



CARESOURCE BEHAVIORAL HEALTH

2026 IHCP Works Annual Seminar - October 6 – 8, 2026

Agenda

277 Rejections	
Claim Denials	
Claim Disputes	
Claim Appeals	
Clinical Appeals	
Arbitration	
Credentialing	
Prior Authorization and Coordination of Benefits	
Post Pay Review	
Resources	
Q and A	





277 Rejections



Claim Rejected, Now What?

- Rejected claims are not in the CareSource system.
 - Neither the Heath Partner Representative nor our Provider Services Representatives have access to the claim image.
- Rejected claims are not clean claims.
 - Do not submit as corrected claims.
- Rejected/voided claims can not be disputed and/or appealed.
- Rejected claims can not be used as proof of timely filing.
 - Clean claim must be received within 90 calendar days of date of service (DOS) or the primary payer's Explanation of Payment (EOP) date.

For more information on how to correct rejection claims:

[Claim Rejection Notifications | Indiana – Medicaid | CareSource](#)



Common Rejections Corrected Claim

Rejection Error: Corrected claim, with no original claim ID

If you are sending a corrected claim with frequency of 7, you must include the last adjudicated Claim ID in the REF*F8 segment.

If the last adjudicated claim ID is unknown:
Review [CareSource Provider Portal](#) or
contact Provider Services at 1-844-607-2831
(Monday – Friday 8 a.m. – 8 p.m. ET).



Common Rejections NPI

Rejection Error: Claim marked for rejection because no active provider is found in Master Provider List (MPL) based on Billing National Provider Identifier (NPI). Claims marked for rejection because there were multiple matches found in MPL based on different combinations of NPI.



Common Rejections NPI – What To Look For

For this error, please review the Indiana Health Coverage Programs ([IHCP](#)) [Provider Healthcare Portal](#) and verify enrollment using the following:

Is the group NPI enrolled with Medicaid?

If no, please follow the above link to enroll the group with IHCP.

Is the group NPI showing active in Medicaid system?

If no, please follow the above link to correct the group enrollment with IHCP.

Is the active date of the group on or after the date of service?

If no, this group cannot bill for services if not effective on DOS.

Does this group enrollment have multiple locations and specialties?

If yes, are you billing the correct NPI and/or taxonomy for the group?

Check the address, does the address in box 33 match the service location in Medicaid?

If no, please correct the claim and resubmit.

Does the zip+4 in box 33 match the zip+4 in Medicaid?

If no, please correct the claim and resubmit.



Common Rejections Rendering Provider

Rejection Error: Rendering provider not linked to billing group in Indiana MPL.



Common Rejections Rendering Provider – What To Look For

For this error, please review the [IHCP Provider Healthcare Portal](#) and verify the following:

Is the individual practitioner NPI registered in Medicaid?

If no, please follow the above link to enroll the practitioner with IHCP.

Is the individual practitioner showing active in Medicaid system?

If no, please follow the above link to update the practitioner enrollment with IHCP.

Is the individual practitioner enrolled as a rendering provider?

If no, please follow the above link to enroll the practitioner as a rendering practitioner.

Is this individual practitioner showing linked to this location?

If yes, Is the effective date on the rendering tab on or after the DOS?

If the DOS is prior to the effective date, the claim is not payable. Please follow the above link to correct the effective date with IHCP.

If no, please follow the above link to enroll the practitioner for the location in question with IHCP.

Are you billing the correct NPI and/or taxonomy of the group specialty in box 33b?

If no, correct and resubmit claim.



Common Rejections Attending Provider

Rejection Error: Claim marked for rejection because the attending provider's NPI submitted on the claim is not valid in IN MPL or not present on the claim.



Common Rejections Attending Provider – What To Look For

For this error, please review the [IHCP Provider Healthcare Portal](#) and verify the following:

Is the individual practitioner NPI registered in Medicaid?

If no, please follow the above link to enroll the practitioner with IHCP.

Is the individual practitioner showing active in Medicaid system?

If no, please follow the above link to update the practitioner enrollment with IHCP.

Is the individual practitioner enrolled as a rendering provider?

If no, please follow the above link to enroll the practitioner as a rendering practitioner.

Is this individual practitioner showing linked to this location?

If yes, Is the effective date on the rendering tab on or after the date of service?

If no, please follow the above link to enroll the practitioner for the location in question.





Claim Denials



Denials

Substance Use Disorder (SUD) vs Outpatient:

[IHCP Behavioral Health Services](#) provider reference module.

Only H0010 and H2034 can be billed under specialty 11/836. Any other services outside of the per diem must be billed by another specialty, including Intensive Outpatient Treatment (IOT) and Partial Hospitalization Programs (PHP).

IHCP Policy/program standards:

- PHP: must include four to six hours of active treatment per day and must be provided at least four days a week.
 - If less than four to six hours (or four days per week) of active treatment is to be provided, the individual services provided (for example, therapy) must be billed instead of PHP.
- IOT: Regularly scheduled sessions, within a structured program, must be at least three consecutive hours per day and at least three days per week.

Note: Services that are less than three hours cannot be billed as IOT, but may be billed as psychotherapy, if provider qualifications and program standards are met.



Behavioral Health Claim Denied For No Prior Authorization (PA)

Was the denial related to an SUD Rehabilitation Treatment Center (RTC) denial?

If yes, review the following scenarios:

- If the facility is providing services, then the facility's name should be the requesting provider.
- If the practitioner is providing services, then the practitioner's name should be the requesting provider.

Important Reminders:

- ✓ SUD Residential initial requests should be submitted for 14 calendar days, and concurrent requests should be submitted in increments of 7 calendar days.
- ✓ Please make sure **ALL** clinicals are submitted for each PA request.
- ✓ Please make sure **ALL** American Society of Addiction (ASAM) dimensions have clinical documentation to support the boxes checked.



NPI – Known Non-Payment (KNP) Denial

Claim with a 99 closed status:

- Can not be disputed.
- Does not count as a clean claim - Provider still has 90 calendar days from the DOS or discharge to submit a clean claim.

Confirm the following per the IHCP provider portal:

- The rendering provider is linked to the service location in box 33.
- The rendering provider is active and enrolled as a rendering provider.
- The group taxonomy matches *Core MMIS/IHCP* provider portal.



UB-04

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8 PATIENT NAME										9 PATIENT ADDRESS																																																																																																													
10 BIRTHDATE										11 SEX										12 DATE										13 HR										14 TYPE										15 SRC										16 DHR										17 STAT										18										19										20										21									
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UB-04 Box 1

[SERVICE LOCATION INFORMATION] – Enter the service location name and address (including the expanded ZIP code+4) where the patient was seen (this address must match the service location address currently on file with the IHCP for the group or billing provider where the service was rendered).

This is a Required field.

IHCP Provider Reference Module: [Claim Submission and Processing](#)



UB-04 – Box 2

1										2										3a PAT. CNTL. #			
																				b. MED. REC. #			
																				5 FED. TAX NO.			
8 PATIENT NAME										a		9 PATIENT ADDRESS										a	
b												b											
10 BIRTHDATE				11 SEX		12 DATE		ADMISSION 13 HR 14 TYPE 15 SRC		16 DHR		17 STAT		18		19		20		21		CONDITION CODES 22 23 24 25	
31 OCCURRENCE CODE		OCCURRENCE DATE		32 OCCURRENCE CODE		OCCURRENCE DATE		33 OCCURRENCE CODE		OCCURRENCE DATE		34 OCCURRENCE CODE		OCCURRENCE DATE		35 OCCURRENCE CODE		OCCURRENCE SPAN FROM		THROUGH			
a				a				a				a				a							
b				b				b				b				b							
38										39 CODE		VALUE CODES AMOUNT		c									
										a				b				c					
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										c				d				e					
										d				e				f					
42 REV. CD.		43 DESCRIPTION								44 HCPCS / RATE / HIPPS CODE								45 SERV. DATE		46 SERV. UNITS			
1																							
2																							
3																							
4																							

UB-04 Box 2

UNLABELED FIELD – Not applicable.

IHCP Provider Reference Module:
[IHCP Claim Submission and Processing](#)
[Medicare Claims Processing Manual](#)
[Crosswalk](#)



UB-04 – Box 76

	F		G		H
	O		P		Q
72 ECI	a		b		c
76 ATTENDING		NPI		QUAL	
LAST				FIRST	
77 OPERATING		NPI		QUAL	
LAST				FIRST	
78 OTHER		NPI		QUAL	
LAST				FIRST	
79 OTHER		NPI		QUAL	
LAST				FIRST	

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF

UB-04 Box 76

ATTENDING – NPI – Enter the attending physician’s 10-digit numeric NPI. Do not use the NPI of a group provider. The attending provider should always be an individual person. Required for inpatient, outpatient, Ambulatory Surgery Center (ASC), and Long-Term Care (LTC).

IHCP Provider Reference Module:

IHCP Claim Submission and Processing



CMS-1500 – Box 24j - Outpatient

22. RESUBMISSION CODE		ORIGINAL REF. NO.	
23. PRIOR AUTHORIZATION NUMBER			
F. \$ CHARGES	G. DAYS OR UNITS	H. EPST: FIRM	I. ID. QUAL
			J. RENDERING PROVIDER ID. #
			NPI
			NPI
			NPI
			NPI
			NPI
			NPI
28. TOTAL CHARGE	29. AMOUNT PAID	30. Rnd for NUCC use	
\$	\$		
33. BILLING PROVIDER INFO & PH. # ()			
a. NPI	b.		

APPROVED OMB 0938-1197 FORM 1500 (02-12)

PHYSICIAN OR SUPPLIER INFORMATION

- **RENDERING PROVIDER ID. #** – Enter the IHCP Provider ID or taxonomy code of the provider that rendered the service. Required, if applicable.
- **Provider ID** – Atypical providers (for example, waiver providers and non-ambulance transportation providers) are required to submit their IHCP Provider ID. If billing for case management, the case manager's Provider ID must be entered here. (Provider ID is indicated by qualifier G2 in field 24I.)
- **Taxonomy** – The taxonomy code includes 10 alphanumeric characters. The taxonomy code is optional unless required for a one-to-one NPI/Provider ID match. (Taxonomy is indicated by qualifier ZZ or PXC in field 24I.)

IHCP Provider Reference Module:

[IHCP Claim Submission and Processing](#)



CMS-1500 SUD vs. Outpatient – Box 24j

22. RESUBMISSION CODE		ORIGINAL REF. NO.	
23. PRIOR AUTHORIZATION NUMBER			
F. \$ CHARGES	G. DAYS OR UNITS	H. FIRST PARTY	I. ID. QUAL
			RENDERING PROVIDER ID #
			NPI
			NPI
			NPI
			NPI
			NPI
			NPI
			NPI
25. TOTAL CHARGE	26. AMOUNT PAID	27. Rptd for NUCC use	
\$	\$		
28. BILLING PROVIDER INFO & PH. # ()			
29. NPI			

APPROVED OMB 0938-1197 FORM 1500 (02-12)

SUD per diem bundled

- No rendering practitioner is billed in 24j as this is billed at a group level

Outpatient is billed per CPT with a rendering practitioner

- Rendering practitioner is required to be billed in 24j

Incorrect claim submissions leads to denials

- Incorrect (PA) requests may generate claim denials

IHCP Provider Reference Module:

[IHCP Behavioral Health Services](#)



CMS-1500 – Box 33 – 33a/b

Billing information for Box 33: [NPI Network Notification](#).

The image shows a portion of the CMS-1500 form. At the top, there are several rows for NPI (National Provider Identifier) information, each with a dashed line for the NPI number. Below this, there are fields for 'ACCOUNT NO.', '27. ACCEPT ASSIGNMENT? (For govt. claims, see back)' with 'YES' and 'NO' checkboxes, '28. TOTAL CHARGE', '29. AMOUNT PAID', and '30. Revid for NUCC use'. Below these is '31. BILLING PROVIDER INFO & PH. # ()'. At the bottom, there is a section for 'PHYSICIAN OR SUPPLIER INFO' with a vertical arrow pointing down. The form also includes the text 'PLEASE PRINT OR TYPE' and 'APPROVED OMB 0938-1197 FORM 1500 (02-12)'.

- **Box 33 - BILLING PROVIDER INFO & PHONE #** – Enter the service location name and address (including **ZIP code+4**) as listed on the provider enrollment profile for the billing provider.
- **33a - BILLING PROVIDER – NPI** – Enter the billing provider NPI.
- **33b - BILLING PROVIDER – [QUALIFIER AND ID NUMBER]** – If the billing provider is an atypical provider, enter the qualifier G2 and the billing provider’s IHCP Provider ID. Required for atypical billing providers. Healthcare providers enter a qualifier of ZZ or PXC and the billing provider taxonomy code in this field.

IHCP Provider Reference Module:
[IHCP Claim Submission and Processing](#)



Rejection vs. Denial

Rejection = Data issue → Resubmit

- If a claim is rejected, timely filing guidelines still apply. Timely filing is calculated from the date of service or discharge.
- Most rejections stem from IHCP enrollment issues. For a KNP denial or “rendering provider is not linked to MPL,” correct your IHCP enrollment before resubmitting to CareSource.

Denial = Policy decision → Dispute/appeal or correct claim

- Don't dispute denials for other insurance or medical records. Submit a corrected claim — with records attached if required — or update coverage in the provider portal if the patient has no other insurance. [CareSource IN Medicaid Provider Manual](#).



Claim Submission Timelines

Initial Claim Contracted Provider	90 calendar days from date of service or discharge to submit a clean claim.
Initial Claim Non-Contracted Provider (IN Medicaid)	90 calendar days from date of service or discharge to submit a clean claim.
Secondary Claims	90 calendar days from the date of the primary payer's EOP to submit a clean claim.
Corrected Claim	60 calendar days from the date of the EOP to submit a corrected claim.



Timely Filing

For CareSource Primary Claims: Was the claim submitted within 90 calendar days of date of service?

Review

- Was this the first claims submission or a corrected claim?
 - If corrected claim, was frequency “7” submitted?
- Was the original claim number submitted?
 - Rejected and Voided claims can not be used for proof of timely filing, corrected, or disputed claims.
- Was the claim received within 90 calendar days of the original date of service if claim paid?

For CareSource Secondary Payer Claims: Was the claim submitted within 90 calendar days of date of primary payer EOP?

Review

- Was the primary payer reported on the claim?
- Was the primary payment reported on the electronic claim or copy of primary EOP included uploaded, keyed or mailed claim?
- Was this a corrected claim?



Denied Claim Clarification on Filing Limit

CareSource will not be able to pay a claim if there is incomplete, incorrect, or unclear information on the claim. As a result, the claim will be denied or voided.

A corrected claim may be submitted for the denied claim with corrected information. For processing, this is still considered an initial claim and initial claims filing limits are enforced.

Reminder: A claim that was rejected at the clearinghouse or accepted and voided when processed cannot be used as proof of timely filing.



Coordination of Benefits (COB)

Review – First step is to review the member's eligibility on the [CareSource Provider Portal](#).

Does CareSource list a primary payer?

Yes: Was the claim submitted with the Primary EOP?

Is CareSource the primary payer per CareSource enrollment?

No: Was the claim submitted with the Primary EOP?

Is the primary payer listed on member's profile active?

No:

- Contact member and have them update their information with CareSource.
- Provider can submit COB update on the CareSource Provider Portal.



3 Ways to Submit Claims to CareSource



1

Electronically

- Electronic Data Interchange (EDI) transaction sent to CareSource through [Availity](#). For list of EDI vendors who transmit to Availity EDI Gateway, click [here](#).
- CareSource Payer ID **INCS1**.
- Availity's Client Services
1-800-282-4548
Monday–Friday
8am – 8pm EST

2

Portal

- Medical claims can be keyed on the [CareSource Provider Portal](#).
- Medical Claim forms (CMS-1500/UB-04) can be uploaded.
- Upload attachments for both keyed claims and uploaded claims forms.

3

Mail

- Ensure printing is aligned to the form and legible.
- Paper claims have the same NPI, TIN, and taxonomy code requirements as electronic claims.
- Mail claims to: **CareSource**
Attn: Claims Department
P.O. Box 3607
Dayton, OH 45401



A large, light purple Venn diagram with two overlapping circles is centered in the background of the slide. The text "Claim Disputes" is overlaid on the intersection of the circles.

Claim Disputes



Definition of a Claims Dispute



A dispute is the **first** formal review of the processing of a claim by CareSource (excluding denials based on medical necessity) and is submitted prior to submitting a claim appeal.

You can submit a claim payment dispute when you disagree with payment and any other post-service claim denial.



Key Information to Include with Dispute



List reason claim/line should be paid.



Provide supporting documentations i.e. IHCP Bulletin, IHCP Provider Reference Module, Policy, Manual.

***NOTE:** If your claim was denied requesting medical records, those should be submitted via the [CareSource Provider Portal](#) as a corrected claim.



Timeframe to Dispute



Ways to Submit a CareSource Claims Dispute



1

Portal

The preferred method of submission is through the [CareSource Provider Portal](#).

2

Postal Mail

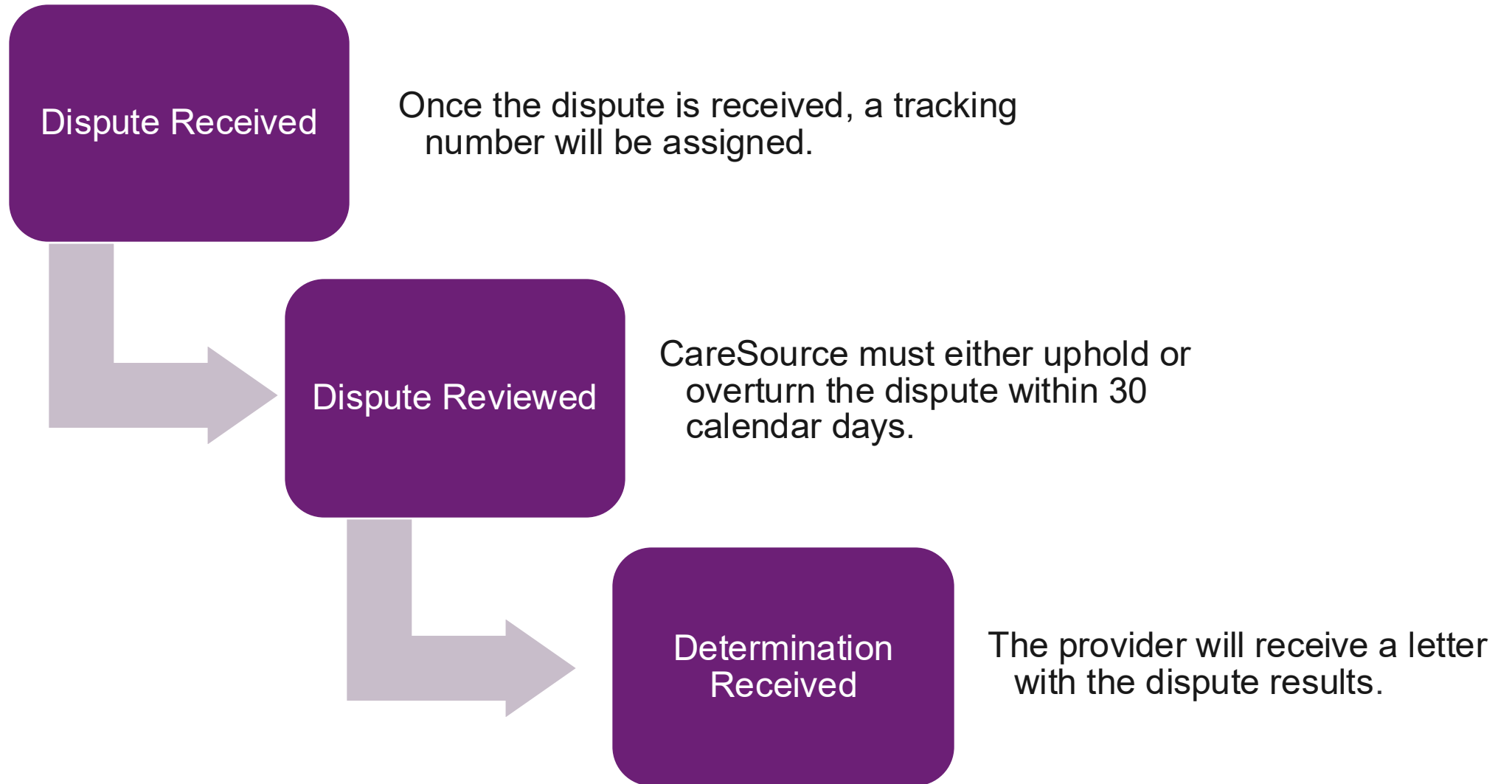
CareSource Grievance & Appeals Department
P.O. Box 2008
Dayton, OH 45401

Submit [dispute form](#) along with documentation to substantiate reason for dispute.

For questions, please call CareSource Health Partner Appeals at 1-888-880-4889, available 8 a.m. to 8 p.m., Monday through Friday, Eastern Time (ET)



CareSource *Dispute Process*



Rejected or Voided Claims

Do Not Dispute

Claims are not eligible since the claims were not received as clean claims.

Claim will need to be resubmitted, and timely filing guidelines will apply.





Claim Appeals



Definition of a Claims Appeal



An appeal is the **second** formal review of the processing of a claim by CareSource (excluding denials based on medical necessity) and is submitted after submitting a claim dispute.

You can submit a claim payment appeal when you disagree with payment and any other post-service claim denial.

Providers must exhaust the claim dispute process as outlined above before filing a claim appeal.



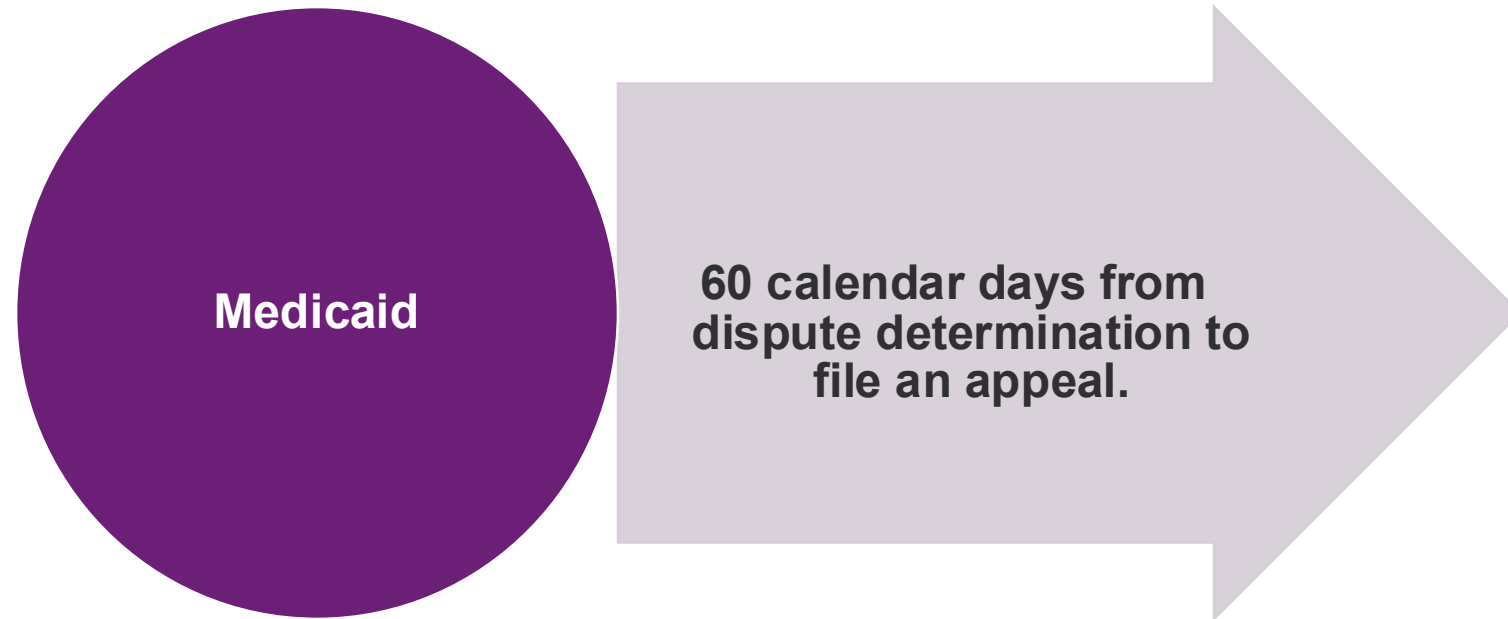
Key Information for a Claims Appeal

Include the following required documentation:

- Progress notes including symptoms and their duration, physical exam findings, conservative treatment that the member has completed, preliminary procedures already completed, and the reason service is being requested.
- Any documentation of specialists' reports or evaluations, any pertinent previous diagnostic reports and therapy notes.
- If the service has already been provided, a copy of the original remittance advice and/or the denied claim.
- If the appeal is regarding a clinical edit denial, the appeal must have all the supporting documentation as to the justification of reversing the determination.



Timeframe to Appeal



Ways to Submit a CareSource Claims Appeal



1

Portal

The preferred method of submission is through the [CareSource Provider Portal](#).

2

Postal Mail

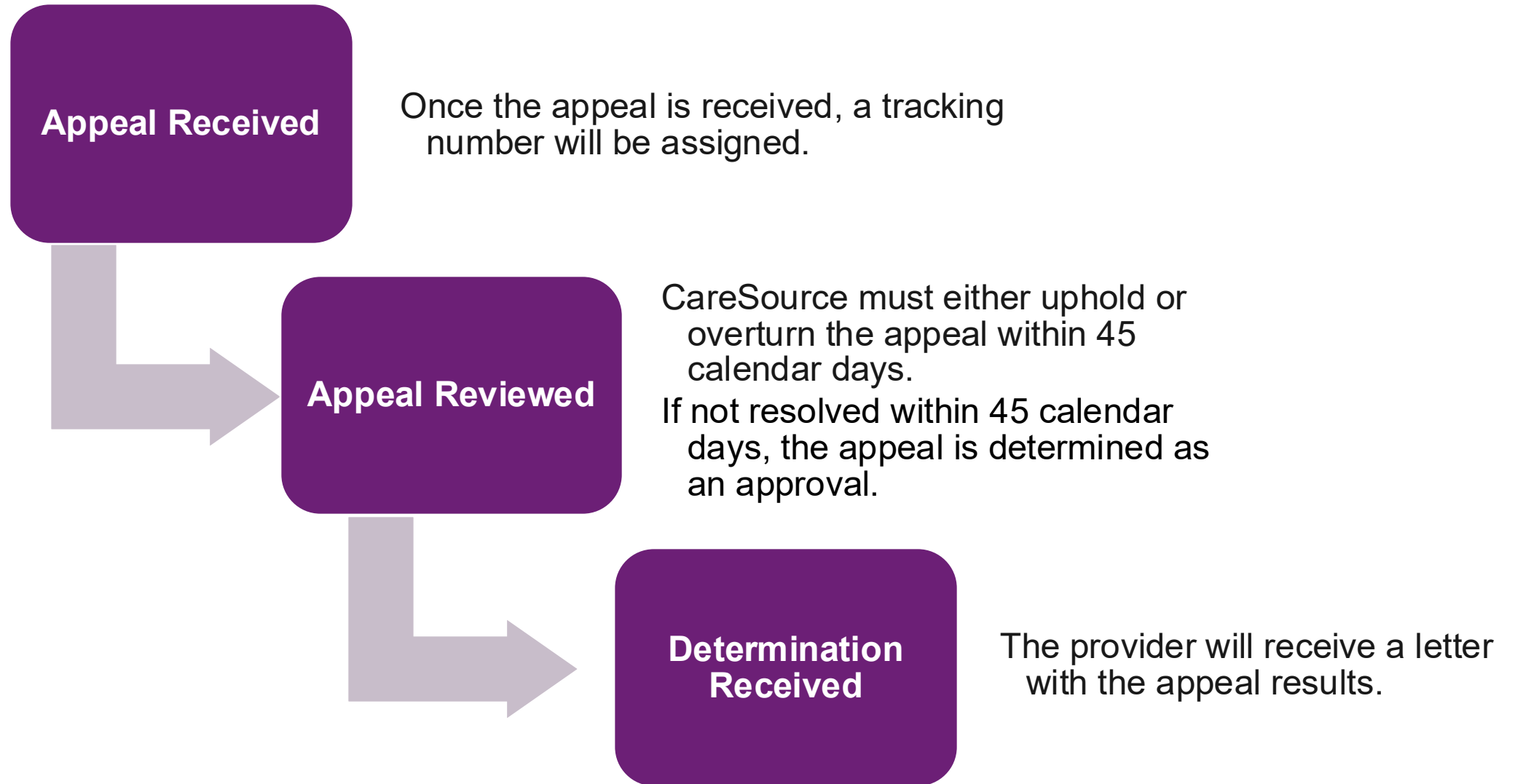
CareSource Grievance & Appeals Department
P.O. Box 2008
Dayton, OH 45401

Submit [appeal form](#) along with documentation to substantiate reason for appeal.

For questions, please call CareSource Health Partner Appeals at 1-888-880-4889, available 8 a.m. to 8 p.m., Monday through Friday, Eastern Time (ET)



CareSource Appeal Process



Claims ineligible to Appeal

Claims that have not been disputed.

Claims must be disputed before filing an appeal.

A claim that has already been appealed.

Providers have **ONE** chance to appeal a claim.





Clinical Appeals



Definition of a Clinical Appeal



A clinical appeal is a written request by a provider to review a prior authorization denial with a clinical decision regarding medical necessity. Clinical denials are issued from the CareSource Utilization Management department.

All appeal requests and associated information are reviewed by clinicians not previously involved with the case.



Medicaid Clinical Appeal of a PA Denial

Pre-Service

Must be submitted with written member consent.

Must be submitted within 48 hours from the date of action notice to submit a pre-service appeal.

If a delay in the care decision could put your patient's life or health at risk, you may request an expedited clinical appeal. Call 1-844-607-2831 (Mon–Fri, 8 a.m.–8 p.m.) or mail an [Expedited Appeal Form](#).

Post-Service

Must be submitted with written member consent.

Must be submitted within 48 hours from date on the notice of action, discharge or authorization denial.

If you have not received an authorization **denial** from the CareSource Utilization Management Department for a service that requires a PA, you must submit a retro-authorization request prior to filing a clinical appeal.



Notification of Resolution

CareSource will decide whether to expedite an appeal within 48 hours*. We will make reasonable efforts to provide prompt verbal notification to the member of the decision to expedite or not expedite the appeal; the attempt will be made by phone.

Expedited appeals will be resolved, and verbal notification will be made within 48 hours* of receipt of the appeal or as expeditiously as the medical condition requires unless the resolution time frame is extended. CareSource will send written notification to both the provider and the member on the same business day of the decision.

*Does not include weekends and state and federal legal holidays.



Extending a Clinical Appeal

Members may verbally request that CareSource extend the time frame to resolve any medical necessity appeal request up to 14 calendar days. CareSource may also request an extension. CareSource will provide a written notice for the extension.



External Review for a Clinical Appeal

CareSource members can request an external review and state hearing concurrently after they have exhausted all CareSource's internal appeals process. The member or a member's representative must submit the request, with member consent, in writing within 120 calendar days from the date of the appeal decision. The IRO will decide to uphold or reverse the decision within **72 hours for an expedited appeal, or 15 business days for a standard appeal**. The determination made by the independent review organization is binding.

To request an external review the member can write to CareSource at:

CareSource

P.O. Box 8738

Attn: External Review

Dayton, OH 45401-8738

Fax: 844-417-6262 - Attn: Independent Review – Appeals Dept.

The request for a state fair hearing must be sent to the State of Indiana Office of Administrative Law Proceeding at:

Office of Administrative Law Proceedings

100 N. Senate Avenue Suite N802

Indianapolis, IN 46204





Arbitration



What is Arbitration?

If you are dissatisfied with the decision of the claim appeal, you may submit the matter to binding arbitration. The binding arbitration process must be conducted in accordance with the rules and regulations of the American Health Lawyers Association (AHLA), pursuant to the Uniform Arbitration Act as adopted in the State of Indiana at [IC-34-57-2-2](#).



Arbitration Process

Exceptions to IC-34-57-2-2:

The provider and CareSource mutually agree to some other binding resolution procedure or process in the agreement between the parties; or

CareSource or the providers are subject to statutorily imposed arbitration procedures for the resolution of these claims. In that case, the statutorily imposed arbitration procedures shall be followed.

- The arbitration process may include, in a single arbitration proceeding, matters from multiple formal claim resolution procedures involving CareSource and the provider.
- The fees and expenses of arbitration or other binding resolution procedure shall be borne by the non-prevailing party.

Providers can submit issues to:

CareSource

Attn: Arbitration

251 N Illinois Street Suite 300

Indianapolis, IN 46204





Credentialing



Credentialing/Recredentialing

CareSource credentials at initial request for participation

- Recredentialed every 3 years
- Council for Affordable Quality Healthcare (CAQH) must be current and access granted to CareSource

Credentialing Partners

- Aperture/Verisys
- Medallion

Complete all forms (Debarment, W-9 etc.)

- W-9 must be signed within the year of the request
- Debarment form: if the question does not apply to your organization, please enter N/A

Reminders:

- Provider must be enrolled at service location that is enrolled with the IHCP
- Incomplete documents will delay credentialing process
- Provider must ensure that they complete their IHCP revalidation timely

Tools:

- [CareSource Provider Manual](#)
- [CareSource Contracting](#)



A large, light purple Venn diagram with two overlapping circles is centered in the background of the slide. The text is overlaid on this diagram.

Prior Authorization (PA) and Coordination of Benefits (COB)



Prior Authorization

CareSource PA Look up tool: [CareSource | Procedure Code Lookup](#)

Services that require PA:

- Inpatient
- SUD
- IOT/PHP
- Applied Behavior Analysis (ABA)

THIS IS NOT AN ALL-INCLUSIVE LIST. PLEASE REFER TO CARESOURCE PROCEDURE CODE LOOK UP TOOL

Service billed must match requesting provider, procedure codes, units, date of service mismatch or missing PA will result in a claim denial.



Prior Authorization (PA) & Coordination of Benefits



When requesting a PA, the primary insurance PA determination must be submitted with the request to CareSource.

CareSource PA and Third-Party Liability Network Notification

The CareSource provider portal has the capability for the provider to update the members primary coverage and initiate CareSource to review the members coverage on file.

Primary insurance must be billed first and a copy of the primary insurance EOP must be billed with the claim. Please note the provider has 90 calendar days from the primary EOP processed date to submit the claim to CareSource.

IHCP Provider Reference Module: [Third-Party Liability](#)





Post Pay Review



Post-Pay Review

Overpayment Recovery - [IN MCD-PY-1111](#)

Possible recovery reasons:

- COB
- retroactive eligibility
- credit balances
- improper payment
- provider level balancing
- claims adjustments

Advanced notification will occur 60 calendar days prior to recoveries. If the recovery occurs outside of the original claim timely filing limits, the corrected claim submission timeframe is 60 calendar days from the date of the recovery.

Normal timely filing limits apply to corrected claims being submitted within original claim timely filing guidelines.





Resources



Education and Resources

IHCP Provider Reference Modules

- [Indiana Medicaid: Providers: IHCP Provider Reference Modules](#)

IHCP Code Sets and Fee Schedules

- [Indiana Health Coverage Programs - Provider Code Sets](#)
- [Indiana Medicaid: Providers: IHCP Fee Schedules](#)

IHCP Bulletins and Updates

- [Indiana Medicaid: Providers: IHCP Bulletins](#)

CareSource Policies

- [Provider Policies | Indiana – Medicaid | CareSource](#)

CareSource Updates & Announcements

- [Updates & Announcements | Indiana – Medicaid | CareSource](#)

CareSource Indiana Medicaid Provider Manual

- [in-hip-hhw-health-partner-manual.pdf](#)

CareSource Provider Disputes or Appeals

- [Provider Disputes or Appeals | Indiana – Medicaid | CareSource](#)



Health Partner Engagement Representatives – Behavioral Health Resolution Specialist

Amanda Denny

Behavioral Health Resolution Specialist

Northern Territory

765-620-6722

Amanda.Denny@CareSource.com

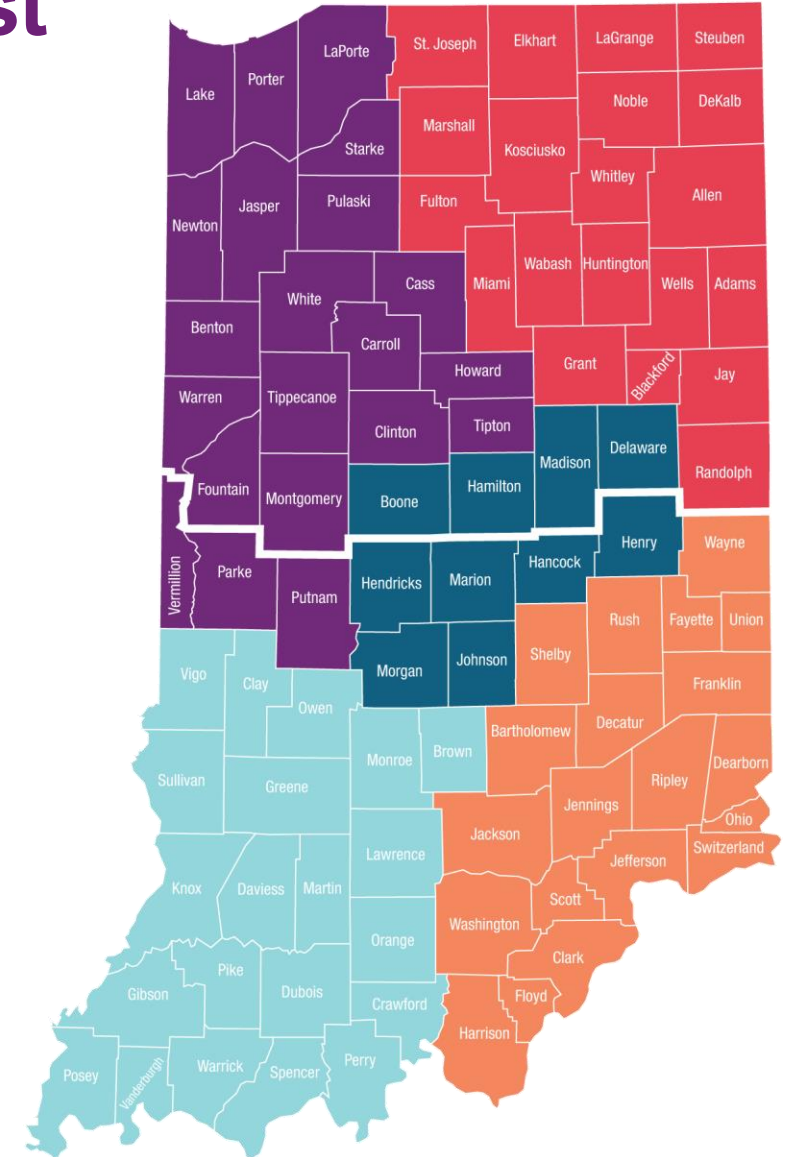
Stephanie Gates

Behavioral Health Resolution Specialist

Southern Territory

317-501-6380

Stephanie.Gates@CareSource.com



Q and A



Evaluation QR Code



Presented by:

Amanda Denny and Stephanie Gates

Thank you for attending.

CARESOURCE.COM      

IN-MED-P-6132050; First Use: 08/31/2026

OMPP Approved: 08/31/2026

