



CMS-1500:

Updates and Insights:

Navigating Regulatory Changes

2026 IHCP Works Annual 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
- 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

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

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

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 date of service (DOS) or discharge date
Out-of-Network Providers	90 calendar days from DOS or discharge date

Exceptions to the Filing Limit

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

Paper Claim Corrections

- A corrected claim can be submitted following the Indiana Health Coverage Programs (IHCP) claim adjustment processes.
- A claim adjustment code is required on all claims, based on the type of Claim submitted.
 - Example: Frequency 7 entered in Box 22 of the *CMS-1500* form.
- The original claim number must also be listed on the corrected claim.
 - Box 22 on the *CMS-1500*.
 - Remember: A rejection must be submitted as a first-time claim, not as a corrected claim.
- Handwriting or stamping on a claim will not be accepted as submission of a corrected claim, and will be rejected with rejection code **RE**.

Paper Claim Corrections CMS-1500 Example

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

The image shows a CMS-1500 paper claim form. Key fields and annotations include:

- Box 22 (Resubmission Code):** Contains the code '7'. A blue arrow points to this box with the annotation "Resubmission code is '7'".
- ORIGINAL REF. NO.:** A field for the original claim number. An orange arrow points to this field with the annotation "Original claim number".
- Box 17a:** Contains a blacked-out number.
- Box 17b:** Contains 'NPI'.
- Box 21:** Contains a blacked-out diagnosis code.
- Box 23:** Contains a blacked-out prior authorization number.
- Box 24:** Contains a blacked-out date of service.
- Box 25:** Contains a blacked-out federal tax ID number.
- Box 26:** Contains a blacked-out patient's account number.
- Box 27:** Contains 'ACCEPT ASSIGNMENT?'. The 'YES' box is checked.
- Box 28:** Contains a blacked-out total charge.
- Box 29:** Contains a blacked-out amount paid.
- Box 30:** Contains a blacked-out field for NUPC Use.
- Box 31:** Contains a blacked-out signature of the physician or supplier.
- Box 32:** Contains a blacked-out field for the date.
- Box 33:** Contains a blacked-out field for the date.
- Box 34:** Contains a blacked-out field for the date.
- Box 35:** Contains a blacked-out field for the date.
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- Box 98:** Contains a blacked-out field for the date.
- Box 99:** Contains a blacked-out field for the date.

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

Documentation for Informal Claims Dispute

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 – Level 1

- 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 have up to 60 calendar days from date of dispute response to initiate a formal claim appeal, which is Level 2.

Informal Claims Dispute – 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.
 - Mon. – Fri., 8 a.m. to 8 p.m. ET.
- **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. Providers have up to 60 calendar days from date of dispute response to initiate a formal 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.

Formal Claims Dispute - Level 2

- If the original determination is upheld, the provider will be notified within **45 calendar days** of receipt of the appeal.
- At that time (or upon receipt of our response if sooner), you will have up to **60 calendar days** from date of appeal response to initiate a Formal Claim Appeal (Level 3).

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

Portal Functionality

Secure Web Portal Login or Registration

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](#) ▾

[Resources](#) ▾

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](#)

Provider Email Sign Up

[Sign Up](#)

t experience on our website.

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

Homepage - MHS (Medicaid)

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

The screenshot shows the MHS (Medicaid) homepage dashboard. At the top, there is a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below the navigation bar, there is a section for "Viewing Dashboard For:" with a dropdown menu for "TIN" and a "Plan Type" dropdown menu set to "Medicaid". A "GO" button is next to the "Plan Type" dropdown. Below this, a welcome message "Welcome, Michelle!" is displayed, followed by a prompt "Get easy access to the features you use most". Below the welcome message, there is a "Quick Actions" section with a description: "Do a quick eligibility check, find patient benefits information, create a new claim or recurring claim or an authorization." This section contains three input fields: "Member ID or Last Name *", "Member Date of Birth" (with a calendar icon and "MM/DD/YYYY" format), and "Select Action Type *" (with a dropdown menu). A "SUBMIT" button is to the right of these fields. Below the "Quick Actions" section, there is an "Authorization Overview" section with two buttons: "Inpatient Authorizations" and "Outpatient Authorizations". Each button has a "View All" link below it. Below the "Authorization Overview" section, there is a "Useful Links" section with three cards: "Reports" (describing a repository of reports), "Provider Analytics" (describing a dashboard for PCP groups), and "Provider Complaints" (describing a way to view submitted complaints).

mhs

Eligibility Patients Authorizations Claims Messaging Help

Viewing Dashboard For: TIN [dropdown] Plan Type: Medicaid [dropdown] GO

Welcome, Michelle!

Get easy access to the features you use most

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 * [input] Member Date of Birth [calendar icon] MM/DD/YYYY Select Action Type * [dropdown] 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.

Provider Analytics [external link icon]
Used by PCP groups to access data/reports/dashboard that assist in providing better health outcomes and lower cost.

Provider Complaints
View submitted complaints to the provider.

Claims Audit Tool

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

The screenshot shows 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 dropdown and a Plan Type dropdown set to 'Medicaid', with a 'GO' button. To the right are 'Upload EDI' and 'Create Claim' buttons. A horizontal menu below these options includes 'Claims', 'Individual', 'Saved', 'Submitted', 'Batch', 'Recurring', 'Payment History', and 'Claims Audit Tool', which is highlighted with a red rectangle. Below the menu, there's a 'Claims: Recent' section with a search bar set to 'Date Range : 02/19/2026 to 03/19/2026' and 'Filter' and 'Search' buttons.

The screenshot shows the 'McKesson Clear Claim Connection' screen. The header includes 'McKesson', 'Clear Claim Connection', and a 'Sign Out Help' link. Below the header is a navigation bar with 'McKesson Edit Development', 'Glossary', and 'About'. The main section is titled 'CLAIM ENTRY' and contains several form fields: 'Claim Type' (dropdown set to 'Professional'), 'Gender' (radio buttons for 'Male' and 'Female'), 'Date of Birth' (text field), 'ICD Code Set' (radio buttons for 'ICD9' and 'ICD10'), and 'Diagnosis Codes' (four text fields). Below these is a 'Bill Type' field. A note states: 'For quick entry, use your Down Arrow key after you enter a procedure code. Qty will default to 1, Billed Amount will default to 100, Date of Service From and To will default to today's date, and Place of Service will default to 11 (Office). Tabbing through these same fields will give you the same defaults.' Below the note is a table with 15 columns: LINE, PROCEDURE, MOD1, MOD2, MOD3, MOD4, QTY, REV. CODE, BILLED AMT., DOS FROM, DOS TO, PLACE OF SERVICE, PROVIDER STATE, LINE DIAG. 1, LINE DIAG. 2, LINE DIAG. 3, LINE DIAG. 4, LINE DIAG. 5, LINE DIAG. 6. The table has 5 rows, each with input fields for these values. At the bottom left is a link 'Add More Procedures >>'. On the right side of the form are 'Clear' and 'Review Audit Results' buttons.

Claims

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

The image displays two screenshots of the mhs web portal interface. The top screenshot shows the 'Create Claim' button highlighted with a pink arrow. The bottom screenshot shows the 'Member ID or Last Name' and 'Birthdate' fields highlighted with pink arrows.

Top Screenshot:

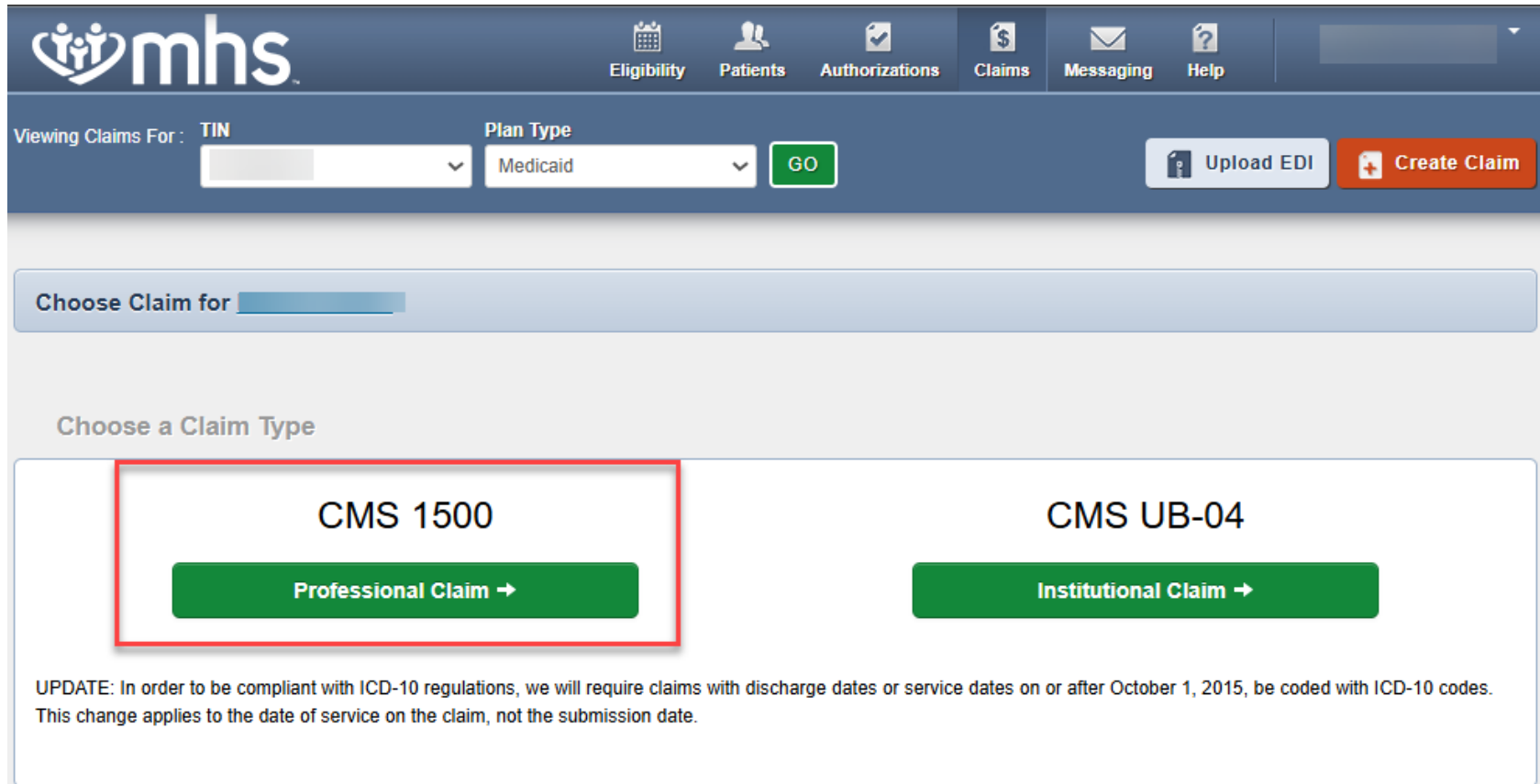
- Header: mhs logo, Eligibility, Patients, Authorizations, Claims, Messaging (98), Help.
- Navigation: Viewing Claims For: [Dropdown] Medicaid [GO] [Upload EDI] **Create Claim** (highlighted with a pink arrow).
- Sub-navigation: Claims, Individual, Saved, Submitted, Batch, Payment History, My Downloads, Claims Audit Tool, Filter.

Bottom Screenshot:

- Header: mhs logo, Eligibility, Patients, Authorizations, Claims, Messaging (98), Help.
- Navigation: Viewing Claims For: [Dropdown] Medicaid [GO] Member ID or Last Name [Input: 123456789 or Smith] Birthdate [Input: mm/dd/yyyy] Find (highlighted with a pink arrow).
- Sub-navigation: Claims, Individual, Saved, Submitted, Batch, Payment History, My Downloads, Claims Audit Tool, Filter.

Claims Submission (1 of 2)

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



mhs

Eligibility Patients Authorizations Claims Messaging Help

Viewing Claims For: TIN Plan Type Medicaid

Choose Claim for

Choose a Claim Type

CMS 1500

CMS UB-04

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

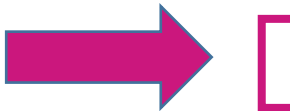
Professional Billing

Professional Claims Submission

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

* Required fields

Patient's Account Number*	XXXXXXXXXX	26
Statement Dates*	From MM/DD/YYYY To MM/DD/YYYY	
Date of current illness, Injury, Pregnancy (LMP)	Select Type... MM/DD/YYYY	14.
Other Date	Select Type... MM/DD/YYYY	15.
Hospitalization	From MM/DD/YYYY To MM/DD/YYYY	18.
Additional Claim Information:	XXXXXXXXXXXX	19a.
Outside Lab?	Yes <input checked="" type="button" value="No"/>	20.
Referral Number	XXXXXXXXXXXX	
Prior Authorization Number	XXXXXXXXXXXX	23a.
CLIA Number	XXXXXXXXXXXX	23b.
Amount Paid	XXXX.XX	29.



Claims Submission (2 of 2)

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

Professional Claim for [LJ](#) [TY](#) Your Progress

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

← Back Next →

* Required field

ICD Version Indicator* ☒ ICD 10

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

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

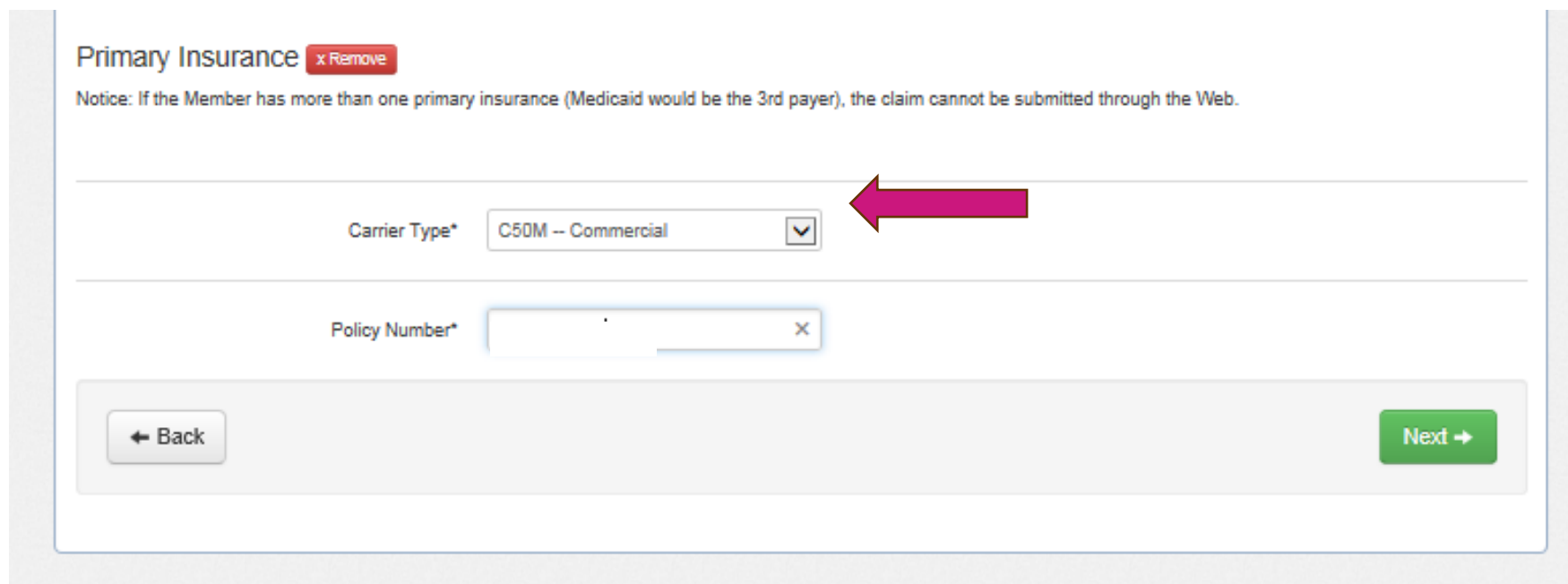
V837 -- PERS OUTSD INDUST VEH INJ NT ACC Remove X

Add Coordination of Benefits

← Back Next →

Claims Submission – Add COB

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



The screenshot shows a web form titled "Primary Insurance" with a red "x Remove" button. Below the title is a notice: "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 two input fields: "Carrier Type*" with a dropdown menu showing "C50M -- Commercial" and a red arrow pointing to it, and "Policy Number*" with a text input field and a clear button (X). At the bottom of the form are two buttons: "← Back" and "Next →".

Primary Insurance x Remove

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

Carrier Type* C50M -- Commercial

Policy Number*

← Back Next →

Claims Submission – Add Service Lines

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

THIS SECTION:
Service Lines
Enter maximum of 50 service lines.

← Back Next →

Total: \$53.00 * Required field Delete Save / Update

+ New Service Line

PROCEDURE / CHARGES

1: 88304 / \$53.00

Now Viewing Line 1: 88304 / \$53.00

Dates of Service* From 04/27/2025 To 04/27/2025 24.a

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

Emergency Yes No 24.c EMG

Procedure Code* 88304 24.d

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

26 Remove X

Diagnosis Code(s)* ☒ L720 - EPIDERMAL CYST 24.e
☒ L989 - DISORDER OF THE SKIN AND SUBCUTANEOUS TISSUE, UNSPECIFIED

Claims Submission – Add Provider Information

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

* Required field

Referring Provider ←

NPI Qualifier

Last Name or Organizational Name First Name

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

NPI Tax ID

Taxonomy # Last Name or Organizational Name First Name

Billing Provider ←

Tax ID

Name* NPI Taxonomy *

Address* City* State* Zip*

Service Facility Location ←

17.

24.j

33.

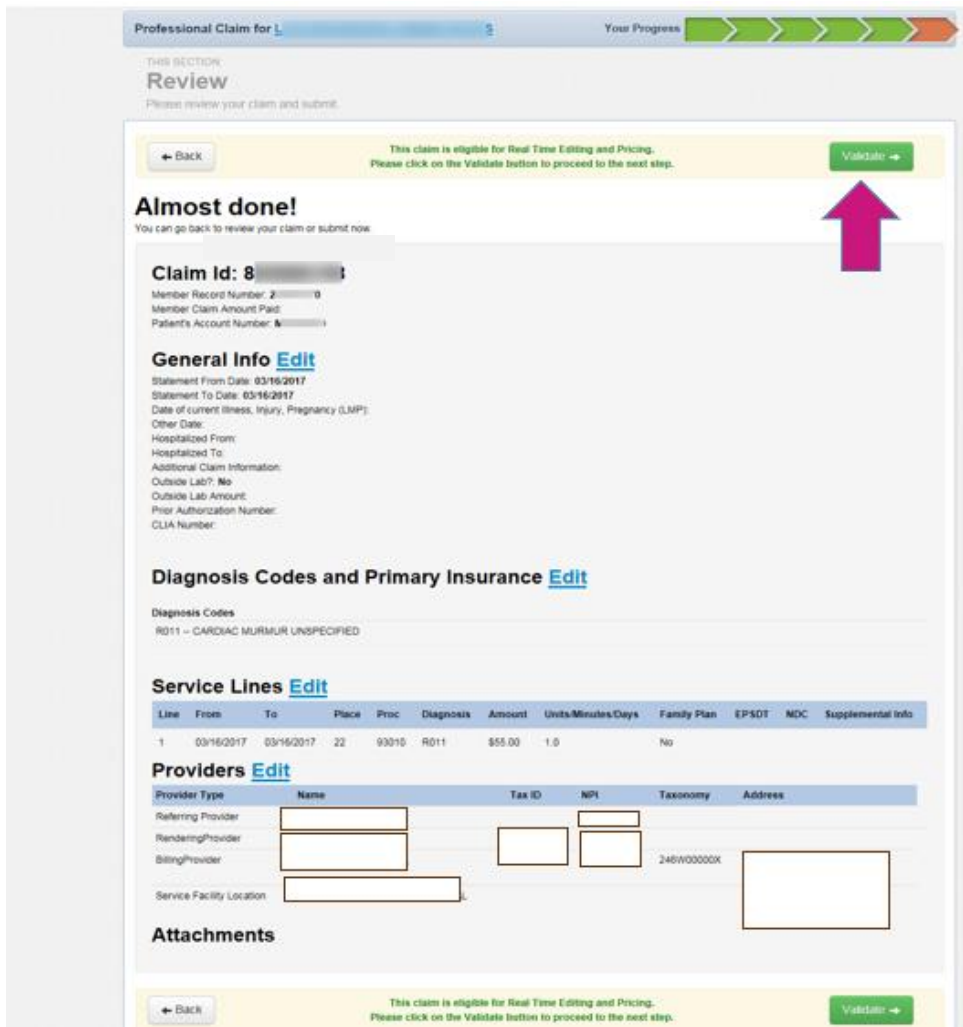
22.

Claims Submission – Document Attachments

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

The screenshot shows a web interface for submitting a professional claim. At the top, a progress bar indicates the current step is 'Attachments'. The section title is 'Attachments' with a sub-note 'Add attachments to the claim (5MB limit)'. A yellow banner at the top of the section says 'If there are no attachments, click Next.' with 'Back' and 'Next' buttons. Below this, a red warning message states: '*Do NOT send password protected files. You must click ATTACH for each file being submitted.' The main area has a 'File*' label, a 'Choose File' button, and a 'No file chosen' status. To the right is an 'Attachment Type*' dropdown menu with 'Select Type...' and an 'Attach' button. A light blue box below says 'There are no attached files.' At the bottom, another yellow banner repeats the 'If there are no attachments, click Next.' instruction with 'Back' and 'Next' buttons. Two pink arrows are overlaid: one pointing to the 'Choose File' button and another pointing to the 'Next' button in the bottom banner.

Claims Submission Review



Professional Claim for [redacted] Your Progress [Progress Bar]

THIS SECTION
Review
Please review your claim and submit.

← Back Validate →

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

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

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

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

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

Service Lines [Edit](#)

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

Providers [Edit](#)

Provider Type	Name	Tax ID	NPI	Taxonomy	Address
Referring Provider	[redacted]	[redacted]	[redacted]		
Rendering Provider	[redacted]	[redacted]	[redacted]		
Billing Provider	[redacted]			248W00000X	
Service Facility Location	[redacted]				

Attachments

← Back Validate →

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

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

RTEP Claim Pricing View

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

The main content area shows a 'COMPLETE!' message: 'You have successfully submitted your claim.' with a 'Print' button. Below this, there are fields for 'Web Reference No. 8' and 'Claim No.'.

A summary section displays the following information:

- RefAcct No: 1
- DOS Range: 09/21/2015 - 09/21/2015
- Member ID: [redacted]
- Billed Amount: \$90.00
- Member Name: [redacted]
- Payment Amount: \$46.75
- Servicing Provider: [redacted]
- Status: APPROVED

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

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

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

RTEP Overview:

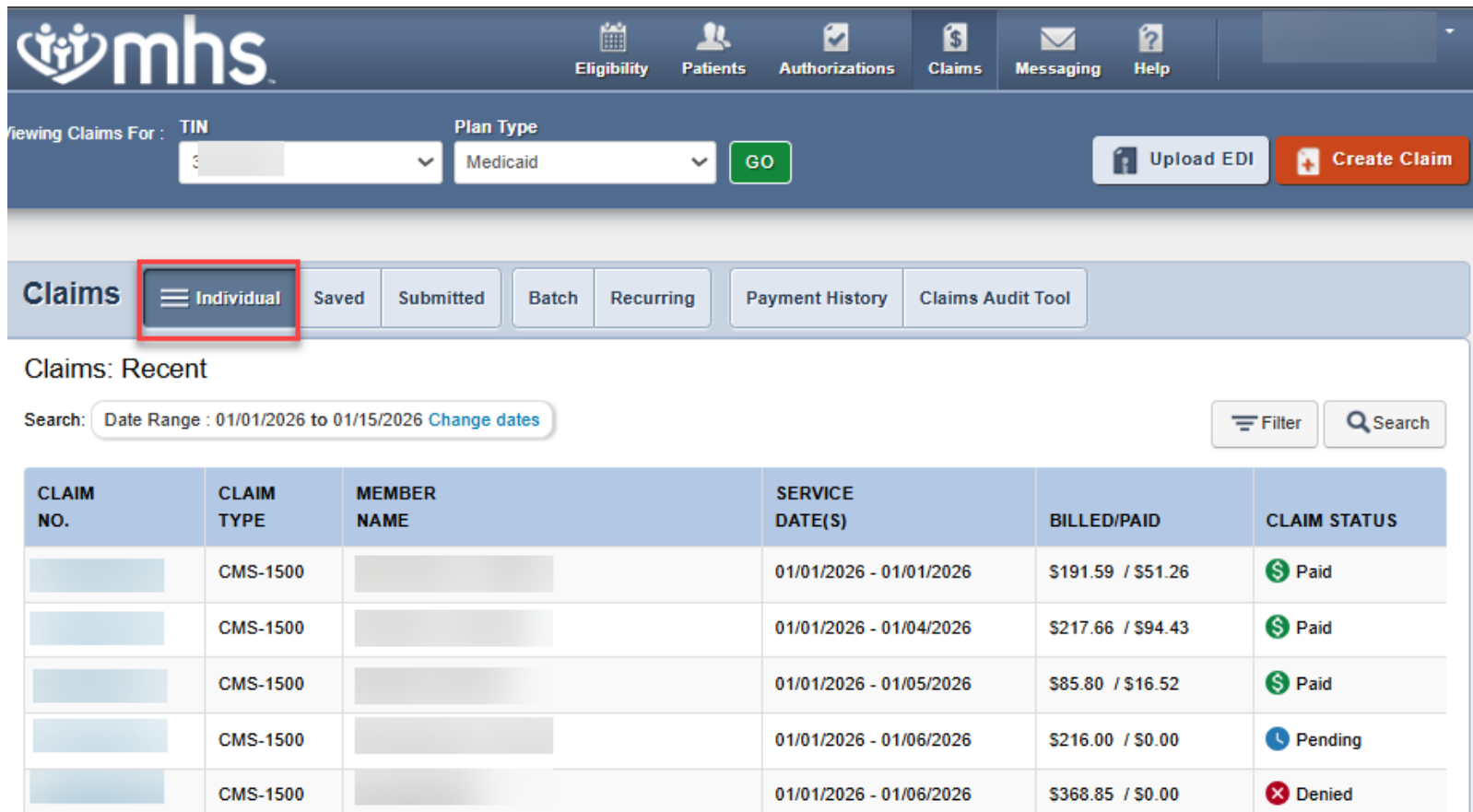
- On the final screen, each procedure code will receive a reimbursement estimate, pending claim explanation, or denial reason.
- Claims with a reimbursement estimate or pending explanation may be impacted by final adjudication, including a change to the reimbursement amount or a denial.
- Adjudication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

Web Portal Claim and Payment Review

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.



The screenshot displays the mhs portal interface. At the top, there is a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below this, a section for 'Viewing Claims For' includes a TIN dropdown, a Plan Type dropdown set to 'Medicaid', and a 'GO' button. To the right are buttons for 'Upload EDI' and 'Create Claim'. A secondary navigation bar contains the 'Claims' section with a sub-menu where 'Individual' is highlighted with a red box. Other options in this bar include 'Saved', 'Submitted', 'Batch', 'Recurring', 'Payment History', and 'Claims Audit Tool'. Below the navigation, the page is titled 'Claims: Recent'. A search bar shows a date range from '01/01/2026 to 01/15/2026' with a 'Change dates' link. To the right of the search bar are 'Filter' and 'Search' buttons. The main content is a table with the following data:

CLAIM NO.	CLAIM TYPE	MEMBER NAME	SERVICE DATE(S)	BILLED/PAID	CLAIM STATUS
	CMS-1500		01/01/2026 - 01/01/2026	\$191.59 / \$51.26	 Paid
	CMS-1500		01/01/2026 - 01/04/2026	\$217.66 / \$94.43	 Paid
	CMS-1500		01/01/2026 - 01/05/2026	\$85.80 / \$16.52	 Paid
	CMS-1500		01/01/2026 - 01/06/2026	\$216.00 / \$0.00	 Pending
	CMS-1500		01/01/2026 - 01/06/2026	\$368.85 / \$0.00	 Denied

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.

The screenshot shows the mhs Claims interface. At the top, there's a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below this, a filter section shows 'Viewing Claims For: TIN' and 'Plan Type: Medicaid' with a 'GO' button. To the right are 'Upload EDI' and 'Create Claim' buttons. A tabbed interface below the filter shows 'Claims' with sub-tabs: Individual, Saved (highlighted with a red box), Submitted, Batch, Recurring, Payment History, and Claims Audit Tool. Below the tabs, a message states: 'Claims listed below have missing information or contain errors. Click 'Edit' to view a claim, then fix any errors or complete it before submitting.' There are three tabs for the claim list: Drafts, Professional Ready to be Submitted, and Institutional Ready to be Submitted. The 'Professional Ready to be Submitted' tab is active, showing a table with columns: DATE CREATED ↑, CLAIM TYPE ↑, CLAIM ID ↑, MEMBER NAME ↑, MEMBER ID ↑, ORIGINAL CLAIM # ↑, TOTAL CHARGES ↑, Edit, and Delete. The table contains four rows of data.

DATE CREATED ↑	CLAIM TYPE ↑	CLAIM ID ↑	MEMBER NAME ↑	MEMBER ID ↑	ORIGINAL CLAIM # ↑	TOTAL CHARGES ↑	Edit	Delete
03/09/2026	CMS-1500					\$1,894.09	Edit	Delete
03/03/2026	Institutional					\$593.45	Edit	Delete
02/26/2026	CMS-1500				Z	\$4,844.55	Edit	Delete
01/29/2026	Institutional				Y	\$8,700.00	Edit	Delete

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**

Eligibility

Patients

Authorizations

Claims

Messaging

Help

Viewing Claims For :

TIN

Plan Type

Medicaid

GO

Upload EDI

Create Claim

Claims

Individual

Saved

Submitted

Batch

Recurring

Payment History

Claims Audit Tool

Filter

SUBMITTED STATUS ↑	DATE SUBMITTED ↑	WEB #/ REF # ↑	CLAIM NUMBER ↑	CLAIM TYPE ↑	MEMBER NAME ↑	MEMBER ID ↑	ORIGINAL CLAIM # ↑	TOTAL CHARGES ↑	
	03/17/2026			CMS-1500				\$232.32	RTEP
	03/16/2026			CMS-1500				\$1,006.00	RTEP
	03/16/2026			CMS-1500				\$5,827.04	RTEP

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.

mhs

Eligibility Patients Authorizations Claims Messaging Help

Viewing Claims For: TIN [dropdown] Plan Type: Medicaid [dropdown] **GO** **Upload EDI** **Create Claim**

Claims Individual Saved Submitted Batch Recurring **Payment History** Claims Audit Tool **Filter**

Transactions

All activity posted to your account between 02/19/2026 and 03/19/2026 .

Instructions: Click a Check Date link to view the payment details from your payment provider. Only available electronic files are linked. The PDF opens in a new window. You can save or print the document. If there are any discrepancies about your payment details, contact Provider Services.

CHECK DATE ↑	CHECK NUMBER ↑	CHECK CLEAR DATE ↑	MAILING ADDRESS ↑	PAYMENT AMOUNT ↑
02/19/2026 (PDF)	[redacted]	EFT	[redacted]	\$565.94
02/19/2026 (PDF)	0000000000	02/19/2026	[redacted]	\$0.00
02/19/2026 (PDF)	[redacted]	EFT	[redacted]	\$44,387.74
02/19/2026 (PDF)	0000000000	02/19/2026	[redacted]	\$0.00

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

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.

Benefits 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 – Helpful Tips

- 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.

Informal Claim on the Secure Provider Portal

mhs Eligibility Patients Authorizations **Claims** Messaging Help

Viewing Claims For: TIN [] Plan Type: Medicaid [] **GO** **Upload EDI** **Create Claim**

Most Recent Payment details do not show final claim status until a payment date is available. Check back before your timely filing deadline.

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

✖ Claim : Denied

[+ Copy Claim](#) [Void/Recoup Claim](#) [Dispute Claim](#)

Claim Accepted In Process Claim Denied

Member	Provider	Claim	Most Recent Payment
Member Name:	Ref/Acct No.:	DOS Range:	Payment Date: Paid Claim Amount:
Member ID:	Servicing Provider:	Received Date:	Check Dated:
Member DOB:	Servicing NPI:	Billed Amount:	

Claim Dispute on the Secure Provider Portal Options

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.
- Please refer to the [MHS Provider Manual](#) for more information.

[Terms and Conditions](#) or (new tab)

[Privacy Policy](#) or (new tab)

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Claim Reconsideration

- Enter your explanation for reconsideration and check email updates.

The screenshot displays the mhs web portal interface. At the top, there is a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. The main content area shows a sidebar with 'Back to Claims' and several 'SELECT' buttons. The central focus is a modal window titled 'Option 2: Reconsideration Claim'. Inside this modal, there is a 'Claim No.' field, a pink informational box stating 'Please refer to the SHP Provider Manual to determine if your request is an appeal or a reconsideration', a 'Reason' dropdown menu currently set to 'Denied for Untimely Filing', a 'Notes' section with a 'Brief Explanation' text area, a '500 Character Limit' warning, an 'Upload Documents' section with a 'Choose Files' button and a note that 'Proof of Timely Filing attachment' is required, an 'Uploaded Files' section, and an 'Email Updates' section with a checkbox to receive status updates. At the bottom of the modal are 'Cancel' and 'Submit Reconsideration' buttons.

Claim Appeals on the Secure Provider Portal

Claim #: [REDACTED] : Denied

+ Copy Claim / Correct Claim

✓ Your Reconsideration request # [REDACTED] has been submitted successfully.

RECONSIDERATION

Claim Accepted In Process Denied In Process OUTCOME TBD

Reconsideration Details

Created Date	Type	Current Status	Reference Number	Tools
06/11/2019	Denial Related to an Authorization	OPEN	[REDACTED]	[Tools Icon]

Member **Provider** **Claim** **Most Recent Payment**

Member Name: [REDACTED] Ref/Acct No.: [REDACTED] DOS Range: [REDACTED] Payment Date: [REDACTED] Granted Claim Amount: [REDACTED]

Member ID: [REDACTED] Servicing Provider: [REDACTED] Received Date: [REDACTED] Check Number: [REDACTED] Total Check Amount: [REDACTED]

Member DOS: [REDACTED] Servicing NPI: [REDACTED] Billed Amount: [REDACTED] Check Date: [REDACTED]

Service Lines

Line	DOS	Proc	Dx	Modifiers	Place of Service	Charged	Total Check Amount	Payment Date	Check Number	Status	Payment Codes
1	05/13/2019		Q059, N319, R32, K592		12	\$381.92	\$0.00	06/11/2019		DENY	L6,Ku

Denial Reason

Denial Code	Description
L6	DENY: BILL PRIMARY INSURER 1ST RESUBMIT WITH EOB
Ku	INFORMATIONAL-RE-ADJUDICATION PROCESS EX CODE

- The **Reconsideration Details** section is viewable to provide status and details.
- **Tools** section allows easy View of included attachments or correspondence letters and the option to add additional attachments to an open reconsideration case still in process.
- The **Most Recent Payment** will display the details of the last check or EFT that was made on the claim.

Coordination of Benefits

Coordination of Benefits

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



Eligibility

Patients

Authorizations

Claims

Messaging

Help

Viewing Eligibility For : TIN

Plan Type

Medicaid

GO

Back to Eligibility Check

Overview

Cost Sharing

Assessments

Health Record

ADT

Care Plan

Authorizations

Referrals

Coordination of Benefits

Claims

Power Account Service Estimate

Document Resource Center

Notes

Coordination of Benefits

[Print Coordination of Benefits](#)

Effective Date	Term Date	Policy Number	Group Number	Carrier Name	Coverage
12/01/2024	12/31/2025	ESYH771369328298	788002	EMPLOYERS NATIONAL	INDIANA MEDICAL AND HOSPITAL

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
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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

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

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Questions?

Thank you for being our partner in care.

