



Introduction to Managed Health Services (MHS)

2026 IHCP Works Annual Seminar

Agenda

- MHS Overview
- Health Programs
- MHS Website
- Claim Process
- Prior Authorization Process
- Coordinated Care Programs
- Improving Access to Care
- MHS Provider Engagement Team
- Questions

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.

Health Programs

MHS Medicaid ID Cards



*Used for both HIP and HIP Maternity



Member and Provider Contact Center

1-877-647-4848

- Dedicated staff available

Monday - Friday from 8:00 a.m. – 8:00 p.m. ET

- Eligibility verification
- Claims status and assistance
- Translation and transportation coordination
- Health needs screening- it is important for members to complete a health needs screening so that the appropriate programs can be identified for patients with needs.
- Interactive Voice Response (IVR) option: telephonic, self-service verification of claims and eligibility

Healthy Indiana Plan



Who is Eligible for the Healthy Indiana Plan (HIP)?

The Healthy Indiana Plan (HIP) is an affordable health insurance program from the State of Indiana for uninsured adult Hoosiers.

Low income Hoosiers ages 19 to 64, who are not receiving Medicare and are interested in participating in a low-cost, consumer-driven health care program.

- Pregnant HIP members benefits falls under HIP Maternity Plan which allows for additional coverage.
- Care coordination services will be individualized based on a member's assessed level of need determined through a health screening.
- Members will select a managed care organization (MCO) responsible for coordinating care in partnership with their medical provider(s).

Hoosier Care Connect



Who is Eligible for Hoosier Care Connect?

Hoosier Care Connect is a health care program for individuals who are aged 59 years and younger, blind, or disabled and some foster care children who are also not eligible for Medicare.

- Hoosier Care Connect members will receive all Medicaid-covered benefits in addition to care coordination services.
- Members will select an MCO responsible for coordinating care in partnership with their medical provider(s).
- Care coordination services will be individualized based on a member's assessed level of need determined through a health screening.

Hoosier Healthwise



**Hoosier
Healthwise**

Who is Eligible for Hoosier Healthwise?

Hoosier Healthwise is a health care program for children up to age 19 and pregnant individuals.

- The program covers medical care such as doctor visits, prescription medicine, mental health care, dental care, hospitalizations and surgeries at little or no cost to the member or the member's family.
- The Children's Health Insurance Program (CHIP) falls under the Hoosier Healthwise program.
 - CHIP is for children up to age 19 whose families have slightly higher incomes.
 - CHIP members are required to pay a low monthly premium for coverage as well as copays for certain services.

MHS Website

MHS Website Resources

mhsindiana.com

- Provides access to Medicaid
- Provider directory search functionality
 - Medicaid Pre-Auth
- PaySpan Electronic Funds Transfer (EFT) information
- Printable current forms, guides and manuals
 - Patient education material
 - Secured Provider Portal
 - Contact Us feature

MHS Secure Provider Portal Features

Access for
Medicaid,
Ambetter and
WellCare

Manage multiple
practices and
lines of business
under one
account

View panels and
membership
information

View member's
prescription and
medical history

Access Gaps in
Care

Access Quality
Reports including
Pay For
Performance

Direct claim
submission

Enhanced claim
detail

Coordination of
Benefits (COB)
processing with
or without
attachments

Claim
adjustment

Claim
auditing tool

Eligibility and
COB
verification

Prior
authorization

Care
Management
Plan

Secure Web Portal Login or Registration

The login/register tool is the same for all **MHS Medicaid** Providers.

The screenshot displays the MHS website interface for providers. At the top, there are navigation links: 'For Members', 'For Providers', and 'Get Insured'. The 'For Providers' link is selected. On the left, a sidebar lists various services: '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 includes a section 'Create your own online account today!' with a description of the portal's benefits and a list of services available to providers. Below this, there is a link to 'Portal Training Guides'. On the right side of the main content area, there are two distinct boxes. The top box is titled 'Secure Provider Portal' and contains a 'Login/Register' button. A large pink arrow points to this button. The bottom box is titled 'Wellcare Complete Provider Portal' and also contains a 'Login/Register' button. A small 'Privacy - Terms' link is visible in the bottom right corner.

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

Claim 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 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

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

PaySpan Health

Web based solution for:

- EFT and ERA

One year retrieval of ERA.

Provided at no cost to providers and allows online enrollment.

Register at: PaySpan

1-877-331-7154 or email
providersupport@payspanhealth.com

PaySpan® Health

FOLLOW THESE INSTRUCTIONS TO GET STARTED WITH PAYSPAN® HEALTH, AN EFT AND ERA WEB BASED SOLUTION:

1

Call 1-877-331-7154 for your unique registration code. Then, visit payspanhealth.com and click **Register**.

2

Enter your registration code and click **Submit**.

3

Enter your PIN, TIN or EIN, and NPI. Then, click **Start Registration**.

National Provider Identifier (NPI)

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)

Adding Tax Code (if applicable)

Submit

OR

Reg Code

What is your Reg Code?

Submit

4

Populate the requested Personal Information. Click **Next**.

Provider Contact Name

Administrator Full Name

Email Address

Confirm Email Address

Telephone Number

Message (call us thru 800-833-0000 for details)

Role
Office Manager

Username

Minimum 8 characters and may include letters (a-z), numbers (0-9), dashes (-), underscores (_), ampersands (&), periods(.)

Password

Confirm Password

Challenge Question
(To what info was your first job?)

Challenge Answer

Save

5

Designate an account for fund transfers by completing the required fields. Click **Next**.

Account Name

This is the account that will be used to identify this incoming account throughout the PaySpan system.

Financial Institution Routing Number

Provider's Account Number with Financial Institution

Confirm Provider's Account Number with Financial Institution

Type of Account at Financial Institution
Business Checking

☒ Enable Electronic Payment

☐ Request Paper Remittance
The Paper does not allow paper remittance.

☒ Designate as additional Paper to this Remitting account

Back Next

6

Verify your information and check the box to agree to the service agreement. Then, click **Confirm**.

7

Within a few business days, you will receive a deposit of less than \$1 from PaySpan. Then, follow these steps to complete registration:

- ▶ Contact your financial institution to obtain the amount deposited by PaySpan.
- ▶ Log into PaySpan, and click **Payments**.
- ▶ Click the **Account Verification** link on the left side of the screen.
- ▶ Enter the amount of the deposit in this format: 0.00.

(The deposit does not need to be returned.)

For PaySpan registration assistance, call: **1-877-331-7154**
Email: providersupport@payspanhealth.com

mhsindiana.com
© 2021 Managed Health Services.
All rights reserved.

0221.PR.P.FL 2/21

 mhs

Confidential and Proprietary Information

20

Claim Process

Claims must be received within **90 calendar days** of the date of service.

- *Exceptions*
 - Newborns (30 calendar days of life or less)
 - Claims must be received within 365 days from the date of service. Claim must be filed with the newborn's Member Identifier (MID) number.
 - Claims with primary insurance must be received within 365 calendar days of the date of service with a copy of the primary explanation of benefits (EOB). If primary EOB is received after the 365 days, providers have **60 calendar days** from date of primary EOB to file claim to MHS.
 - Retro eligibility
 - Provider must submit claims within one year of retro eligibility assignment being established through Indiana Health Coverage Program.

Claim Resubmissions

Claim Resubmissions (Corrected Claims)

- Claims can be resubmitted:
 - The preferred method is via the Secure Provider **MHS Secure Portal**
 - Or
 - Hard copy resubmissions:
 - All resubmission must include acceptable documentation.
 - Such as proof of eligibility, timely filing, COB.

Providers have **60 calendar days** from the date of Explanation of Payment (EOP) to file a resubmission. *Please note, claims will not be reconsidered after this timeline.*

Provider Dispute Process

- Level 1: Informal Claims Dispute or Objection Form
- Level 2: Formal Claim Dispute - Administrative Claim Appeal
- Level 3: Arbitration
- For assistance or questions after completing step one:
- Provider Services Phone Requests & Web Portal Inquiries
- If additional assistance is needed anytime after Level 1 and after calling the Contact Center or completing Web Portal inquiry:
- Contact your Provider Engagement Account Manager (PEAM) **MHS PEAM MAP**

Claim Dispute/Appeal Form – Medical and Behavioral Health

Medical Claims Address:

Managed Health Services
P.O. Box 3002
Attn: Appeals Department
Farmington, MO 63640-3802

Behavioral Health Claims Address:

Managed Health Services BH
P.O. Box 6800
Attn: Appeals Department
Farmington, MO 63640-3817

Helpful Tips

Helpful Tips:

- Please submit the following information when sending an email for claims inquiry to the provider relations regional mailbox (**attach spreadsheet if multiple claims but below fields must be included**)
 - Issue Reference Number(s);
 - Tax identification number (TIN)
 - Group/Facility Name
 - Practitioner Name & NPI
 - Member Name and MID Number
 - Product (Medicaid/Ambetter/Wellcare)
 - Claim Number(s)
 - DOS or DOS Range if multiple denials
 - Related Prior Authorization Numbers (this is key if issue involves claims denied for no authorization)
 - Provider reason for dispute

Prior Authorization Process

Prior Authorization (PA)

- Prior Authorizations should be submitted online via the Secure Provider Portal at: **MHS Provider Portal**.
- When using the portal, supporting documentation can be uploaded directly.
 - Authorization status can also be checked on the portal.
- Prior Authorizations must be completed via electronic fax or through the Availity Portal for Inpatient facilities.
- PA can be initiated through the MHS referral line at 1-877-647-4848 Monday - Friday from 8:00 a.m. – 8:00 p.m. ET.
- The PA process begins at MHS by speaking with the MHS non-clinical referral staff.

Prior Authorizations are not a guarantee of payment.

Pre- Authorization Tool

For Providers
Provider Portal Login
Behavioral Health ▾
Clinical & Payment Policies
Dental Providers
Education & Trainings ▾
Email Sign Up
Enrollment and Updates ▾
News ▾
Pharmacy ▾
Prior Authorization ▴
Medicaid Pre-Auth
Medicare Pre-Auth
Ambetter Pre-Auth 
Quality Improvement ▾
Resources ▾

Medicaid Pre-Auth

DISCLAIMER: All attempts are made to provide the most current information on the Pre-Auth Needed Tool. However, this does NOT guarantee payment. Payment of claims is dependent on eligibility, covered benefits, provider contracts, correct coding and billing practices. For specific details, please refer to the provider manual. If you are uncertain that prior authorization is needed, please submit a request for an accurate response.

Vision services need to be verified by [Centene Vision Services](#) .

Dental services need to be verified by [Centene Dental Services](#) .

Musculoskeletal services need to be verified by [Evolent](#) .

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

Medication under the pharmacy benefit needs to be verified by [State Unified PDL](#) .

NOTE: Services identified as administered by a Vendor may be specific to certain provider specialties, locations, procedure and diagnosis codes. For example, Physical Therapy services rendered by Chiropractic specialty providers or via Telehealth locations are NOT managed by Evolent. Any service rejected by the Vendor as outside of their scope of managed services, please enter a request to establish Health Plan authorization requirements.

Non-participating providers must submit Prior Authorization for all services.

For non-participating providers, [join our network](#).

Prior Authorization at a Glance

Prior Authorization is NOT Required	Prior Authorization IS Required
The following services do NOT require prior authorization:	The following services REQUIRE prior authorization:
• Services rendered in an emergency room or urgent care center • Services rendered by a public health or welfare agency • Family planning services billed with a contraceptive management diagnosis	• Services rendered by an out-of-network provider, with the exception of emergency and urgent care services • Admission of a member to an inpatient facility • Hospice services • Anesthesia services for pain management or dental procedures. • Services rendered at home, other than DME, orthotics, prosthetics, supplies and therapeutic injections • Services rendered by a chiropractor

Prior Authorization Check



[Check Prior Authorization Requirement](#)

Check the **Pre Auth Tool** to verify authorization guidelines.

Pre Authorization – Web Page

Ambetter Pre-Auth 
Quality Improvement 
Resources 

Prior Authorization at a Glance

Prior Authorization is NOT Required

The following services do NOT require prior authorization:

- Services rendered in an emergency room or urgent care center
- Services rendered by a public health or welfare agency
- Family planning services billed with a contraceptive management diagnosis

Prior Authorization IS Required

The following services REQUIRE prior authorization:

- Services rendered by an out-of-network provider, with the exception of emergency and urgent care services
- Admission of a member to an inpatient facility
- Hospice services
- Anesthesia services for pain management or dental procedures.
- Services rendered at home, other than DME, orthotics, prosthetics, supplies and therapeutic injections
- Services rendered by a chiropractor

Prior Authorization Check

Enter Service Code *

Q 21235

Check Prior Authorization Requirement



Required

Code: 21235 - GFT; EAR CARTILAGE AUTOGEN NOSE/EAR

Pre-authorization required for all providers.

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

Evolut

Physical, Occupational, and Speech Therapy

- Utilization management of these services is managed by Evolut for Medicaid
- All Health Plan approved training/education materials are posted on the Evolut website, **RadMD**, under the Resources tab. For new users to access these web-based documents, a RadMD account ID and password must be created.
- Chiropractors rendering therapy services are exempt from the Evolut program.

Evolut Cardiac Services

Evolut manages prior authorizations for the Cardiac Services below: This is not an all-inclusive list.

- Pacemaker
- Revision or Replacement of Implanted Cardiac Device
- Coronary Artery Bypass Grafting (Non-Emergent)
- Coronary Angioplasty and Stenting
- Non-Coronary Angioplasty and Stenting
- Automated Implantable Cardioverter Defibrillator

Emergency related procedures do not require authorization.

Evolut Musculoskeletal

MHS has entered into an agreement with Evolut to implement a Musculoskeletal Safety and Management Program. This program includes prior authorization for medical necessity and appropriate length of stay (when applicable) for both inpatient and outpatient settings.

- Emergency-Related Procedures do not require authorization.
- It is the responsibility of the ordering physician to obtain authorization.
- Providers rendering musculoskeletal services, must verify that the necessary authorization has been obtained; failure to do so may result in non-payment of your claims.

Evolut Utilization Management Contact Information

Web Portal Intake:

- Evolut

Contact Information:

- Medicaid: 1-866-904-5096
 - Monday - Friday from 8:00 a.m. – 8:00 p.m. EST.

Inpatient Prior Authorization

To notify MHS of an inpatient admission:

- **MHS Secure Portal**
- Fax using the **IHCP Universal Prior Authorization Form** to 1-866-912-4245

Prior Authorization Timelines

- All elective inpatient/outpatient services must be prior authorized with MHS at least 48 hours prior to the date of service.
- All urgent and emergent services must be faxed in or submitted via the MHS Secure Provider Portal to MHS within 24 hours after the admit.
- Approved prior authorizations must be updated for changes in dates of service or Current Procedural Terminology/Healthcare Common Procedure Coding System (CPT)/(HCPCS) codes within 90 calendar days of the original date of service.

Failure to obtain prior authorization for services may result in claim denials!

Prior Authorization/Medical Necessity Appeals on the Provider Secure Portal

Medicaid prior authorization/medical necessity denial appeals can be submitted to MHS via the secure provider portal and will allow for tracking.

If MHS denies the requested services, the attending physician has the right to a peer-to-peer discussion with an MHS physician, upon written member consent.

- Urgent PA turn around time is **24 hours**.
- Standard PA turn around time is **48 hours**.
- Peer-to-Peer requests must be within 7 business days after the adverse determination.
- Providers initiate peer-to-peer discussions and expedited appeals by calling an MHS appeals coordinator at 1-877-647-4848, Mon. – Fri. 8 a.m. – 8 p.m. ET.

Prior Authorization Grievance and Appeals

Medical Necessity and Grievance and Appeals

Managed Health Services

ATTN: Appeals

P.O. Box 441567

Indianapolis, IN 46244

Remember: Appeals must be initiated **within 48 hours** of the denial to be considered. Please note, this is different than a claim appeal request.

Behavioral Health Prior Authorization

Medical necessity behavioral health appeals should be mailed or faxed to:

**MHS Behavioral Health
ATTN: Appeals Coordinator
12515 Research Blvd, Suite 400
Austin, TX 78701
FAX: 1-866-714-7991**

Behavioral Health Medical Necessity appeals must be received by MHS within **48 hours** of the date listed on the denial determination letter. The monitoring of the appeal timeline will begin the day MHS receives and receipt-stamps the appeal.

Coordinated Care Programs

Care Management Programs

- MHS Care Management is made up of nurses and social workers.
- **Care Managers will:**
 - Help members, doctors and other providers, including behavioral health providers.
 - Help members obtain services covered by their Medicaid benefit package.
 - Help explain and inform members about their condition.
 - Work with provider's healthcare plan for the member.
 - Inform members about community resources.

Disease Management Programs

MHS works with our disease management sister company **Envolve People Care Disease Management** to provide disease management services to members diagnosed such as:

- Asthma
- Diabetes
- Chronic obstructive pulmonary disease (COPD)

Envolve People Care Disease Management provides outreach through personal health coaches.

Respiratory therapists and certified diabetic educators provide home visits to members at highest risk.

Members with diagnoses will receive educational materials and intervention based on severity.

MHS also provides disease management for behavioral health conditions such as depression and Attention Deficit Hyperactivity Disorder (ADHD).

Right Choice Program

- Members identified as high utilizers in need of specialized intervention are enrolled into the Right Choices Program (RCP).
- The member is “locked-in” to their primary medical provider and delivery of care for specialty services is coordinated through that provider’s office.
- RCP participants are assigned to:
 - One primary medical provider (PMP)
 - One pharmacy

Smoking Cessation

- The Indiana Tobacco Quitline
 - 1-800-QUIT-NOW (1-800-784-8669).
 - Free phone-based counseling service that helps Indiana smokers quit.
 - One-on-one coaching for tobacco users trying to quit.
 - Provider resources available via the MHS website.

Improving Access to Care

Appointment Standards

PMP and Specialists	
Appointment Type	Appointment Standard
Urgent care appointments with PMP that do not require prior authorization	Within 48 hours of request
Urgent care appointments with specialist that do not require prior authorization	Within 48 hours of request
Non-urgent appointments with PMP	Within 10 business days of request
Non-urgent appointment with specialist	Within 15 business days of request
Physical exams and wellness check appointment	Within 30 calendar days of request
First prenatal appointment with PMP	Within 10 business days of request
First prenatal appointment with specialist	Within 10 business days of request
Well-child visit with PMP	Within 10 business days of request

Transportation Benefits

WellTrans arranges transportation for all MHS Hoosier Healthwise, Hoosier Care Connect, and Healthy Indiana Plan (HIP) members who qualify for transportation services.

Members will call the MHS Toll Free line at (877) 647-4848, Monday - Friday from 8:00 a.m. – 8:00 p.m. ET, which is listed on the back of their insurance card to confirm eligibility and schedule a rides to and from:

- Doctor visits
- Medicaid enrollment visits and reenrollment visits
- Pharmacy visits

Transportation Benefits (1 of 2)

Advance Notice Requirements for Routine/Standard Trips:

- 2 calendar days before the member's scheduled appointment.
- Members may book transportation up to 45 calendar days in advance.

Urgent Care Trips:

- Urgent & Discharge Trips: Available twenty-four hours a day, three hundred and sixty-five days.

Hours of Operation:

- Scheduled Trips: Monday–Friday, 8:00 a.m. – 8:00 p.m. ET
- Closed Holidays: New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving, Christmas

Transportation Benefits (2 of 2)

MHS will process all Medicaid emergent and non-emergent ambulance claims, including air ambulance.

Claims for the following services should be sent to MHS:

- 911 transports
- Medically necessary non-emergent hospital transports requiring an ambulance with advanced life support (ALS) or basic life support (BLS).

Providers must submit prior authorization for air ambulance transport (non-emergent fixed wing airplane).

Culturally and Linguistic Appropriate Services (CLAS)



CLAS refers to healthcare services that are respectful of and responsive to the cultural and linguistic needs of patients.



Visit **CLAS**



Provider guides page for a brochure about CLAS standards.

Culturally and Linguistically Appropriate Services (CLAS) - Contact

- Available to MHS members and providers at no cost.
- Can accommodate most languages and locations.
- Interpretation services available in person or telephonically.
- Please contact MHS Member Services at
1-877-647-4848
Monday - Friday from 8:00 a.m. – 8:00 p.m. ET.

MHS 24/7 Nurse Advice Line

- The MHS Nurse Advice Line (1-877-647-4848) is available 24 hours a day, seven days a week to answer members' health questions.
- The Nurse Advice line staff is bilingual in English and Spanish. Additional languages are available.

MHS My Health Pays® Healthy Rewards Program

- MHS will reward members' healthy choices through our My Health Pays® Rewards program. Members can earn dollar rewards by staying up to date on preventive care.
- These rewards will be added to a My Health Pays® Prepaid Visa Card.
- Members may use My Health Pays® rewards to help pay for everyday items at Walmart, utilities, transportation, telecommunications (cell phone bill), childcare services, education and rent.

My Health Pays



MHS Provider Engagement Team

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

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

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

NETWORK OPERATIONS

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

NEW PROVIDER CONTRACTING

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

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

CENTENE VISION

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

CENTENE DENTAL

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

Questions?

Thank you for being our partner in care.

