



Prior Authorization: Streamlining the Process for Success

2026 IHCP Works Annual Seminar

Agenda

- Who is MHS
- Medical Prior Authorization (PA)
- Prior Authorization Updates
- Need to Know
- Web Portal
- Fax Authorizations
- Prior Authorization and Medical Necessity Appeals
- Prior Authorization Denial and Appeal Process
- Behavioral Health (BH) PA Updates
- BH Prior Authorizations Appeals
- Fax Request
- Pertinent Information
- MHS Network Team
- Questions

MHS Overview

Who Is MHS?

- Managed Health Services (MHS) is a health insurance provider that has been proudly serving Indiana residents for 30 years through Hoosier Healthwise (HHW), the Healthy Indiana Plan (HIP) and Hoosier Care Connect (HCC).
- MHS is your choice for better healthcare.

Medical Prior Authorization (PA)

Medical Prior Authorization (PA)

Medical PA is an approval from MHS to provide services designated as needing authorization before treatment and/or payment.

- Emergency Room (ER) services do not require PA.
 - Admission must be called into MHS Prior Authorization Department within two business days. Please contact 1-877-647-4848.
- Urgent concurrent = Emergent inpatient admission. Determination timeline within 24 hours of receipt of request.

PA Guidelines for Medical and Behavioral Health

MHS adheres to the following timelines for PA decisions:

- Up to 48 hours for standard PA decisions.
- Within 24 hours for urgent PA decisions.
- Concurrent review request within 48 hours.

Possible Reasons for Delayed Decisions:

- Incomplete or insufficient information submitted with the request.
- Requests requiring review by the Medical Director.
- If the provider requests an inpatient level of care for a covered/eligible condition, but the procedure and documentation support an outpatient/observation level of care, the case will be sent for Medical Director review.

Important Note: The Medical Management team does not verify member eligibility or benefit limitations. It is the provider's responsibility to confirm eligibility and verify benefit coverage is assigned to MHS.

Medical Prior Authorization

MHS Medical Management will review State guidelines and clinical documentation.

- If the provider requests an inpatient level of care for a covered or eligible condition, but procedure and documentation supports an outpatient or observation level of care, MHS will send the case for Medical Director review.
- Elective procedures that require PA must be submitted to MHS at least two business days prior to the date of service.

***Authorizations do not guarantee payment.**

Transfer Prior Authorization Requests

- MHS requires notification and approval for all transfers from one facility to another, at least two business days in advance.
- MHS requires notification within two business days following all emergent transfers.

***Higher level of care changes require PA, and it is the responsibility of the new transferring facility to obtain.**

Ways to Obtain a Prior Authorization

- Check to see if a Medicaid Pre-Authorization is necessary by using our online tool. If an authorization is needed, you can access our **MHS Provider Portal** to submit a request online.
- The **Prior Authorization** link will take you to the Medicaid Pre-Auth page.
- For imaging, outpatient surgeries and testing, requests for services may be obtained via:

Phone: 1-877-647-4848

Fax: 1-866-912-4245

Online: **MHS Provider Portal**

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](#)

Prior Authorization

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

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

Expand the links below to find out more information.

[How to Obtain a Prior Authorization](#)
[List of Services Requiring Prior Authorization \(PA\)](#)
[Prior Authorization Requirements](#)
[MHS Prior Authorization Statistics for 2025 - Hoosier Care Connect \(HCC\)](#)
[MHS Prior Authorization Statistics for 2025 - Hoosier Healthwise \(HHW\)](#)
[MHS Prior Authorization Statistics for 2025 - Healthy Indiana Plan \(HIP\)](#)

How to Obtain a Prior Authorization

Reminder: As of 12/1/2025, all out of network providers require an authorization. Authorization requests will be reviewed, but MHS members will be directed to seek services from an in-network provider.

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

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

Check Prior Authorization Requirement

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

Prior Authorization Web Tool – No

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Prior Authorization Check

Enter Service Code *

Q 99394

Check Prior Authorization Requirement



Not Required

Code: 99394 - PREV VISIT EST AGE 12-17

No Pre-authorization required for all providers.

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

Prior Authorization Web Tool - Conditional

Medicaid Pre-Auth

Medicare Pre-Auth

Ambetter Pre-Auth [↗](#)

Quality Improvement [▼](#)

Resources [▼](#)

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Prior Authorization Check

Enter Service Code *

Check Prior Authorization Requirement



Code: 90834 - PSYTX W PT 45 MINUTES
Prior authorization is required after 20 units in calendar year.

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



[How to Use the MHS Prior Authorization Tool Elmer \(PDF\)](#)

Log into the **MHS Provider Portal** to submit a Prior Authorization.

Prior Authorization Web Tool - Yes

Medicare Pre-Auth
Ambetter Pre-Auth ↗
Quality Improvement ▼
Resources ▼

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- Services rendered by a chiropractor

Prior Authorization Check

Enter Service Code *

Check Prior Authorization Requirement



Required

Code: 75563 - CARD MRI W/STRESS IMG & DYE

Authorization required through Evolent for these services.

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

Log into the **MHS Provider Portal** to submit a Prior Authorization.

Prior Authorization Web Tool – Revenue Code –Yes

Medicaid Pre-Auth
Medicare Pre-Auth
Ambetter Pre-Auth ↗
Quality Improvement ▼
Resources ▼

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- Services rendered at home, other than DME, orthotics, prosthetics, supplies and therapeutic injections
- Services rendered by a chiropractor

Prior Authorization Check

Enter Service Code *

483

Check Prior Authorization Requirement



Required

Code: 483 - ECHOCARDIOLOGY /LOCAL EXC/DESTRUC LES/TISSUE RE

Authorization required through Evolent for these services.

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

Log into the **MHS Provider Portal** to submit a Prior Authorization.

Information Needed For Prior Authorization

Information Needed to Complete All Prior Authorization Request:

- Member's Name, Medicaid ID, and Date of Birth
- Type of service needed
- Date(s) of service
- Ordering Physician with National Provider Identifier (NPI) number
- Servicing/Rendering Physician with Rendering NPI number
- Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes requested for approval, also the Rev codes being billed
- Diagnosis code
- Contact person, including phone and fax numbers
- Clinical information to support medical necessity
- Home care requires a signed Plan of Care (POC) and physician orders must be included for all types of requests, as well as Certificate of Medical necessity for most Durable Medical Equipment (DME) items.

Continuity of Care Prior Authorization Requests

- MHS will honor pre-existing authorizations from any other Indiana Medicaid payor following the below mentioned guidelines:
 - During the first 90 calendar days during member enrollment, or up to the expiration date of the previous authorization, whichever occurs first, and upon notification of transition to MHS.
 - Providers must include the approval from the prior payor or fee-for service (FFS), once the member transfers to MHS.

***Reference: MHS Provider Manual Chapter 7**
Provider Manual

Sub-Acute Care Prior Authorization Requests

- MHS conducts clinical review for ongoing authorization and coordination of discharge needs for our members in Sub-acute facilities at least every three to five calendar days.
- One-day sub-acute care request turnaround time.
- A Preadmission Screening and Resident Review (PASRR) is required before admission and must be submitted with the admission request and when updated according to IAC requirements.

Sub-Acute Care

The PASRR is submitted to MHS with the admission request and should include complete current information regarding:

- Member's condition
- Level of functioning (prior to admission)
- Medications
- Therapies provided
- Participation in therapies
- Progress toward goals
- New or amended goals
- Updates from care conferences
- Updates to the member's plan of care
- Discharge plans and needs identified (Home Health/ DME, etc.)
- Anticipated discharge date

Inpatient Prior Authorization Requests

- Notification of an inpatient admission and any clinical information may be submitted for medical necessity review via:
 - **MHS Provider Portal**
 - **IHCP Universal PA Form** submitted via fax 1-866-912-4245
- Phone notifications of admission and submission of clinical information for members enrolled in Hoosier Healthwise, the Healthy Indiana Plan (HIP), or Hoosier Care Connect will not be accepted.

Prior Authorization Updates

Prior Authorization Update Requests

- Providers can update previously approved PA within 90 calendar days of the original date of service prior to claim denial for changes to:
 - Dates of service
 - CPT/HCPCS codes
 - Provider demographic changes

***Providers are encouraged to make corrections to the existing PA prior to submitting the claim.**

Need to Know

Outpatient Radiology Prior Authorization Request

- MHS partners with Evolent for outpatient radiology PA process.
- PA requests must be submitted via:
 - Evolent Website: **RadMD.com**
 - Evolent phone number: 1-866-904-5096

**Not applicable for ER, Observation, or Inpatient.*

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

Cardiac Services

Evolut manages prior authorizations for the cardiac services below:

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

Telephonic Intake: Direct: 1-574-784-1005 | Toll Free: 1-855-415-7482

Facsimile Intake: 1-463-207-5864

***This is not an all-inclusive list.**

Durable & Home Medical Equipment (DME/HME)

- Non-Participating DME providers require prior authorization on all services. Prior Authorization requests must be submitted by the ordering physician. All requests should be faxed directly to MHS.
- Orders are sent directly to and coordinated by MHS and delivered to the member.
- Does not apply to items provided by and billed by physician office.
- To initiate a prior authorization:
Log into the **MHS Provider Portal** click on “Create Authorization.” Choose DME and you will be directed to the DME portal for order entry.
- **Phone Number:** 1-844-218-4932.
- **Fax Number:** 1-866-912-4245.

Ambulance Coverage

Prior authorization is required to ensure medical necessity for the following non-emergent ambulance services:

Ambulance:

A0426 - Ambulance service, adv. life support, non-emergency transport, level 1

A0428 - Ambulance service, basic life support, non-emergent transport.

A0999 - Unlisted ambulance service

T2003 - Non-emergency transportation encounter/trip

T2004 - Non-emergency transportation commercial carrier

Air Transport:

A0140 - Non-emergency transportation and air travel

A0430 - Air Ambulance, conventional air services, one way (fixed wing)

A0999 - Unlisted Ambulance service

Pharmacy Requests

MHS Pharmacy Benefit Manager is Express Scripts, Inc. (ESI)

- Preferred Drug Lists and authorization forms are available on our **MHS website**.
- PA requests:
 - Phone: 1-866-399-0928
 - Fax non-specialty drugs: 1-866-399-0929
 - Fax specialty drugs: 1-833-645-2742
- Formulary integrated into many Electronic Health Records (EHR) solutions.
- Online PA submission available through CoverMyMeds:
 - covermymeds.com/main/
- Specialty Drugs
 - AcariaHealth General Customer Care
 - Phone: 1-800-511-5144 Fax: 1-877-541-1503

Web Portal

Secure Portal Registration or Login

Sign up or log into the **MHS Provider Portal**.



For Members ▾For Providers ▾Get Insured

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

Availity



Check Eligibility, submit and check Claims and submit and confirm Auths

Sign Up



32

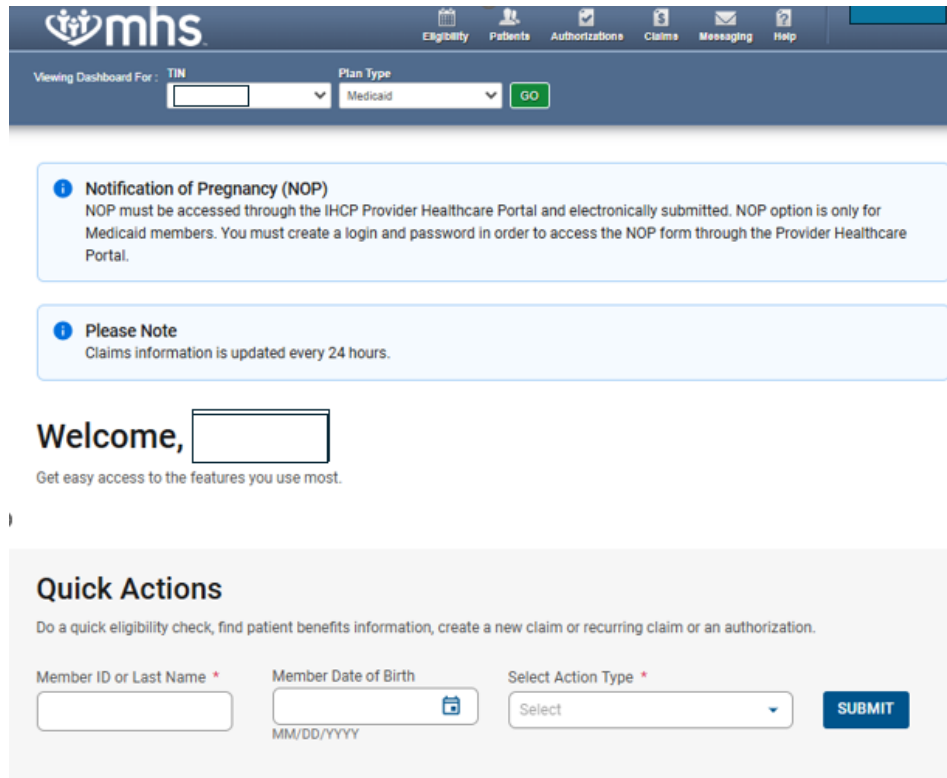
Web Authorization

- Providers can submit PAs online via the MHS Secure Provider Portal.
- When using the portal, providers can upload supporting documentation directly.
- Providers can check the authorization status on the portal.
- Same steps for Behavioral Health (BH) and Medical using appropriate links.

Exceptions: Must submit Hospice, Home Health, and biopharmaceuticals PA requests via fax at 1-866-912-4245.

Homepage – MHS (Medicaid)

After logging into the **MHS Provider Portal** this homepage will appear that allows providers to access information.



The screenshot shows the MHS Provider Portal homepage. At the top is a navigation bar with the MHS logo and links for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below the navigation bar is a dashboard header with a 'Viewing Dashboard For' section containing a TIN input field and a Plan Type dropdown menu set to 'Medicaid', with a 'GO' button. The main content area features two informational boxes: 'Notification of Pregnancy (NOP)' and 'Please Note' regarding claims information updates. Below these is a 'Welcome, [redacted]' message with a 'Get easy access to the features you use most.' link. The 'Quick Actions' section provides a form for eligibility checks, including fields for Member ID or Last Name, Member Date of Birth, and a dropdown for Select Action Type, with a 'SUBMIT' button. At the bottom is the 'Authorization Overview' section with buttons for 'Inpatient Authorizations' and 'Outpatient Authorizations', each with a 'View All' link.

mhs

Eligibility Patients Authorizations Claims Messaging Help

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

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

Please Note
Claims information is updated every 24 hours.

Welcome, []
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 * [] Member Date of Birth [MM/DD/YYYY] Select Action Type * [Select] [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

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.

PAI Provider Survey

This survey enables providers to update their accessibility information.

Provider Resources

Supplies you with tools and resources that are easy to find and supportive to your work.

Member Management Forms

Member Disenrollment and Panel Management Forms

To learn more about submitting a NOP, visit the IHCP Provider Healthcare Portal

Learn more about Fee Schedules, Drug Resources, NOP Submissions and more.

Peer to Peer Contact Form

Peer to Peer calls are offered to physicians and other practitioners after a requested service has been denied.

Pharmacy

For HIP Pharmacy information and PDLs, please visit the HIP Pharmacy Page. Contains forms, FAQs and search tools.

Go Paperless - Payspan

Convenient paperless claim payment and remittance advice platform.

Creating a New Authorization

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

The image displays two screenshots of the mhs web application interface, illustrating the steps to create a new authorization.

Top Screenshot: The 'Create Authorization' button is highlighted with a pink arrow. The interface includes a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below the navigation bar, there are dropdown menus for 'Viewing Authorizations For: TIN' and 'Plan Type' (set to Medicaid), a 'GO' button, and the 'Create Authorization' button.

Bottom Screenshot: The search fields for 'Member ID or Last Name' and 'Birthdate' are highlighted with pink arrows. The 'Member ID or Last Name' field contains the text '123456789 or Smith', and the 'Birthdate' field contains the text 'mm/dd/yyyy'. The 'Find' button is also visible. The interface includes the same navigation bar and dropdown menus as the top screenshot.

Creating a New Authorization

Select an Authorization Type

The screenshot displays a web form titled "Enter Authorization". The form is divided into three main sections: "1. PROVIDER REQUEST", "2. REVIEW REQUEST", and "3. FINISH UP". The "1. PROVIDER REQUEST" section is currently active and contains a checkbox for "Urgent Request" and a dropdown menu labeled "Select an Authorization Type". The dropdown menu is open, showing three options: "Select an Authorization Type" (highlighted in blue), "Inpatient Medical", and "Outpatient Medical". The "2. REVIEW REQUEST" section is currently empty. The "3. FINISH UP" section is at the bottom of the form.

Enter Authorization

1. PROVIDER REQUEST

☐ Urgent Request

Select an Authorization Type ▼

- Select an Authorization Type
- Inpatient Medical
- Outpatient Medical

2. REVIEW REQUEST

3. FINISH UP

Adding Information for Authorization

Inpatient Medical Auth Type Selected

Choose Service Type

Enter Authorization

1. PROVIDER REQUEST

☐ Urgent Request

Inpatient Medical ▼

Surgical?

☐ Yes

☒ No

Choose Service Type ▼

- Choose Service Type
- C-Section Delivery
- Medical
- Neonate
- Premature/False Labor
- Rehab Inpatient
- Skilled Nursing
- Surgical Inpatient
- Transplant
- Vaginal Delivery

3.1

Outpatient Medical Auth Type Selected

Enter Authorization

1. PROVIDER REQUEST

☐ Urgent Request

Outpatient Medical ▼

Lab Testing?

☐ Yes

☒ No

Requesting Provider

Requesting Provider NPI or Last Name

NEXT >

3. FINISH UP

Adding Procedure

Add Additional Service Line and Service Line Details

Authorization For
AI [REDACTED] RK DOB: ([REDACTED]) | MEDICAID NBR: 1 [REDACTED]

PROVIDER REQUEST
 [REDACTED]
Primary Diagnosis: A213: GASTROINTESTINAL TULAREMIA
NPI: 149 [REDACTED]
TIN: 310 [REDACTED]
Phone: [REDACTED]

If you need an authorization for an out-of-network provider, please contact 1-866-406-2803.

Enter Authorization
1. PROVIDER REQUEST [EDIT](#)
2. SERVICE LINE
Servicing Provider
☒ Same as Requesting Provider
[REDACTED]
NPI: 1 [REDACTED]
TIN: ** [REDACTED]
Name: [REDACTED]
Start Date [REDACTED] – End Date [REDACTED]
Units/Visits/Days [REDACTED]
Select a Place Of Service **▼**
Primary Procedure
Procedure Code [REDACTED]

 Add New Service Line
NEXT >
3. FINISH UP

Creating a New Authorization

Service Line Details:

The screenshot shows a web form titled 'Enter Authorization'. It has two main sections: '1. PROVIDER REQUEST' and '2. SERVICE LINE'. The '2. SERVICE LINE' section is active and contains the following fields:

- Now adding new service line**: A text field showing 'Service Line 1: 1477554756 / 44970' with a close icon.
- Servicing Provider**: A dropdown menu with 'Brown' selected. A red arrow points to this field.
- Same as Requesting Provider**: A checkbox that is currently unchecked.
- Start Date** and **End Date**: Two date input fields.
- Units/Visits/Days**: A text input field.
- Primary Procedure**: A text input field with 'Procedure Code' below it.
- CODE LOOKUP**: A blue link.
- Add Additional Procedures**: A button with a plus icon.
- Select a Place Of Service**: A dropdown menu.

Below the '2. SERVICE LINE' section, there is a 'Questionnaire' section with an 'Attachment' label and a text area for uploading files (5Mb limit). It includes a 'Browse' button and an 'Attach' button.

- Provider request will appear on the left side of the screen.
- Update Servicing Provider. Check box if same as Requesting Provider.
- Update Servicing Provider if not the same.
- Update Start Date and End Date.
- Update Total Units, Visits or Days.
- Update Primary Procedure.
- Add any additional procedures.
- Add additional Service Line if applicable: All Service Lines added will appear on the left side of the screen.

New Authorization Submission

- Submit a new Authorization:
 - **Confirmation number**

The image shows a web application interface for submitting a new authorization. On the left is a form titled '1. PROVIDER REQUEST' with an 'EDIT' link. Below it are sections for '2. SERVICE LINE' (also with an 'EDIT' link) and '3. FINISH UP'. The 'FINISH UP' section contains fields for a phone number (123) 456-7890, a fax number (098) 765-4321, and an email address jmuliner@centene.com. There is a 'Questionnaire' section with a 'Questionnaire' button. Below that is an 'Attachment' section with the text 'Upload any relevant attachments. (5Mb limit)' and a file upload area showing a file named 'Smart Sheet for Testing.pdf' with 'Attach' and 'Remove' buttons. At the bottom of the form is a large black 'SUBMIT' button, which is pointed to by a red arrow. On the right is a 'Success!' modal window with a close button (X). The modal contains a list of items: 'Your confirmation number is #1', 'Member's Name', 'Date of Birth', and 'Medicaid Number'. A red arrow points to the confirmation number in the modal. The background shows a dark sidebar with 'PROVIDER REQUEST' and 'SERVICE LINES' sections, and a top bar with 'Authorization For' and 'Enter Authorization' tabs.

Fax Authorizations

Fax Authorizations

MHS Medical Management Department Prior Authorization

Fax: 1-866-912-4245

Patient Information					
IHCP Member ID (RID):					
Date of Birth:					
Patient Name:					
Address:					
City/State/ZIP Code:					
Patient/Guardian Phone:					
PMP Name:					
PMP NPI:					
PMP Phone:					
Ordering, Prescribing, or Referring (OPR) Provider Information					
OPR Physician NPI:					
Medical Diagnosis (Use of ICD Diagnostic Code Is Required)					
Dx1		Dx2		Dx3	

← Member ID, DOB, Patient Name required.

← Medical Diagnosis code(s) required.

← Check Service category.

Please check the requested assignment category below:

- | | | |
|--------------------------------------|---|---|
| ☐ DME | ☐ Inpatient | ☐ Physical Therapy |
| ☐ Purchased | ☐ Observation | ☐ Speech Therapy |
| ☐ Rented | ☐ Office Visit | ☐ Transportation |
| ☐ Home Health | ☐ Occupational Therapy | ☐ Other |

PA Forms can be found on the website.

Fax Authorizations- Pertinent Information

Requesting Provider Information	
Requesting	
Taxonomy:	
Taxpayer Identification Number (TIN):	
Provider Name:	
Rendering Provider Information	
Rendering Provider NPI/Provider ID:	
TIN:	
Name:	
Address	
City/State/ZIP Code:	
Phone:	
Fax:	

Enter the **Requesting** provider's information

Enter the **Rendering** provider's individual NPI#

Fax Authorization

Fax Authorizations – Procedures

Dates of Service Start Stop		Procedure/ Service Codes	Modifiers		Service Description	Taxonomy	Place of Service (POS)	Units	Dollars

Please complete all fields to ensure the PA request will be processed accurately.

Prior Authorization and Medical Necessity Appeals

Prior Authorization/Medical Necessity Appeals

- Appeals must be initiated within 48 hours of the denial to be considered.
- Members may continue to receive benefits while the appeal is pending but may be liable for the costs if the decision is unfavorable. Determination will be communicated to the provider within 48 hours of the receipt.
- Decisions regarding expedited appeals are made no later than 24 hours.
- Peer-to-Peer (P2P) requests must be within 48 hours of the adverse determination.

Prior Authorization Submission

- Prior Authorization/Medical Necessity Appeals may be submitted to MHS in the following ways:
 - Web: **Secure Provider Portal**
 - Call: Medicaid: 1-877-647-4848
Monday - Friday 8:00 a.m. to 8:00 p.m. EST.
 - Email: **Appeals@mhsindiana.com**
 - Fax: Medicaid: 1-866-714-7993
 - Mail: MHS Grievance & Appeals
P.O. Box 441567
Indianapolis, IN 46244

Prior Authorization Denial and Appeal Process

Prior Authorization Denial and Appeal Process

- **If MHS denies the requested service:**
 - And the member is still receiving services; you have the right to an expedited appeal. The attending physician must request the expedited appeal.
 - Or if the member already has been discharged, the attending physician must submit an appeal in writing within 60 calendar days of the denial.
 - The attending physician has the right to a P2P discussion with an MHS physician.
 - Providers initiate P2P discussions and expedited appeals by calling an MHS Appeals Coordinator at 1-877-647-4848.
- * **PA appeals are also known as medical necessity appeals.**

Peer to Peer

P2P Discussion

- You must request P2P within 48 hours of the adverse determination.

***A PA appeal is different than a claim appeal request.**

PA Denial and Appeal Process

- PA and appeals can be completed through our Secure Web Portal:
MHS Secure Portal
- Appeals can also be mailed to:
Authorization/Medical Necessity
Managed Health Service
Attn: Appeals Coordinator
P.O. Box 441567
Indianapolis, IN 46244
- To check status of an Appeal or Grievance email:
Appeal status inquiries should be sent to MHS Indy Appeals:
appeals@mhsindiana.com
Grievance status inquiries should be sent to MHS Indy
Compliance Outreach:
compliance_outreach_in@centene.com

P2P phone line (855-696-2613), extension 87058 will transfer to the P2P Schedulers.

Behavioral Health (BH) PA Updates

Behavioral Health Authorization (1 of 3)

Facility Services:

- Inpatient Admissions
- Intensive Outpatient Treatment (IOT)
- Outpatient (may be different timeframes depending on codes billed)
- Partial Hospitalization
- Substance Use Disorder (SUD) Residential Treatment

***Authorizations do not guarantee payment.**

Behavioral Health Authorization (2 of 3)

Professional Services:

- Psychiatric Diagnostic Evaluation
- Behavioral Health Outpatient Therapy (BHOP Therapy)
- Electroconvulsive Therapy
- Psychological Testing (unless for autism, then no authorization is required)
- Developmental testing, with interpretation and report {(non- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT))}
- Neurobehavioral status exam, with interpretation and report
- Neuropsychological testing per hour, face-to-face:
 - Unless for autism, then no authorization is required
- Applied Behavior Analysis (ABA) Services – are approved by units
- All Non-participating providers (not contracted)

***Authorizations do not guarantee payment.**

Behavioral Health Authorization Forms

- Please visit our [Behavioral Health Forms](#) page to access the complete list of forms required for prior authorization submissions:

BH Forms

Inpatient and Residential Treatment for Substance Use Disorder (SUD)

- [Discharge Consultation Documentation \(PDF\)](#)
- [Initial Assessment Form for Substance Use Disorder Treatment Admission](#) 
- [Reassessment Form for Continued Substance Use Disorder Treatment](#) 
- [Residential/Inpatient Substance Use Disorder Treatment Prior Authorization Request Form](#) 

Outpatient Treatment Request (OTR) Form

- [Applied Behavioral Analysis Treatment OTR \(PDF\)](#)
- [IN Medicaid ABA Provider Request Tip Sheet \(PDF\)](#)
- [Intensive Outpatient Day Treatment Form \(PDF\)](#)
- [HHW/HIP Outpatient Treatment Request \(OTR\) Form \(PDF\)](#)

- When submitting a prior authorization request for Behavioral Health Services, ensure all sections are filled out accurately, including service details, provider information, and member details.

Behavioral Health Authorization (3 of 3)

When submitting a prior authorization request for Behavioral Health Services, please include the following documents as applicable:

Type of Document	Supporting Documents
Member Treatment Summary (Narrative)	A written summary detailing the member's treatment history and current care plan.
Assessment Findings	Results from clinical evaluations, diagnostic tests, or any behavioral health assessments.
Prescribed Medications	Include a list of current medications along with dosages and duration of use.
Psychotherapy Documentation	Specify prescribed therapy, goals, objectives, and the member's individualized care plan.
Diagnoses	Clearly document all relevant behavioral health and physical diagnoses.
Treatment Plan	Include measurable goals, timelines, and strategies to address the member's specific needs.
Supporting Medical Records	Relevant clinical notes, progress reports, or prior treatment outcomes.
Service Request Details	Provide details regarding requested services (e.g., frequency, duration, and intensity).
Additional Documentation	Any other pertinent information or supporting materials that may assist in the authorization process.

BH Prior Authorization Appeals

BH Prior Authorization Appeals Contact

- BH PA Appeals may be submitted to MHS in the following ways:

Web: **Secure Provider Portal**

Email: **Appeals@mhsindiana.com**

Call: Medicaid: 1-877-647-4848

Fax: Medicaid: 1-866-714-7991

Mail: MHS Appeals
 P.O. Box 10378
 Van Nuys, CA 91410-0378

Fax Request

Fax Request

All **BH Forms** can be obtained for the following treatments:

- Outpatient Treatment Request (OTR)
- Intensive Outpatient/Day Treatment Form
- Mental Health Chemical Dependency
- Applied Behavioral Analysis Treatment Psychological & Neuropsych Testing Authorization Request Form

Outpatient Treatment Request (OTR) Form

- [Applied Behavioral Analysis Treatment OTR \(PDF\)](#)
 - [IN Medicaid ABA Provider Request Tip Sheet \(PDF\)](#)
 - [Intensive Outpatient Day Treatment Form \(PDF\)](#)
 - [HHW/HIP Outpatient Treatment Request \(OTR\) Form \(PDF\)](#)
- Fax completed forms to **1-866-694-3649**.

BH Forms

All **BH Forms** can be obtained for the following treatments:

- Residential/Inpatient Substance Use Disorder (SUD) Treatment Prior Authorization Form:

Inpatient and Residential Treatment for Substance Use Disorder (SUD)

- [Discharge Consultation Documentation \(PDF\)](#)
 - [Initial Assessment Form for Substance Use Disorder Treatment Admission](#) 
 - [Reassessment Form for Continued Substance Use Disorder Treatment](#) 
 - [Residential/Inpatient Substance Use Disorder Treatment Prior Authorization Request Form](#) 
-
- Fax Inpatient: **1-844-288-2591**
 - Fax Outpatient: **1-866-694-3649**

Pertinent Information

Pertinent Information

When requesting Intensive Outpatient Treatment (IOT), please follow the chart below:

(IOT) Rendered In a Facility	(IOT) Rendered In Professional Setting
Facility providers that bill institutional claims (<i>UB-04</i> claim form or the electronic equivalent) must submit PA with one of the following revenue codes based on the type of service rendered: ✓ 905 – Psychiatric-Behavioral Health Treatments/Services-Intensive Outpatient Services ✓ 906 – Chemical Dependency-Behavioral Health Treatments/Services-Intensive Outpatient Services ✓ No procedure codes to be submitted with revenue codes	Professional providers that bill claims (<i>CMS-1500</i> claim form or the electronic equivalent) must submit PA with one of the following procedure codes, based on the type of service rendered: ✓ S9480 - Psychiatric IOT ✓ H0015 - Drug & Alcohol IOT ✓ No revenue codes to be submitted with procedure codes

Pertinent Information Substance Use Disorder (SUD)

When completing the “Rendering Provider Information” section of the authorization form, ensure the following:

- ✓ Enter the IHCP/MHS-enrolled **SUD facility NPI** in the Requesting and Rendering Provider NPI field.

	Requesting Provider Information
	Requesting Provider NPI/Provider ID:
	Taxonomy:
	Taxpayer Identification Number (TIN):
	Provider Name:
	Provider Address:
	Rendering Provider Information
	Rendering Provider NPI/Provider ID:
	TIN:
	Name:
	Address:
	City/State/ZIP Code:
	Phone:
	Fax:

Pertinent Information Previously Approved Prior Authorization (PA)

- Previously approved PA's can be updated within 30 calendar days of the original request submission to accommodate changes such as:
 - Practitioner Information
 - Dates of Service (DOS)
- **Exceptions:**
 - Updates are not permitted if the new DOS overlaps with a previous adverse determination, such as a denial or partial approval.
 - Updates cannot include retroactive days (i.e., dates more than one business day prior to the initial request submission).
- **Important:**
 - All updates or corrections to PAs must be requested before any related claims are denied. Timely submissions ensure continuity of care and accurate claims processing.

Pertinent Information Limitations on Outpatient Mental Health Services

MHS adheres to the IHCP Mental Health and Addiction Limitation Policy which imposes the following restrictions:

- A maximum of 20 BHOP units per member, per practitioner, per rolling 12 months applies to the specified CPT codes.

Important Guidelines:

- HHW Package C members are allowed up to 30 BHOP units per rolling 12 months under this policy.

Providers are encouraged to carefully monitor utilization to ensure compliance with these limitations.

Code	Description
90832 – 90834	Individual Psychotherapy
90837 – 90840	Psychotherapy, with patient and/or family member & Crisis Psychotherapy
90845 – 90847 90849 – 90853	Psychoanalysis & Family/Group Psychotherapy with or without patient



This is not a conclusive list

Benefit Limitations Denials

Claims exceeding the benefit limit will deny as:

- Maximum Benefit Reached, claim denial code EX Mb:

If the member requires additional services beyond the 20-unit limitation, providers may request prior authorization for additional units.

Approval will be given based on the necessity of the services as determined by the review of medical records.

Providers will need to determine if they have provided 20 units to the member in the calendar year to determine if a prior authorization request is needed.

“Per Provider” is defined by MHS as per individual rendering practitioner NPI being billed on the *CMS-1500* claim form (Box 24J).

MHS Network Team



MHS Resources

- For additional information, please contact your MHS Provider Engagement Account Manager to schedule an appointment today
- Additional resources available on the **MHS Website**
- Register online for additional **Monthly Web Sessions**

PEAM Manager Map Color Key



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

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.

