- To initiate arbitration, the provider should submit a written request to MHS on company letterhead. The request must be postmarked no later than 60 calendar days after the date the provider received MHS' decision on the Administrative Claim Appeal.

Arbitration requests need to be mailed to:

MHS Arbitration
429 N Pennsylvania St., 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 the:
Office of Administrative Law Proceedings
100 N. Senate Avenue, Room N802,
Indianapolis, IN 46204

Additional Claim Assistance

Provider Engagement Account Manager (PEAM) Regional Mailboxes

- If all claim denials are upheld after following the dispute processes and the provider has not received resolution by calling Provider Services or utilizing the secure messaging on the Provider Portal, please contact MHS Provider Relations through the Claim Issues Mailbox assigned to your region.
- Issues will be logged by the internal Provider Relations team and providers will receive a response email with next steps and any assigned reference numbers.
- Please do not email your Provider Engagement Account Manager directly, as this may delay the time in getting a response due to their travel.

MHS Secure Provider Portal Functionality

Secure Web Portal Login or Registration

The screenshot shows the MHS website's Provider Portal Login page. At the top, there is a navigation bar with the MHS logo on the left and three links: "For Members", "For Providers", and "Get Insured". Below the navigation bar, the page is divided into a left sidebar and a main content area. The sidebar, titled "For Providers", contains a list of links: "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 titled "Create your own online account today!". This section includes a paragraph explaining that MHS offers convenient and secure tools to assist users, a note that creating an account is free and easy, and a list of benefits: "Verify member eligibility", "Submit and check claims", "Submit and confirm authorizations", and "View detailed patient list". Below this list is a link for "Portal Training Guides". To the right of the main content area, there are two distinct boxes. The first box, titled "Secure Provider Portal", states that this login does not include Wellcare Complete and has a "Login/Register" button. The second box, titled "Wellcare Complete Provider Portal", states that Wellcare Complete requires a distinct password and login and also has a "Login/Register" button. In the bottom right corner of the page, there is a small icon for "Privacy - Terms".

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.

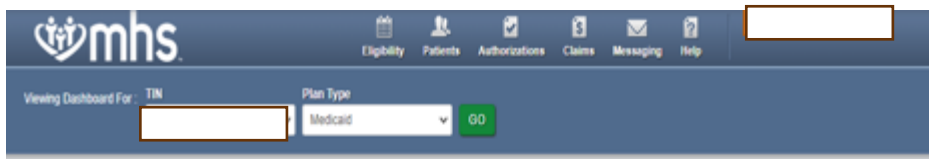
Login/Register

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 header of the MHS portal. It features the 'mhs' logo on the left. To the right of the logo is a navigation bar with icons and labels for 'Eligibility', 'Patients', 'Authorizations', 'Claims', 'Messaging', and 'Help'. Further right is a search bar. Below the navigation bar is a section for 'Viewing Dashboard For:'. It includes a 'TIN' field with a dropdown menu, a 'Plan Type' dropdown menu currently set to 'Medicaid', and a green 'GO' button.

Notification of Pregnancy (NOP)

NOP must be accessed through the IHCP Provider Healthcare Portal and electronically submitted. NOP option is only for Medicaid members. You must create a login and password in order to access the NOP form through the Provider Healthcare Portal.

Please Note

Claims information is updated every 24 hours.

Welcome, Kimberly!

Get summaries of claims data at a glance and easy access to the options you use most.

Admin Settings

Add and manage user access and information.


Add User


Edit User Access


Add a TIN

Quick Actions

Do a quick eligibility check, find patient benefits information, create a new claim or recurring claim or an authorization.

Member ID or Last Name *

Member Date of Birth


MM/DD/YYYY

Select Action Type *

SUBMIT

Authorization Overview

Inpatient Authorizations

[View All](#)

Outpatient Authorizations

[View All](#)

Useful Links

Reports

This repository contains reports that are uploaded and maintained by the health plan.

Patient Analytics

This is a PHM tool that supports providers in the delivery of timely, efficient, and evidence-based care to our members.

Provider Analytics [↗](#)

Used by PCP groups to access data/reports/dashboard that assist in providing better health outcomes and lower cost.

Claims

Provider Portal Claims Functionalities:

- Submit new claim.
- Review claims information on file for a patient.
- Correct claims.
- View payment history.

Submit a New Claim:

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

The image displays two screenshots of the mhs Provider Portal interface, illustrating the steps to submit a new claim.

Top Screenshot: The main navigation bar includes links for Eligibility, Patients, Authorizations, Claims, Messaging (with a 98 badge), and Help. Below the navigation bar, the 'Viewing Claims For' section shows a dropdown menu set to 'Medicaid' and a green 'GO' button. To the right, there are buttons for 'Upload EDI' and 'Create Claim'.

Bottom Screenshot: This screenshot shows the 'Create Claim' workflow. The 'Viewing Claims For' section remains the same. Below it, a search bar is visible with fields for 'Member ID or Last Name' and 'Birthdate' (formatted as mm/dd/yyyy), followed by a red 'Find' button. The bottom navigation bar is identical to the top screenshot.

Claim Submission

Choose the Claim Type:

- Professional or Institutional Claim Submission.

The screenshot shows the mhs web portal interface. At the top, there is a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. A dropdown menu for 'Provider Name' is on the right. Below the navigation bar, there is a section for 'Viewing Claims For:' with a dropdown for 'Tax ID Number' and a dropdown for 'Medicaid', followed by a green 'GO' button. To the right of this are two buttons: 'Upload EDI' and 'Create Claim'. Below this is a section titled 'Choose Claim for,' with a dropdown menu. Underneath, there is a section titled 'Choose a Claim Type' with two options: 'CMS 1500' and 'CMS UB-04'. The 'CMS UB-04' option is highlighted with a red box. Below these options are two green buttons: 'Professional Claim →' and 'Institutional Claim →'. At the bottom, there is an 'UPDATE' notice regarding ICD-10 regulations.

mhs

Eligibility Patients Authorizations Claims Messaging Help Provider Name

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.

Facility Billing

UB-04 Billing

Add the provider information.
Click **save** and click **next** to proceed

Provider Details Basic information about the patient's status and condition.

← Back Next →

* Required field

Billing Provider

NPI* 56. Search

Taxonomy 282N00000X 57.

Selected Provider

Billing Name*

Address* City* AVON State* Indiana Zip* 46123-7085

Pay-to Provider Same As Billing Provider

NPI* Taxonomy* 282N00000X IRS/Tax ID Number* Pay-To Name* 2.

Address* City* State* Zip*

Click **Add New Service Line**
and enter the service line's
information.

THIS SECTION:
Service Lines Enter maximum of 97 service lines.

← Back Next →

Total: \$1,046.00
Non-Covered: \$0.00

* Required field Delete Save / Update

+ New Service Line

Now Viewing Line 1: 403 / \$206.00

PROCEDURE / CHARGES

Revenue Code* 403 Lookup 42.

MAMMOGRAPY SCREENING / REGIONAL LYMPH NODE EXCISION

HCPCS / Rate / HIPPS 77063 44.

Code

NDC Guide

Modifiers XX Add Please enter the modifier and click the Add button.

Service Date* 08/04/2025 45.

UB-04 Adding Insurance

- Enter Additional Insurance (if applicable).

The screenshot shows the mhs web portal interface. At the top, there is a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below this, a header section displays 'Viewing Claims For:' followed by a dropdown menu set to 'Medicaid' and a 'GO' button. To the right of the header are buttons for 'Upload EDI' and 'Create Claim'.

The main content area is titled 'Institutional Claim for' followed by a redacted member ID. A progress bar labeled 'Your Progress' shows a sequence of steps, with the current step highlighted in orange. Below the progress bar, the section is titled 'THIS SECTION: Additional Insurance' with the instruction 'Enter additional insurance details.'

A yellow banner message states: 'You may skip this section if there is no additional insurance.' with a 'Next →' button. Below this, the 'Primary Insurance' heading is highlighted with a pink arrow. A notice below the heading reads: 'Notice: If the Member has more than one primary insurance (Medicaid would be the 3rd payer), the claim cannot be submitted through the Web.'

The form contains several input fields for insurance details:

- Carrier Type: Select... (dropdown menu)
- Policy Number: XXXXXXXX
- Amount Allowed: XXXX.XX
- Deductible: XXXX.XX
- Copay: XXXX.XX
- Co-Insurance: XXXX.XX

On the right side of the form, there are two tabs labeled '50' and '60'.

Enter Diagnosis Codes

The screenshot shows the 'mhs' web application interface. At the top, there's a navigation bar with links for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below this is a header section for 'Viewing Claims For' with a dropdown menu set to 'Medicaid' and a 'GO' button. To the right are buttons for 'Upload EDI' and 'Create Claim'.

The main content area is titled 'Institutional Claim for' followed by a dropdown menu. Below this is a 'Your Progress' bar with several green arrows and one orange arrow. The section is titled 'THIS SECTION: Diagnosis Codes' with the instruction 'Enter all relevant diagnosis codes.'.

Below the title is a 'Required field' section with a 'Back' button and a 'Next' button. The main form area contains several fields for entering diagnosis codes:

- ICD Version Indicator***: A radio button is selected for 'ICD 10'. A note states: 'Please note that for the claim statement dates entered, valid ICD-10 codes only are accepted.'
- Principal Diagnosis Code***: A text input field with a placeholder 'XXXX e.g. V87;'. To its right is a 'POA Indicator' dropdown menu set to 'Select...'. A large pink arrow points to this field.
- Admitting Diagnosis Code***: A text input field with a placeholder 'XXXX e.g. V87;'. To its right is a 'POA Indicator' dropdown menu set to 'Select...'. A blue 'Add' button is next to it.
- Diagnosis Codes (57A-Q)**: A text input field with a placeholder 'XXXX e.g. 140;'. To its right is a 'POA Indicator' dropdown menu set to 'Select...' and a blue 'Add' button.
- Patient Reason for Visit**: A text input field with a placeholder 'XXXX e.g. V87;'. To its right is a blue 'Add' button.
- External Cause of Injury Code (ECI)**: A text input field with a placeholder 'XXXX e.g. V87;'. To its right is a blue 'Add' button.
- Prospective Payment Code**: A text input field.
- Positioning Codes**: A text input field with a placeholder 'VV e.g. IV' and a blue 'Add' button.

On the right side of the form, there are several grey arrow-shaped buttons pointing right, labeled with numbers: 67., 69., 67.a-q, 70., 72., 71., and 68.70.

Adding Attachments

mhs

Eligibility Patients Authorizations Claims Messaging Help

Viewing Claims For : [dropdown] Medicaid [dropdown] GO Upload EDI Create Claim

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

THIS SECTION: **Attachments** Add attachments to the claim (5MB limit). Supported types are .jpg, .tif, .pdf and .tiff

← Back If there are no attachments, click Next. Next →

Attachments

*Do NOT send password protected files. You must click ATTACH for each file being submitted.

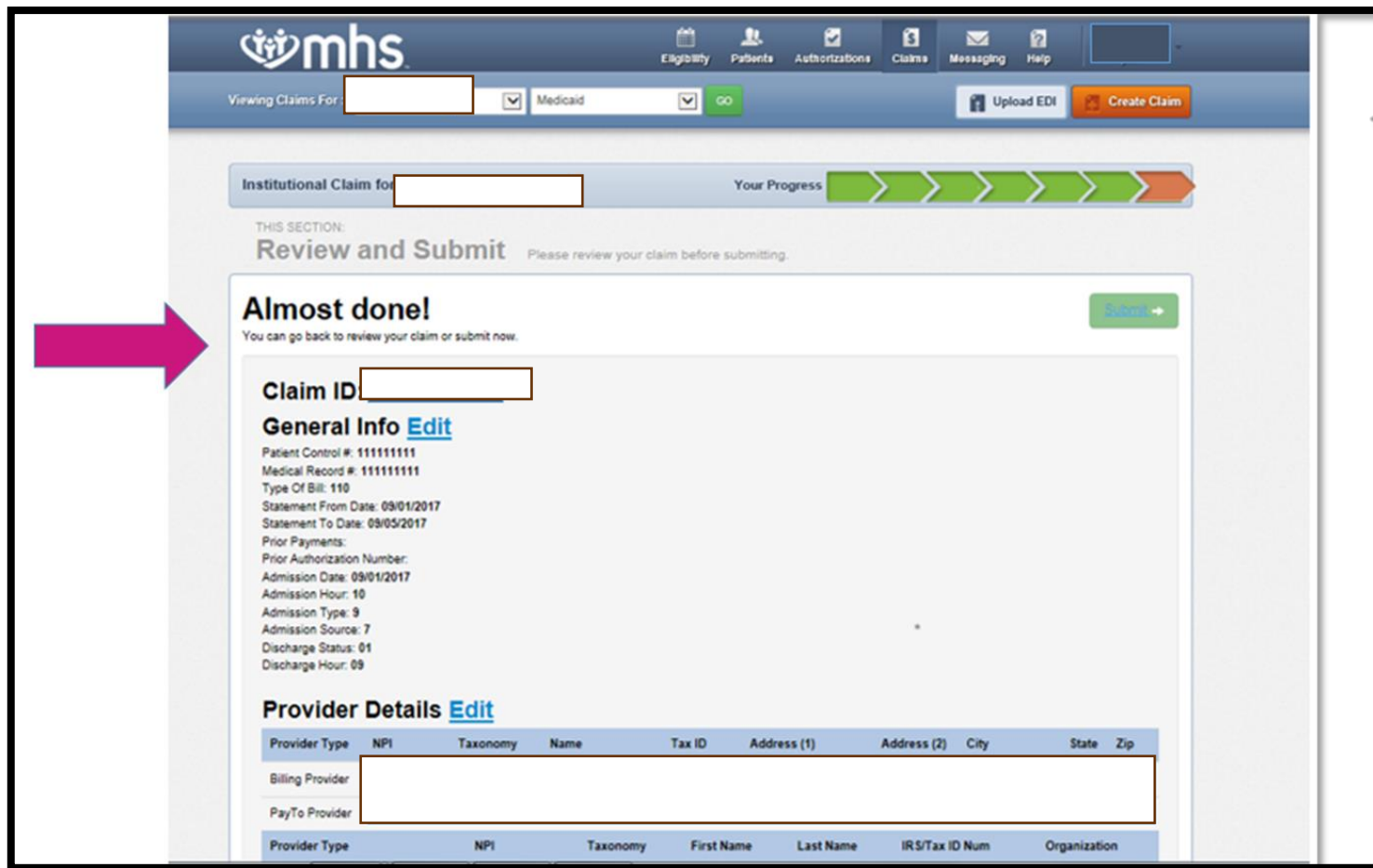
File* Attachment Type*

[text input] Browse... Select Type... [dropdown] Attach

There are no attached files.

← Back If there are no attachments, click Next. Next →

Review Claim and Submit



The screenshot displays the mhs web portal interface for reviewing and submitting a claim. The top navigation bar includes links for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below this, a 'Viewing Claims For' section shows a dropdown menu set to 'Medicaid' and a 'GO' button. To the right are 'Upload EDI' and 'Create Claim' buttons.

The main content area is titled 'Institutional Claim for [redacted]' and shows a progress bar with seven green arrows, indicating the current step is 'Review and Submit'. Below this, the text 'THIS SECTION: Review and Submit' is followed by the instruction 'Please review your claim before submitting.'

A large pink arrow points to the 'Almost done!' section, which includes a 'Submit' button. Below this, the 'Claim ID' is shown as [redacted]. The 'General Info' section is titled 'General Info' with an 'Edit' link. It lists the following details:

- Patient Control #: 111111111
- Medical Record #: 111111111
- Type Of Bill: 110
- Statement From Date: 09/01/2017
- Statement To Date: 09/05/2017
- Prior Payments:
- Prior Authorization Number:
- Admission Date: 09/01/2017
- Admission Hour: 10
- Admission Type: 9
- Admission Source: 7
- Discharge Status: 01
- Discharge Hour: 09

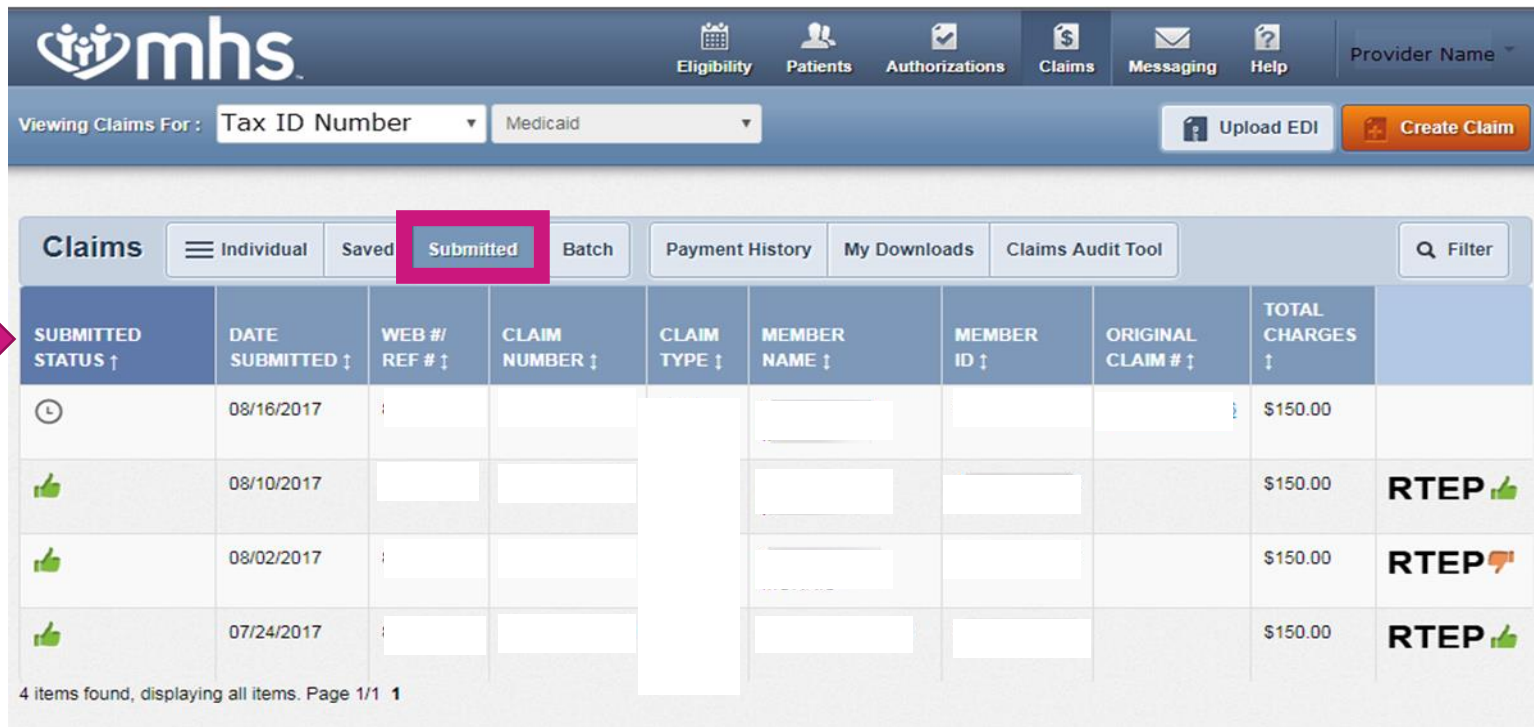
The 'Provider Details' section is titled 'Provider Details' with an 'Edit' link. It contains two tables. The first table is for the 'Billing Provider' and the second table is for the 'PayTo Provider'. Both tables have columns for Provider Type, NPI, Taxonomy, Name, Tax ID, Address (1), Address (2), City, State, and Zip. The 'Billing Provider' table has a single row with a redacted name. The 'PayTo Provider' table has a single row with a redacted name.

Provider Portal Claim and Payment Review

Submitted Claims

The Submitted tab will only display claims created via the MHS Secure Provider Portal:

- Paid is a **green** thumbs up.
- Denied is an **orange** thumbs down.
- Pending is a clock.
- Real Time Editing and Pricing (RTEP) claims also show if eligible (i.e., line 3 was submitted, but was not eligible for RTEP).



The screenshot shows the MHS Secure Provider Portal interface. The top navigation bar includes the MHS logo and links for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below the navigation bar, there are dropdown menus for 'Viewing Claims For:' (set to Tax ID Number) and 'Medicaid'. To the right of these are buttons for 'Upload EDI' and 'Create Claim'. The main content area displays the 'Claims' tab, with sub-tabs for Individual, Saved, Submitted (highlighted with a pink box), and Batch. There are also links for Payment History, My Downloads, and Claims Audit Tool. A search filter is available on the right. The table below lists submitted claims with columns for Submitted Status, Date Submitted, Web #/Ref #, Claim Number, Claim Type, Member Name, Member ID, Original Claim #, Total Charges, and a final column for RTEP status. A pink arrow points to the Submitted Status column header.

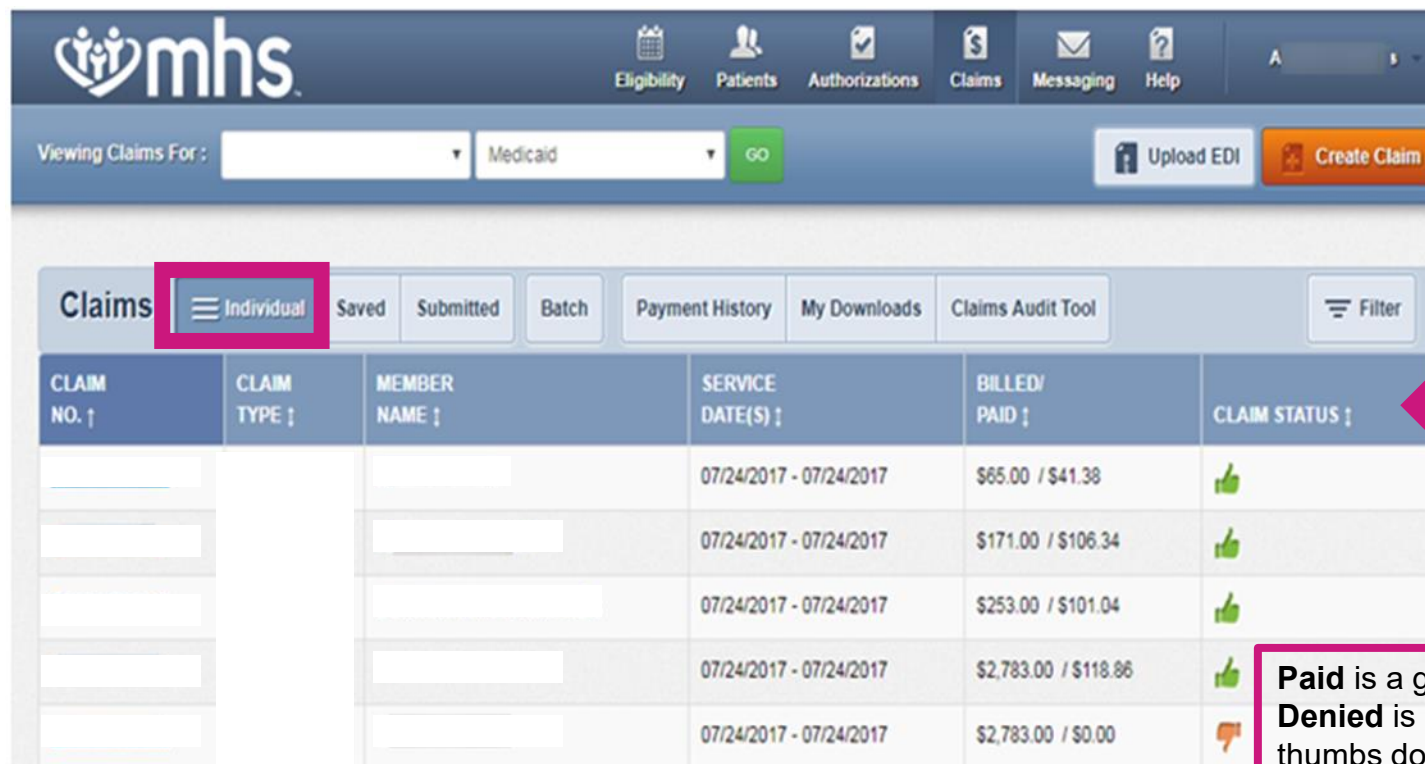
SUBMITTED STATUS ↑	DATE SUBMITTED ↑	WEB #/ REF # ↑	CLAIM NUMBER ↑	CLAIM TYPE ↑	MEMBER NAME ↑	MEMBER ID ↑	ORIGINAL CLAIM # ↑	TOTAL CHARGES ↑	
🕒	08/16/2017							\$150.00	
👍	08/10/2017							\$150.00	RTEP 👍
👍	08/02/2017							\$150.00	RTEP 🚫
👍	07/24/2017							\$150.00	RTEP 👍

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

Individual Claims

On the Individual tab, submitted using Provider Portal, Clearinghouse, or paper:

- 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 ↓
			07/24/2017 - 07/24/2017	\$65.00 / \$41.38	👍
			07/24/2017 - 07/24/2017	\$171.00 / \$106.34	👍
			07/24/2017 - 07/24/2017	\$253.00 / \$101.04	👍
			07/24/2017 - 07/24/2017	\$2,783.00 / \$118.86	👍
			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**.

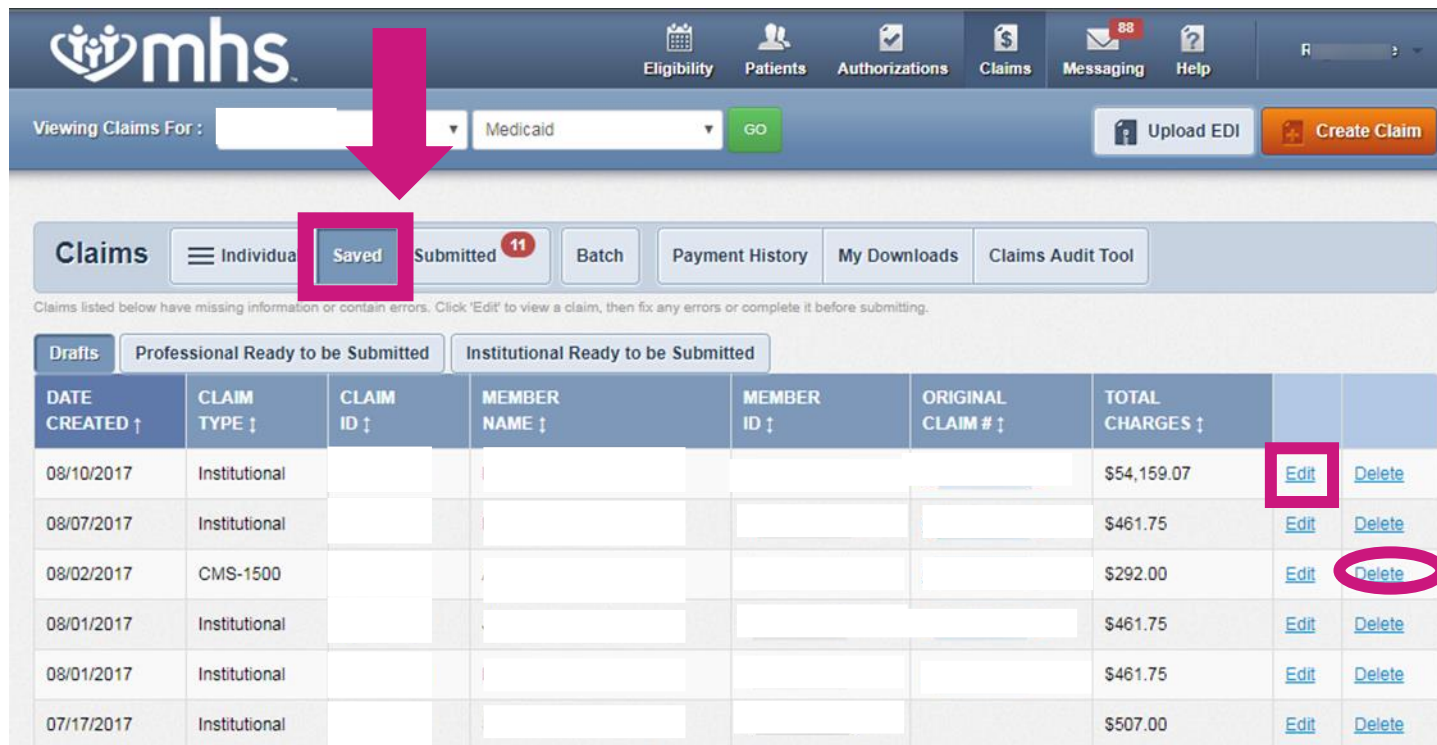
Saved Claims

To view Saved claims: Drafts, or Institutional:

1. Select Saved. 
2. Click Edit to view a claim. 
3. Fix any errors or complete before submitting.

Or

1. Click Delete to delete saved claim that is no longer necessary. 
2. Click OK to confirm the deletion.



Viewing Claims For: Medicaid

Claims **Saved**

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.

The screenshot displays the mhs portal interface. At the top, there's a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below this, a section for 'Viewing Claims For' includes a TIN field, a Plan Type dropdown (set to Medicaid), and a GO button. To the right are buttons for 'Upload EDI' and 'Create Claim'. A central navigation bar contains tabs for 'Claims', 'Individual', 'Saved', 'Submitted', 'Batch', 'Recurring', 'Payment History' (highlighted with a red box), and 'Claims Audit Tool'. A 'Filter' button is also present. Below the tabs, the 'Transactions' section shows activity between 06/20/2021 and 07/20/2021. An information box provides instructions on clicking the Check Date to view a PDF of payment details. A table follows with the following data:

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

Add Attachment If Applicable

The screenshot displays the mhs web portal interface for adding attachments to a claim. The top navigation bar includes links for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below this, a search bar shows 'Viewing Claims For:' with a dropdown menu set to 'Medicaid' and a 'GO' button. To the right are buttons for 'Upload EDI' and 'Create Claim'.

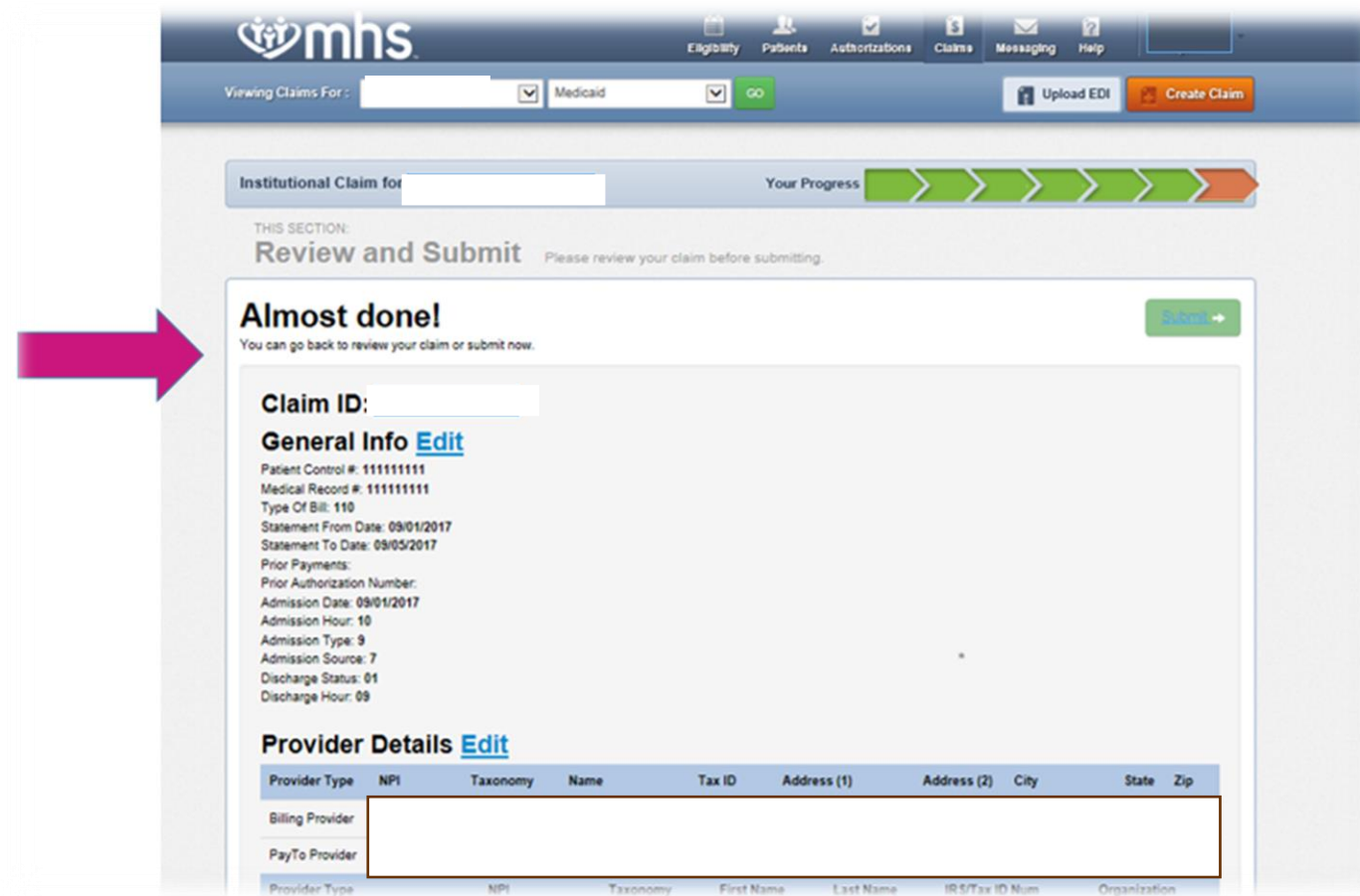
The main content area is titled 'Institutional Claim for' followed by a text input field. A progress bar labeled 'Your Progress' shows a sequence of steps, with the current step highlighted in orange. Below this, the section is titled 'Attachments' with the instruction 'Add attachments to the claim (5MB limit)'. A note specifies 'Supported types are .jpg, .tif, .pdf and .tiff'.

The 'Attachments' section contains a yellow banner with a 'Back' button, the text 'If there are no attachments, click Next.', and a 'Next' button. Below this, a red warning message states: '*Do NOT send password protected files. You must click ATTACH for each file being submitted.'.

The main form area has two fields: 'File*' and 'Attachment Type*'. The 'File*' field includes a text input box and a 'Browse...' button. The 'Attachment Type*' field is a dropdown menu with 'Select Type...' as the current selection. An 'Attach' button is positioned to the right of these fields. Below the form, a light blue box indicates '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. A pink arrow points to the 'File*' input field, and another pink arrow points to the 'Next' button at the bottom right.


Review and Submit Claim



mhs

Eligibility Patients Authorizations Claims Messaging Help

Viewing Claims For: Medicaid

Institutional Claim for Your Progress 

THIS SECTION:
Review and Submit Please review your claim before submitting.

Almost done!

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

Claim ID:

General Info [Edit](#)

Patient Control #: 1111111111
Medical Record #: 1111111111
Type Of Bill: 110
Statement From Date: 09/01/2017
Statement To Date: 09/05/2017
Prior Payments:
Prior Authorization Number:
Admission Date: 09/01/2017
Admission Hour: 10
Admission Type: 9
Admission Source: 7
Discharge Status: 01
Discharge Hour: 09

Provider Details [Edit](#)

Provider Type	NPI	Taxonomy	Name	Tax ID	Address (1)	Address (2)	City	State	Zip
Billing Provider	<input type="text"/>								
PayTo Provider									

Provider Type	NPI	Taxonomy	First Name	Last Name	IRS/Tax ID Num	Organization
---------------	-----	----------	------------	-----------	----------------	--------------

Electronic Funds Transfer(EFT) and Electronic Remittance Advice (ERA)s

PaySpan Health

- Web-based solution for:
 - EFTs and ERAs
- One-year retrieval of remittance advice.
- Provided at no cost to providers and allows online enrollment.
- Registration and more information here:
[PaySpan](#)
- For questions call PaySpan:
1-877-331-7154 8:00a.m-8:00p.m EST.

Tips to Remember

- Clicking on items (claim numbers, check numbers, dates) that are highlighted **blue** will reveal additional information.
- When filtering to find a claim or payment history, only a 30-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.
- To utilize the correct claim feature, the claim needs to be in a paid or denied status.

Online Claims Reconsiderations On the MHS Secure Provider Portal

Summary of Online Reconsiderations

Skip the phone call.

- Providers can make their case directly on the Provider Portal.

Make the case.

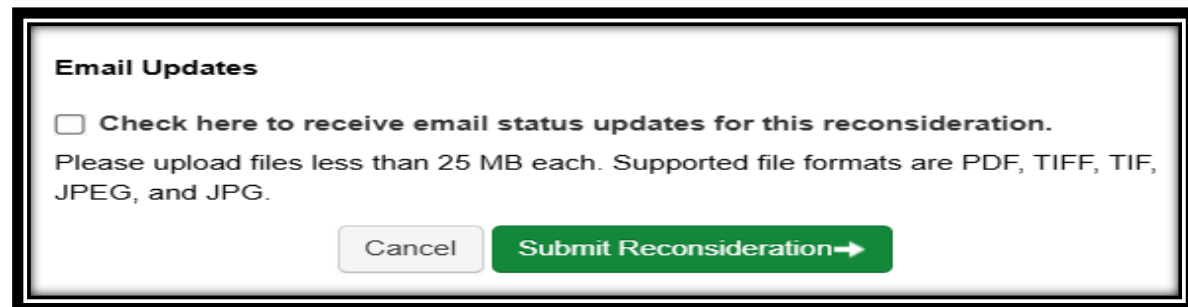
- Providers can submit informal Dispute/Reconsideration comments using expanded text fields.

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.

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 Reconsideration Tips

- It is important to note that all requests submitted via the online Provider Portal for Level 1 will be considered an Informal Dispute. Secure messages are not considered Reconsiderations/Appeals.
- Calling MHS Provider Services will not pause the time frame for timely submissions for Informal Disputes.
- Providers do not need to call prior to submitting an online Claim Reconsideration/Information Dispute.
- Providers may include a Dispute Form, but it is not required, as they may include comments directly into the Provider Portal.

Level 1 Informal Claim Dispute and Level 2 Claim Appeals On The MHS Secure Provider Portal

[Back to Claims](#)

Claim Details




 Claim

Denied

[+Copy Claim](#)

[Void/Recoup Claim](#)

[Dispute Claim](#)



Claim Accepted

In Process

Denied

Member	Provider	Claim	Most Recent Payment	
Member Name:	Ref/Acct No.:	DOS Range: 08/04/2025 - 08/04/2025	Payment Date:	Paid Claim Amount: \$0.00
Member ID:	Servicing Provider:	Received Date: 08/11/2025	Check/EFT Number:	Total Check Amount:
Member DOB:	Servicing NPI:	Billed Amount: \$1,240.00	Check Dated:	

Service Lines

Level 1 and Level 2 Claim Appeals Options On The MHS Secure Provider Portal

[Back to Claims](#) | Claim #Y2:

SELECT

Option 1: Correct the claim

Most providers use this option when there is a mistake on the submitted claim.

SELECT

Option 2: Reconsiderations

Most providers use this option when there is a dispute in payment and/or additional documentation required.

SELECT

Option 3: Informally dispute the claim

A dispute is a informal review performed by the Claims Department.

- A response will be issued within **30 calendar day** of submission.
- You will still have the opportunity to select **Option 4: 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.

SELECT

Option 4: 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.

Claim Reconsiderations

Enter your explanation for reconsideration and check email updates.

Reconsider Claim

Claim No:

For reconsiderations only. Not for appeals/Claim disputes
Example: If an authorization was not obtained and/or you need to review for medical necessity, submit an appeal.
Any submission on this form will be treated as a reconsideration.
Please refer to your Provider Manual.

Reconsideration Type

Denied for Untimely Filing

Notes
Brief Explanation

500 Character Limit

Upload Documents
Proof of Timely Filing attachment Required

Choose Files

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.

Cancel

Submit Reconsideration →

Level 1 Claim Appeals Details

[Back to Claims](#)
Claim Details

Claim # T **Denied**

[COPY](#)
[DISPUTE](#)

```

graph LR
    A((Claim Accepted)) --> B((Claim Denied))
    B --> C((Dispute Submitted))
    C -- Dispute U026IA1234566 --> D((Claim Denied Decision Upheld))
    
```

Dispute/Appeal Details

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

Member

Provider

Claim

Most Recent Payment

Participant Name	Ref/Acct No.	DOS Range	Payment Date	Paid Claim Amount
		08/12/2020 - 08/15/2020	---	\$0.00
Member ID	Servicing Provider	Received Date	Check/EFT No.	Total Check Amount
		09/12/2020	---	---
Member DOB	Servicing NPI	Billed Amount	Check Dated	
		\$6,1234.12	---	

Service Lines

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

Level 1 Informal Claim Dispute Detail Screen

Back to Claims

Claim Details

Claim #

Denied

COPY

DISPUTE

Dispute

U026IA1234566

Appeal

ABCDE1234567

✓

Claim Accepted

✗

Claim Denied

✓

Dispute Submitted

✗





Claim Denied (Decision Upheld)

✓

Appeal Submitted

Outcome TBD

Dispute/Appeal Details

Created Date	Type	Current Status	Reference No.	Tools
2/15/2021	Appeal - Claim Paid at the Incorrect Amount	In Progress		 
1/26/2021	Dispute - Claim Paid at the Incorrect Amount	Resolved		 

Member

Participant Name

Member ID

Member DOB

Provider

Ref/Acct No.

Servicing Provider

Servicing NPI

Claim

DOS Range

Received Date

Billed Amount

Most Recent Payment

Payment Date

Check/EFT No.

Check Dated

Paid Claim Amount

Total Check Amount

Service Lines

Label

Label

Label

Label

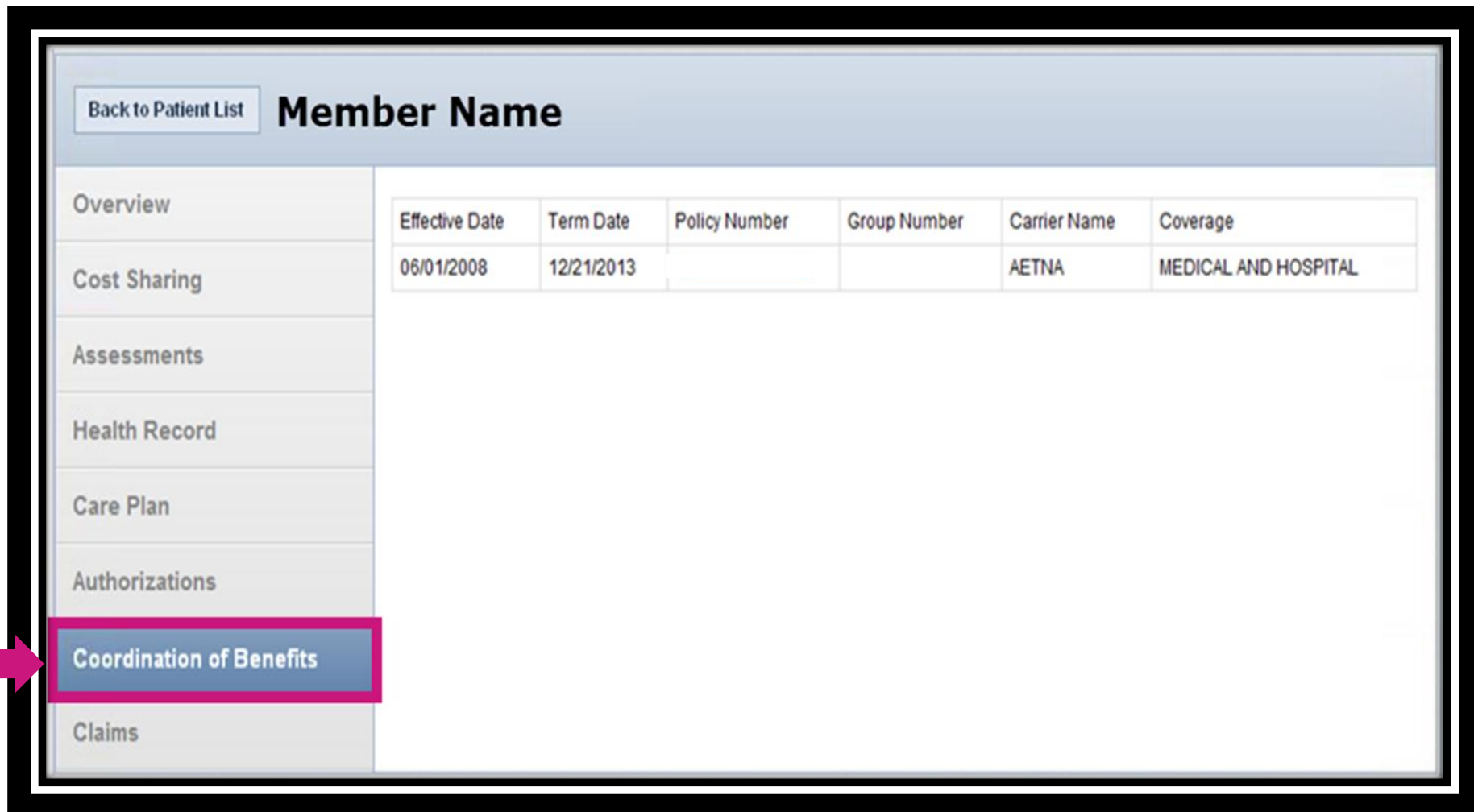
Label

Label

Label

Coordination of Benefits

This screen shows if a member has other insurance.



The screenshot displays a web application interface for patient management. On the left is a vertical sidebar with navigation links: Overview, Cost Sharing, Assessments, Health Record, Care Plan, Authorizations, Coordination of Benefits, and Claims. The 'Coordination of Benefits' link is highlighted with a blue background and a red rectangular border, with a red arrow pointing to it from the left. The main content area has a header with a 'Back to Patient List' button and a 'Member Name' label. Below the header is a table with insurance information.

Effective Date	Term Date	Policy Number	Group Number	Carrier Name	Coverage
06/01/2008	12/21/2013			AETNA	MEDICAL AND HOSPITAL

Prior Authorization

Authorizations

View previously submitted or create a new authorization.

[Back to Patient List](#)

Member Name

Overview

Cost Sharing

Assessments

Health Record

Care Plan

Authorizations

Referrals

Coordination of Benefits

Claims

Document Resource Center

Notes

Authorizations

STATUS	AUTH NBR	FROM DATE	TO DATE	DIAGNOSIS	AUTH TYPE	SERVICE
APPROVE	<input type="text"/>	02/06/2018	05/06/2018	M51.36	OUTPATIENT	Office Visit
APPROVE	<input type="text"/>	03/14/2017	01/05/2018	G89.4	OUTPATIENT	Office Visit

Create a New Authorization

Click on **AUTH NBR** above

Auth Status: APPROVE

Auth Nbr:

Service:

Provider of Service(s):

le(s): M51.36

Explanation: Pay

Auth Type: OUTPATIENT

From Date: 02/06/2018

To Date: 05/06/2018

Procedure Code(s): 99214

Notes & Attachments: [View](#)

Line Item	Service type	Start Date	End Date	Units Req.	Units Apprd	Servicing Provider	Location	Status	Medical Necessity	Decision Date
1	Office Visit	02/06/2018	05/06/2018	3	3		Office	APPROVE	Met as requested	01/31/2018

Authorization Considerations

Need to know what requires authorization:

- Pre-Authorization tool.
- PA Tool.


How to obtain authorization:

- Online: Obtaining Prior Authorization.
- Phone: 1-877-647-4848 8:00am-8:00pm EST.
- Fax: 1-866-912-4245.

Authorizations do not guarantee payment.

Prior Authorization

[Home](#) [Find a Provider](#) [Portal Login](#) [Events](#) [Careers](#) [Contact Us](#) [Language](#) [Q](#)

 [For Members](#) [For Providers](#) [Get Insured](#)

For Providers

- [Provider Portal Login](#)
- [Behavioral Health](#)
- [Clinical & Payment Policies](#)
- [Dental Providers](#)
- [Email Sign Up](#)
- [Enrollment and Updates](#)
- [Pharmacy](#)
- [Prior Authorization](#)**
- [Medicaid Pre-Auth](#)
- [Medicare Pre-Auth](#)
- [Ambetter Pre-Auth](#)

Prior Authorization

A Prior Authorization (PA) is an authorization from MHS to provide services designated as requiring approval prior to treatment and/or payment. All procedures requiring authorization must be obtained by contacting MHS prior to rendering services. PA is required for certain services/procedures which are frequently over- and/or underutilized or services/procedures which are complex and may indicate a need for case management.

Check to see if a pre-authorization is necessary by using our online tool located on the sidebar. It's quick and easy. If an authorization is needed, you can access our [Provider Portal](#) to submit online.

Expand the links below to find out more information.

- [How to Obtain a Prior Authorization](#)
- [List of Services Requiring Prior Authorization \(PA\)](#)
- [Prior Authorization Requirements](#)

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
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1-877-647-4848
Kelvin.D.Orr@mhsindiana.Com

NEW PROVIDER CONTRACTING

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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.



Questions?

Thank you for being our partner in care.
