2021 IHCP Works Seminar

MDwise Claims 201

By: Tonya Trout

Providing health coverage to Indiana families since 1994

Topics of Discussion

- Ambulance – Point of Pickup (POP)
- Sterilization Forms
- Hysterectomy Billing
- Vaccines for Children (VFC)
- FQHC RHC Wraparound payment
- Paper Claims
- Contracted vs Non-contracted Provider
- Formal vs Informal Disputes
- Contact Information
- Questions

Ambulance Point of Pick-up (POP) Zip Code

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Ambulance Point of Pick-up Zip Code

Electronic Transaction Loop Data Elements

837P 2310E

- N401 Ambulance Pick-up City Name
  N402 Ambulance Pick-up State Code
  N403 Ambulance Pick-up Zip Code

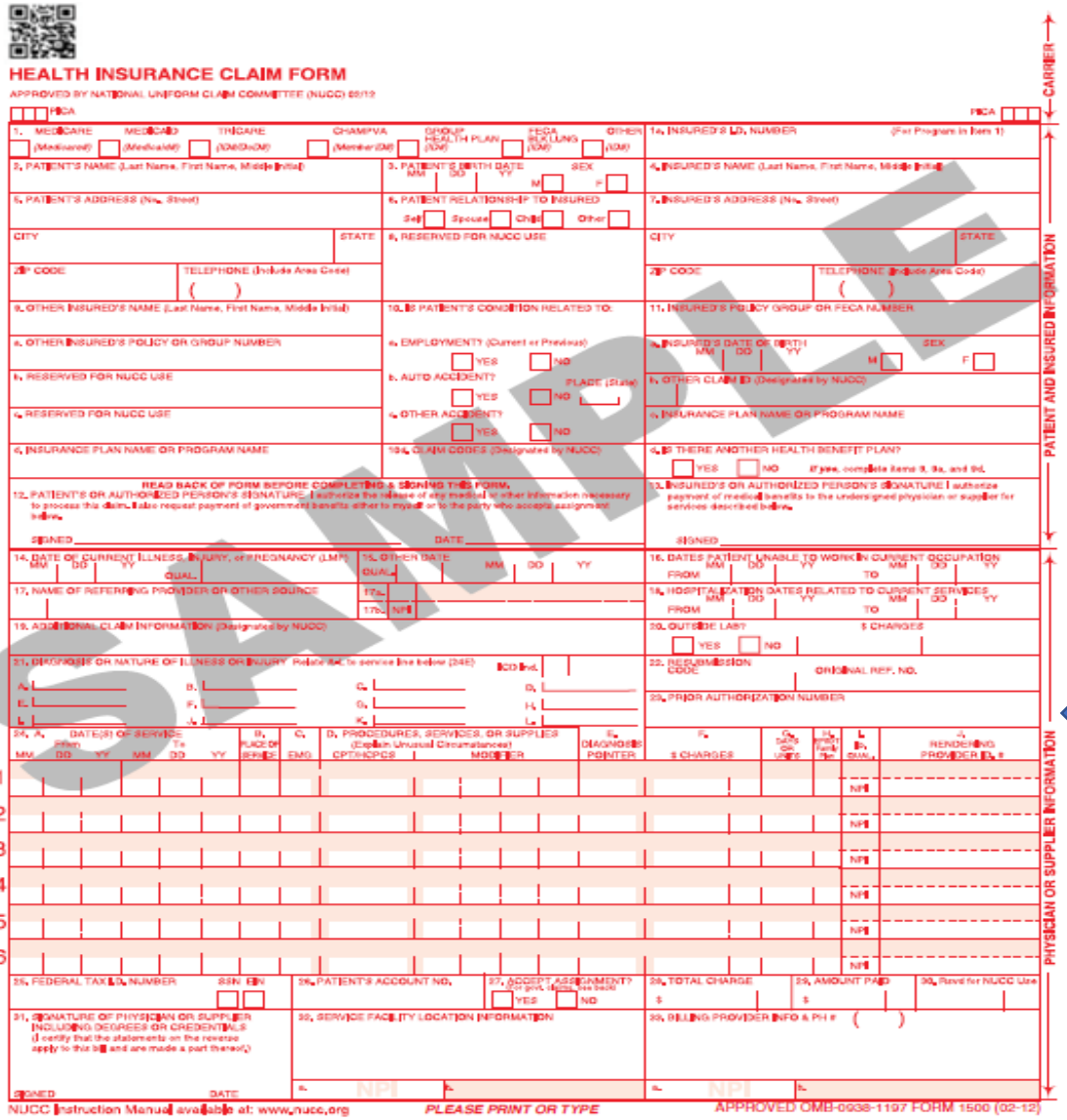
837I 2300

- HI01-1 "BE"
  HI01-2 "A0"
  HI01-5 Ambulance Pick-up ZIP code

Hardcopy claim Field/Location Value(s)

- CMS 1500 form Box 23 Ambulance Pick-up Postal Code or ZIP Code
- UB-04 form Locators 39-41
- Value Code "A0"

HCFA 1500 CLAIM FORM



"POP" Box 23

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UB 04 Field Descriptions

Field location UB-04	Description	Inpatient	Outpatient
1	Provider Name and Address	Required	Required
2	Pay-To Name and Address	Situational	Situational
3a	Patient Control Number	Required	Required
3b	Medical Record Number	Situational	Situational
4	Type of Bill	Required	Required
5	Federal Tax Number	Required	Required
6	Statement Covers Period	Required	Required
7	Future Use	N/A	N/A
8a	Patient ID	Situational	Situational
8b	Patient Name	Required	Required
9	Patient Address	Required	Required
10	Patient Birthdate	Required	Required
11	Patient Sex	Required	Required
12	Admission Date	Required	Required, if applicable
13	Admission Hour	Required	Required, if applicable
14	Type of Admission/Visit	Required	Required
15	Source of Admission	Required	Required
16	Discharge Hour	Required	N/A
17	Patient Discharge Status	Required	Required
18-28	Condition Codes	Required, if applicable	Required, if applicable
29	Accident State	Situational	Situational
30	Future Use	N/A	N/A
31-34	Occurrence Codes and Dates	Required, if applicable	Required, if applicable
35-36	Occurrence Span Codes and Dates	Required, if applicable	Required, if applicable
37	Future Use	N/A	N/A
38	Responsible Party Name and Address	Required, if applicable	Required, if applicable
39-41	Value Codes and Amounts	Required, if applicable	Required, if applicable
42	Revenue Code	Required	Required
43	Revenue Code Description	Required	Required
	NDC Code	Required, if applicable	Required, if applicable

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UB-04 CMS-1450 CLAIM FORM

1	2	3a PAT. CNTL #	1234	4 TYPE OF BILL
Any Hospital	Any Hospital	b. MED. REC. #	98765	0111
123 Any Street	456 Any Street	5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM / THROUGH	7
Anytown NJ 08999	Anytown NJ 08999	221234567	11 03 06 / 11 04 06	RESERVED

8 PATIENT NAME a Patient ID if different from Sub

b Doe, John

9 PATIENT ADDRESS a 1234 Main Street

b Anytown c NJ d 08999 e Country code if other than USA

10 BIRTHDATE	11 SEX	ADMISSION 12 DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	CONDITION CODES 18–28	29 ACDT STATE	30
03 20 1971	M	11 03 06	08	3	3	12	01	Condition Codes Required Identifying Events	PA	RESERVED

31–34 OCCURRENCE CODE / DATE; 35–36 OCCURRENCE SPAN CODE / FROM / THROUGH; 37

Occurrence and Occurrence Span Codes may be used to define a significant event that may affect payer processing

37: FUTURE USE

38

John Doe
1234 Main Street
Anytown, NJ 08999

	39 CODE	VALUE CODES AMOUNT	40 CODE	VALUE CODES AMOUNT	41 CODE	VALUE CODES AMOUNT
a	A1	952 00				
b	Value Codes and amounts required when necessary to process claim					
c						
d						

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0129	Semi-Private	200.00		2	400 00	0 00	Future Use
0250	Pharmacy			1	50 00	0 00	
0360	OR Services				100 00	0 00	

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Sterilization Forms

Sterilization

MDwise reimburses for sterilizations for members when a valid consent form accompanies all claims connected with the service. (IAC: *405 IAC 5-28-8)*

The individual MUST meet the following requirements:

- Has voluntarily given informed consent (*42 CFR 441.257* through *441.258*)
- Is **21 years old** or older at the time the informed consent is given (*42 CFR 441.253*)
- Is neither mentally incompetent nor institutionalized (*42 CFR 441.251*)

Sterilization-Cont.

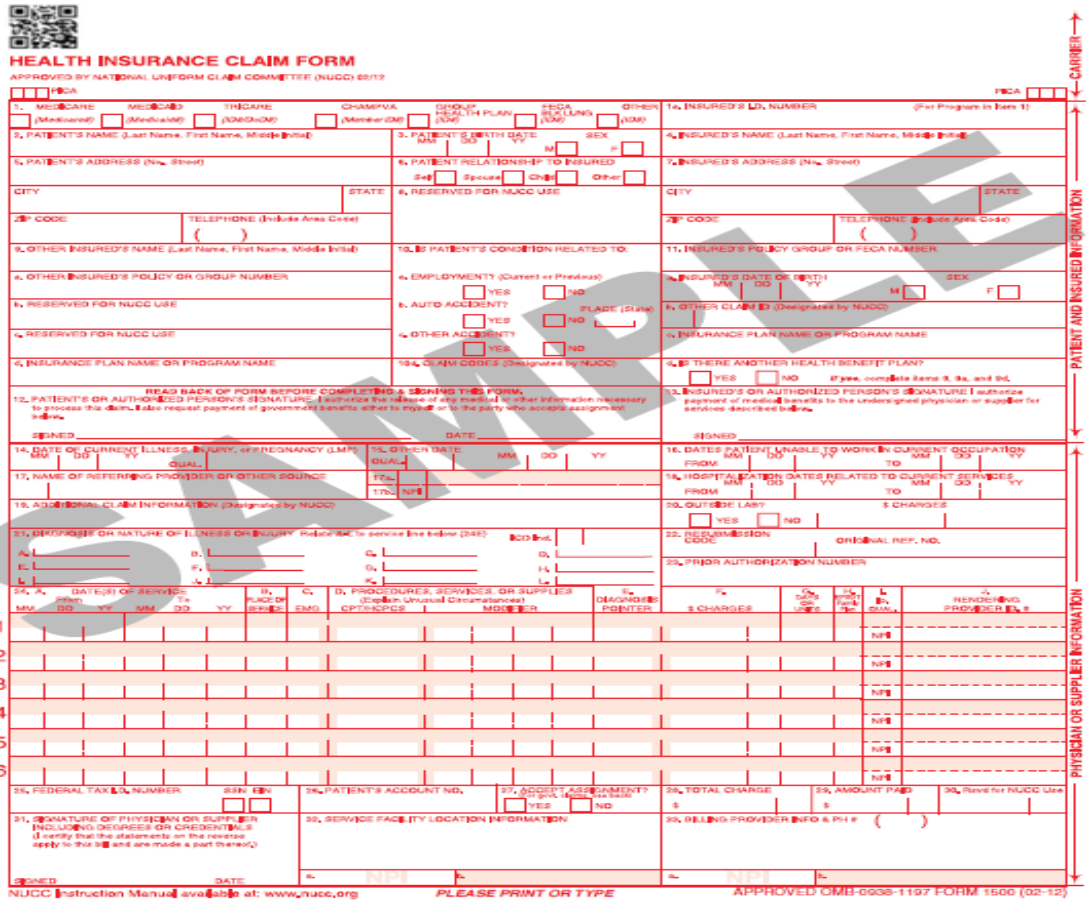
- The consent must be signed within 30 days but not more than 180 days
- For sterilizations planned concurrent with a delivery, the member must give the informed consent at least 30 days before the expected date of delivery. The following exceptions apply to premature delivery (defined by the IHCP as labor before 37 weeks' gestation) or emergency abdominal surgery
- The member must sign the Sterilization consent form 72 hours before the sterilization when done at time of a premature delivery

Sterilization Exceptions

- The physician must indicate the reason for the surgery being performed early and the individual's expected date of delivery.
- A sterilization consent form is not necessary when a provider renders a patient sterile as a result of an illness or injury.
- A sterilization consent form is not required when only a partial sterilization is performed.

HCFA 1500 CLAIM FORM

You *MUST indicate* "**partial sterilization**" on the claim form, in the shaded line above the CPT or HCPCS procedure code. For electronic claims, a claim note may be used.



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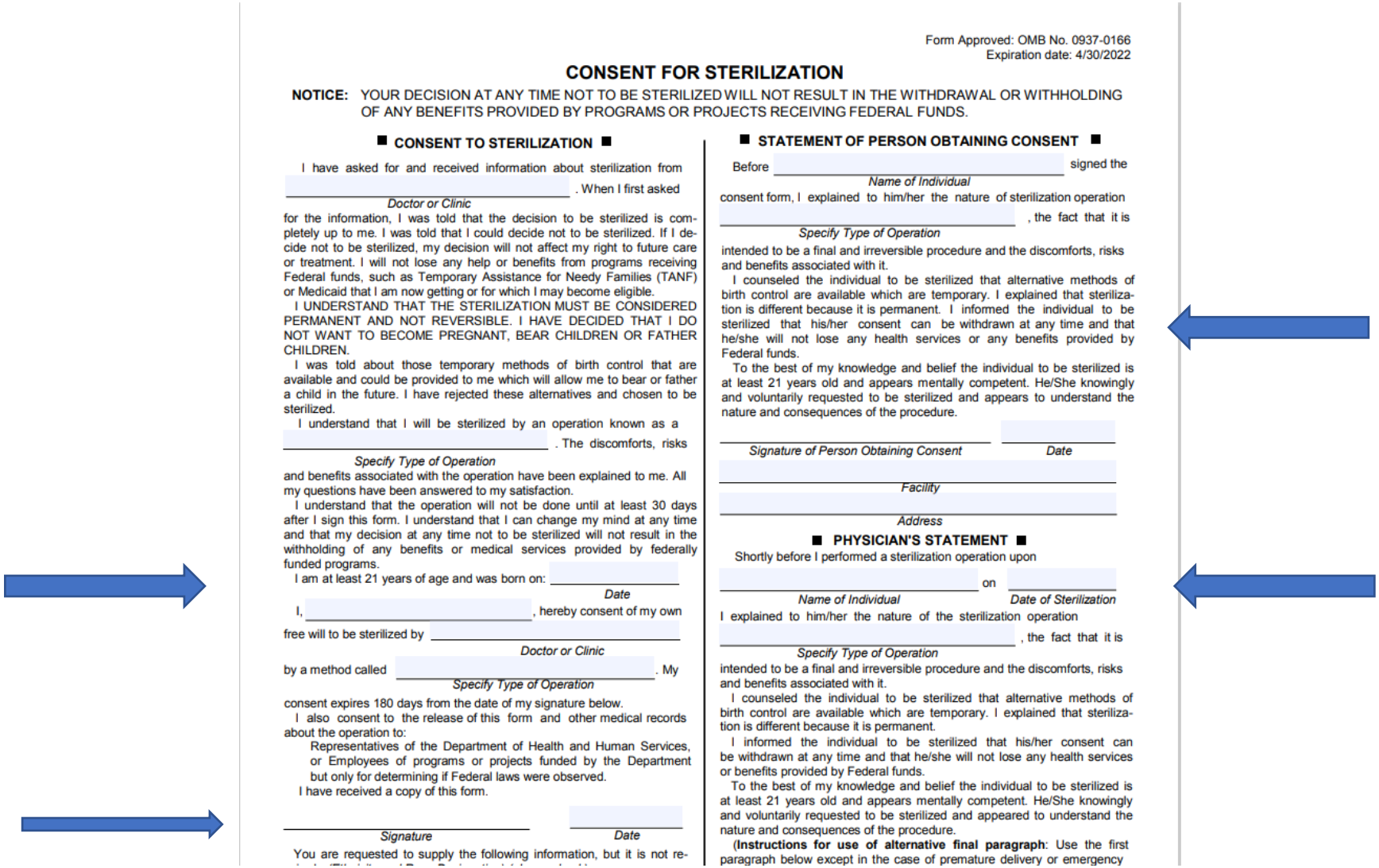
Common reasons sterilization claims are denied - Recap

- A copy of the consent form is NOT attached.
- There are blank lines on the consent form. (All lines in sections I, II, and IV must be completed, except lines 21, 22, and 23 which are required only in certain cases.)
- Lines are not completed correctly on the consent form, or inaccurate information is included rather than what is needed.
- On the consent form, there are fewer than 30 days from the date of the client's signature (line 8) to the date of the sterilization operation (line 19).
- The sterilization date on the consent form (line 19) is not the same as the sterilization date on the claim.

Common reasons sterilization claims are denied - Recap

- The provider who signs the consent form (line 24) is not the provider listed on the claim as performing the sterilization procedure.
- The provider's signature is illegible on the consent form and the provider's name is not printed above his or her signature (line 24).
- The handwriting on the consent form is illegible or the photocopy quality is too poor to read.
- No expected date of delivery is listed with a premature delivery (line 22).

Sterilization Form



Form Approved: OMB No. 0937-0166
Expiration date: 4/30/2022

CONSENT FOR STERILIZATION

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

■ CONSENT TO STERILIZATION ■

I have asked for and received information about sterilization from _____ (*Doctor or Clinic*). When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as Temporary Assistance for Needy Families (TANF) or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a _____ (*Specify Type of Operation*). The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least 30 days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on: _____ (*Date*)

I, _____, hereby consent of my own free will to be sterilized by _____ (*Doctor or Clinic*) by a method called _____ (*Specify Type of Operation*). My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

Representatives of the Department of Health and Human Services, or Employees of programs or projects funded by the Department but only for determining if Federal laws were observed.

I have received a copy of this form.

_____ (*Signature*) _____ (*Date*)

You are requested to supply the following information, but it is not re-

■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before _____ (*Name of Individual*) signed the consent form, I explained to him/her the nature of sterilization operation _____ (*Specify Type of Operation*), the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

_____ (*Signature of Person Obtaining Consent*) _____ (*Date*)

_____ (*Facility*)

_____ (*Address*)

■ PHYSICIAN'S STATEMENT ■

Shortly before I performed a sterilization operation upon _____ (*Name of Individual*) on _____ (*Date of Sterilization*) I explained to him/her the nature of the sterilization operation _____ (*Specify Type of Operation*), the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(**Instructions for use of alternative final paragraph**: Use the first paragraph below except in the case of premature delivery or emergency

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Sterilization Form – Required Lines

Section I ■ **CONSENT TO STERILIZATION** ■

I have asked for and received information about sterilization from

(1) _____ . When I first asked
Doctor or Clinic

for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as Temporary Assistance for Needy Families (TANF) or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a

_____ . The discomforts, risks
Specify Type of Operation

and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least 30 days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on: _____
Date

I, (4) _____ , hereby consent of my own free will to be sterilized by (5) _____
Doctor or Clinic

by a method called (6) _____ . My consent expires 180 days from the date of my signature below.
Specify Type of Operation

I also consent to the release of this form and other medical records about the operation to:

Representatives of the Department of Health and Human Services, or Employees of programs or projects funded by the Department but only for determining if Federal laws were observed.

I have received a copy of this form.

(7) _____ (8) _____
Signature *Date*

■ **STATEMENT OF PERSON OBTAINING CONSENT** ■

Before (12) _____ signed the consent form, I explained to him/her the nature of sterilization operation
Name of Individual

(13) _____ , the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.
Specify Type of Operation

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

(14) _____ (15) _____
Signature of Person Obtaining Consent *Date*

(16) _____
Facility

(17) _____
Address

Section IV

■ **PHYSICIAN'S STATEMENT** ■

Shortly before I performed a sterilization operation upon

(18) _____ on (19) _____
Name of Individual *Date of Sterilization*

I explained to him/her the nature of the sterilization operation

(20) _____ , the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.
Specify Type of Operation

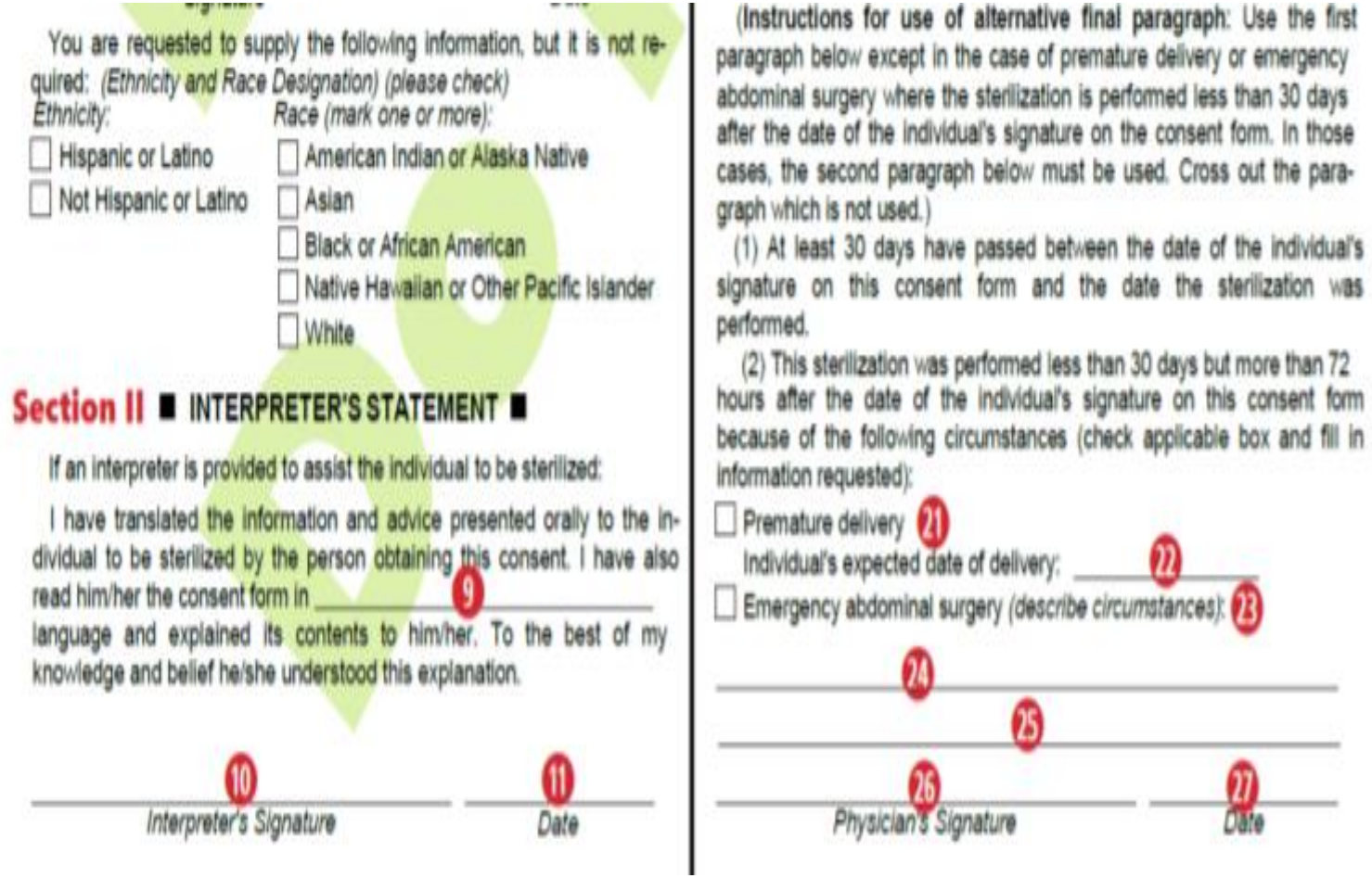
I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(Instructions for use of alternative final paragraph: Use the first

Sterilization Form – Required Lines



You are requested to supply the following information, but it is not required: *(Ethnicity and Race Designation) (please check)*

Ethnicity:
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Race (mark one or more):
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White

Section II ■ INTERPRETER'S STATEMENT ■

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in 9 _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

10 _____ *Interpreter's Signature*

11 _____ *Date*

(Instructions for use of alternative final paragraph: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least 30 days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

☐ Premature delivery 21

Individual's expected date of delivery: 22 _____

☐ Emergency abdominal surgery *(describe circumstances)*: 23

24 _____

25 _____

26 _____ *Physician's Signature*

27 _____ *Date*

Sterilization Reminders/Tips

- Voluntary informed consent is required before sterilization services will be paid for, and the consent form should be attached to all claims.
- The consent form must be completed at least 30 days, but not more than 180 days, prior to the sterilization procedure.
- The form cannot be completed retroactively.

Hysterectomy Billing

- MDwise covers medically necessary hysterectomies performed to treat an illness or injury.
- MDwise does not cover when performed solely to render member permanently incapable of bearing children, where performed as a primary or secondary procedure.
- Informed Consent and Acknowledgement Statement for Hysterectomies are required

Hysterectomy Billing

- MDwise covers hysterectomies only when medically necessary and only when the member has given informed consent.

Note:
Providers cannot, under any circumstances, use the *Consent for Sterilization* form for hysterectomy procedures.

Hysterectomy procedures are not sterilization procedures. MDwise will not pay for these procedures when performed solely for the purpose of sterilization.

Hysterectomy Acknowledgement Form

Acknowledgement of Receipt of Hysterectomy Information

Member Name: _____

RID: _____
Physician Name: _____
Provider Number _____
AMA Ed. Number
_____

It has been explained orally and in writing to _____
that the hysterectomy to be performed on her will render her permanently incapable of bearing children.

☐ Signed before surgery

☐ Signed after surgery (at the time of the hysterectomy, eligibility was not established).

_____ _____
(Member or Representative Signature) (Date)

Physician Statement

The hysterectomy in the above case is being done for medically necessary reason(s), and the resulting sterilization is incidental and is not, at any time ever, the reason for this surgical operation.

Diagnosis(ses) _____

_____
(Physician Signature) (Date)

Vaccines For Children (VFC)

Vaccines For Children

- Vaccines for Children (VFC) is a federally funded program that provides vaccines at no cost to providers for children under 19 years of age who might not otherwise be vaccinated because of inability to pay.
- For dates of service on or after January 1, 2020, for children under the age of 19, if a vaccine is available through the VFC program, MDwise will not provide reimbursement for a non-VFC vaccine (referred to as private stock vaccine).
- To guarantee that all Hoosier children receive immunizations as needed, providers are encouraged to enroll in the VFC program if they are not currently enrolled.

Enrollment in the VFC Program

- The federal VFC program includes private and public practitioners across Indiana. The ISDH Immunization Division handles VFC provider enrollment and education as well as VFC vaccine orders and distribution. To enroll in the VFC program, providers should complete the following steps:
  - Review the ISDH VFC program eligibility statements to ensure that your practice is able to meet all program requirements:
  - Provider Eligibility for Publicly Funded Vaccine Programs
  - Childhood Vaccine Eligibility Statement

Enrollment in the VFC Program (Cont'd)

- Download the *Immunization Provider Contact Request Form*, accessible from the Document Center at in.gov/isdh.
- Complete the form and submit it to the ISDH in one of the following ways:
  - Email to enrollments@isdh.in.gov
  - Fax to (317) 233-3719
- A representative from the ISDH Immunization Division will contact the provider within 5 business days after receiving the form to help complete the necessary enrollment paperwork and schedule a time to visit the provider's location.

Vaccines For Children

Appropriate diagnosis code in the primary position (and indicated with the diagnosis pointer for the vaccine and administration procedure codes)

DX	DESCRIPTION
Z00.121	*Encounter for routine child health examination with abnormal findings*
Z00.129	*Encounter for routine child health examination without abnormal findings*

Vaccines For Children

Appropriate vaccine administration procedure code with the SL modifier:

DX	DESCRIPTION
90471 SL	*Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections);* ***1 vaccine*** *(single or combination vaccine/toxoid); VFC vaccine administration*
90472 SL	***Each additional vaccine*** *(single or combination vaccine/toxoid); VFC vaccine administration*
90473 SL	*Immunization administration by intranasal or oral route;* ***1 vaccine*** *(single or combination vaccine/toxoid); VFC vaccine administration*
90474 SL	***Each additional vaccine*** *by intranasal or oral route (single or combination vaccine/toxoid); VFC vaccine administration*

FQHC And RHC Wraproud Payments

- The Indiana Health Coverage Programs(IHCP) announces, effective July 1,2021, federally qualified health center(FQHC) and rural health clinics(RHC) medical wraparound payments will be automatically processed on a claim-by-claim basis by Gainwell Technologies.

- Providers will no longer submit to Myers and Stauffer to receive the difference between the managed care entity(MCE) payment and the FQHC/RHC rate for claims on or after July 1, 2021

FQHC and RHC:continued

- Effective July 1, 2021 providers will need to bill the encounter code T1015-Clinic visit/encounter, all inclusive

- Providers should bill for only 1 unit of service, if more then 1 is billed the payment will be delayed, only 1 unit is allowed per member, per day, per diagnosis code.

- Place of service (POS) codes 02, 03 and 04 have been added to the list of allowable POS codes for valid FQHC and RHC Encounter claims

  02-Telehealth

  03-School

  04-Homeless Shelter

Paper Claims vs Electronic Claims

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Paper Claims Vs Electronic Claims

Electronic Claim submission provides significant benefits to the provider including:

- ✓Reduces operation costs associated with paper claims (printing, postage, etc.).
- ✓Increases accuracy of data and efficient information delivery.
- ✓Reduces claim delays because errors can be corrected and resubmitted electronically.

Paper Claims Vs Electronic Claims (Cont'd)

- ✓Tracking and monitoring claim progress.
- ✓Expedites processing turnaround and potential payment time frames.
- ✓Fastest way for clean claims to be considered for reimbursement.

Paper Claim Submission

There are a few scenarios when it would be more efficient to send in a paper claim. Claims that require attachments are processed more quickly in the paper claim process as electronic claims cannot include attachments:

- Sterilization
- Hysterectomy
- Certain DME and Pharmacy codes that are manually priced.

Retro Eligibility
PA Request

Retro-eligibility PA Request

405 IAC 5-3-9 Requirement Sec. 9. Prior authorization will be given after services have begun or supplies have been delivered only under the following circumstances:

(1) Pending or retroactive member eligibility. The prior authorization request must be submitted within twelve (12) months of the date of the issuance of the member's Medicaid card.

(2) Mechanical or administrative delays or errors by the office.

(3) Services rendered outside Indiana by a provider who has not yet received a provider manual.

(4) Transportation services authorized under 405 IAC 5-30. The prior authorization request must be submitted within twelve (12) months of the date of service.

Retro-eligibility PA Request

(5) The provider was unaware that the member was eligible for services at the time services were rendered. Prior authorization will be granted in this situation only if the following conditions are met: (A) The provider's records document that the member refused or was physically unable to provide the member identification (RID) number.

(B) The provider can substantiate that the provider continually pursued reimbursement from the patient until Medicaid eligibility was discovered.

(C) The provider submitted the request for prior authorization within sixty (60) days of the date Medicaid eligibility was discovered

Authorization

For more information on any auth scenario, see our MDwise Prior Authorization Reference and Contact Guide

The full listing of *Procedure Codes That Require Authoriation* is accessible from the MDwise webpage: https://www.mdwise.org/for-providers/forms/prior-authorization

Informal & Formal Disputes

Informal Claim Dispute

- Provider disagrees in writing with how the claim was adjudicated:
  - Must be commenced within 60 days from the date on the Explanation of Payment (EOP).
  - MDwise should reach a decision and notify the provider within 30 calendar days.

Formal Claim Dispute

- Provider disagrees with 1st level decision:
  - Provider has 60 days from the date of the 1st level decision.
  - MDwise will compose a panel of persons not involved with the 1st level dispute to review the 2nd level dispute.
  - MDwise should reach a decision and notify the provider within 45 calendar days.
  - The panel's decision is MDwise's final action on the claim. This is for providers contracted with MDwise; out-of-network providers may request arbitration review of the panel's decision.

Contact & Resource Information

Contacts

MDwise Claims: Provider Customer Service Unit

- 1-833-654-9192

MDwise Customer Service

- 1-800-356-1204

Contacts for Provider Reps

MDwise Network
Provider Relations Territory Map

Region 1
Paulette Means
pmeans@mdwise.org
317-822-7226

Region 2
Danielle Nesbit
dnesbit@mdwise.org
317-793-0872

Region 3
LaKisha Browder
lbrowder@mdwise.org
317-983-7819

Region 4
Robin King
rking@mdwise.org
317-619-5622

Region 5
Amanda Deaton
adeaton@mdwise.org
317-793-0873

Region 6
Tonya Trout
ttrout@mdwise.org
317-308-7329

Region 7
Rebecca Church
rchurch@mdwise.org
317-308-7371

Region 8
Chris Bryant
cbryant@mdwise.org
317-517-4776

Lauren de Blecourt, RN
ldeblecourt@mdwise.org
317-407-5910
(Behavioral Health – CMHCs, OTPs, IMD, SUD)

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Contacts

Territory	PR Representative	Phone	Email
Region 1	Paulette Means	317.822.7490	pmeans@mdwise.org
Region 2	Danielle Nesbitt	317.793.0872	dnesbitt@mdwise.org
Region 3	Lakisha Browder	317.983.7819	lbrowder@mdwise.org
Region 4	Robin King	317.619.5622	rking@mdwise.org
Region 5	Amanda Deaton	317.793.0873	adeaton@mdwise.org
Region 6	Tonya Trout	317.308.7329	ttrout@mdwise.org
Region 7	Rebecca Church	317.308.7371	rchurch@mdwise.org
Region 8	Chris Bryant	317.517.4776	cbryant@dmwise.org
Behavioral Health	Lauren de Blecourt	317.407.5910	ldeblecourt@mdwise.org

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Resources

Claims Page

- https://www.mdwise.org/for-providers/claims

Claims Forms

- https://www.mdwise.org/for-providers/forms/claims
  - Claim Adjustment Request Form
  - Claims Dispute Form
  - Provider Refund Remittance Form

Claims Inquiries

- Providers can use myMDwise provider portal to quickly view the status of their claims.

thank you!

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Questions

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