














CLAIMS 101

2021 Annual IHCP Works Seminar





Agenda

-  MHS Overview
-  Claim Submission Process
-  MHS Provider Claims Issue Resolution Process
-  Additional Claims Assistance
-  Portal Functionality
-  Professional Billing
-  Facility Billing
-  Web Portal Claim Payment and Review
-  Online Claim Reconsiderations on the MHS Secure Provider Portal
-  Prior Authorization
-  MHS Team
-  Summary
-  Questions

MHS Overview

Who is MHS?

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

MHS Products



Claim Submission Process

Behavioral Health Claim Submission



Electronic Submission:

- Payer ID **68068**
- MHS accepts Third Party Liability (TPL) information via Electronic Data Interchange
- It is the responsibility of the provider to review the error reports received from the Clearinghouse (Payer Reject Report)



Online Submission through the **MHS Secure Provider Portal:**

- Verify Member Eligibility
- Submit and manage both Professional and Facility claims, including 937 batch files
- To create an account, go to: mhsindiana.com



Paper Claims:

- MHS Behavioral Health
PO Box 6800
Farmington, MO 63640-3818




Claim Inquiries:

- Check status online
- Call Provider Services at 1-877-647-4848

Claim Billing with Ease

NPI, Tax ID, Zip +4

-  This information is necessary for the system to make a one-to-one match based off of the information provided on the claim and the information on file with Indiana Medicaid.
- Member Information
 - Newborn's Medicaid Identification number is required for payment

Attachment Forms:

- Required forms need to accompany the claim form

Secondary Claims (TPL):

- Accepted electronically from vendors or via the MHS Secure Provider Portal

Claim Submission




 Contracted or In-Network providers: 90 calendar days from the date of service or discharge date.

 Exceptions:





- Newborns (30 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 Medicaid Identification number.
- TPL – Claims with primary insurance must be received within 365 days of the date of service with a copy of the primary Explanation of Benefits. If primary EOB is received after the 365 days, providers have *60 days* from date of primary EOB to file claim to MHS. If the third party does not respond within 90 days, claims may be submitted to MHS for consideration. Claims submitted must be accompanied by proof of filing with the patient's primary.

Claim Submission

Claim Acceptance & Adjudication

-  System reviews claim for errors and critical fields (i.e. dates of service, billing/rendering provider, etc.) prior to acceptance.
-  Regulatory requirements (federal and state) mandate certain information to be present in order to accept and pay a claim.
-  National Provider Identifier (NPI) common rejection/denial; provider information on claim **must** match record at IHCP enrollment – a State requirement.

Paper Claim Corrections

-  A corrected claim can be submitted following IHCP claim adjustment processes.
-  A claim adjustment code is required on all claims, based on the type of claim submitted.
 - Example: Frequency 7 entered in Box 22 of the CMS-1500 form.
 - Example: Frequency 7 used as the last digit for the bill type on a UB-04 form (i.e. 1x7)
-  The original claim number must also be listed on the corrected claim.
 - Box 22 on the CMS-1500 and box 64 on the UB-04.
 - Remember a rejection, must be submitted as 1st time claim, not as a corrected claim.
-  Handwriting or stamping on a claim will not be accepted as submission of a corrected claim, and will be rejected with code RE.

Paper Claim Corrections

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


The image shows a paper claim form with several fields filled out. Annotations highlight key areas for corrections:


- Original claim number:** An orange arrow points to box 18, 'HOSPITALIZATION DATES RELATED TO CURRENT SERVICES', which contains the number '1'.
- Resubmission code is "7":** A blue arrow points to box 22, 'RESUBMISSION CODE', which contains the number '7'.

Other visible fields include:

- Box 14: DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (EMP) with fields for QUAL, MM, DD, YY.
- Box 15: OTHER DATE with fields for QUAL, MM, DD, YY.
- Box 16: DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION with FROM and TO fields.
- Box 17: EMPLOYER OR OTHER SOURCE with fields for 17a and 17b.
- Box 19: ADDITIONAL CLAIM INFORMATION (Designated by NUCC).
- Box 20: OUTSIDE LAB? with YES and NO checkboxes (NO is checked).
- Box 21: DIAGNOSIS OR NATURE OF ILLNESS OR INJURY with A-L sub-fields and ICD-9 code '0'.
- Box 23: PRIOR AUTHORIZATION NUMBER.
- Box 24: DATE(S) OF SERVICE with sub-fields for FROM, TO, PLACE OF SERVICE, PROCEDURE, SUPPLIES, DIAGNOSIS POINTER, CHARGES, DAYS OF UNITS, PRICE PER UNIT, and RENDERING PROVIDER ID #.
- Box 25: FEDERAL TAX ID NUMBER, SSN/EIN, PATIENT'S ACCOUNT NO., ACCEPT ASSIGNMENT?, TOTAL CHARGE, AMOUNT PAID, and Rev'd for NUCC Use.
- Box 31: SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE(S) OR CREDENTIALS.
- Box 32: BILLING DISCHARGE INFO & PH #.

Laboratory Billing

 All providers that bill laboratory services on a **CMS-1500** form must have Clinical Laboratory Improvement Amendments (CLIA) certification or a CLIA waiver certification equal to the procedure code being billed and included on the CMS-1500.




 **EXc1 DENIED: INVALID CLIA NUMBER:**
This denial code will appear on the providers EOP. This verification will ensure that MHS is compliant with the CMS guidelines. Providers will have to submit a corrected claim timely with proper CLIA certificate number entered on their claim submission.

Laboratory Billing

Physician's Office Lab Testing (POLT)


Policy CC.PP.055 To ensure laboratory tests are performed in the correct setting, the health plan will limit the performance of in-office laboratory testing to the CPT® and HCPCS codes listed in the Short Turnaround Time (STAT) laboratory (lab) code list included in this policy.


Laboratory Billing


-  These are tests that are needed immediately, in order to manage medical emergencies or urgent conditions. To this end, specific clinical laboratory tests have been designated as appropriate to be performed in the office setting.
-  The health plan's automated claims adjudication system will deny in-office (location 11) laboratory procedures that are not included on the STAT lab list found on the MHS Indiana website.
-  Policy can be found at:


<https://www.mhsindiana.com/content/dam/centene/mhsindiana/policies/payment-policies/CC.PP.055.pdf>

Transportation Claims

-  Managed Health Services (MHS) will process all Medicaid emergent and non-emergent ambulance claims, including air ambulance, which would have previously been processed by LCP Transportation.

-  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).
 - Air ambulance

-  Only providers enrolled with the Indiana Health Coverage Programs (IHCP) are eligible for reimbursement. Claims must be filed within 180 days of the Date of Service (DOS) for non-contracted providers and within 90 days of DOS for contracted providers.

-  Claims should be submitted to MHS via a CMS-1500 professional claim form. Claims may be submitted via EDI (preferred), MHS web portal or paper.

Transportation Claims

-  MHS will follow IHCP billing guidelines for coding and reimbursement.

For more information on Medicaid ambulance billing guidelines, please visit:





<https://www.in.gov/medicaid/providers/files/transportation-services.pdf>

-  **Claim Inquiries:**




- Check status online
- Call Provider Services at 1-877-647-4848

Claim Rejections

Claim Rejection

-  A rejection is an unclean claim that contains invalid or missing data elements required for acceptance of the claim in the claim process system.
-  Timely filing is not substantiated.
-  Rejected claims need corrected and submitted as a new claim.
-  Examples of rejected claims
 - Provider/practitioner not enrolled in IHCP
 - Invalid member RID number
 - Incorrect type of bill for the service or location
 - Missing or invalid modifier




Claim Rejections


-  EDI rejections require the provider to contact their clearinghouse and obtain a payer rejection report.
-  Paper to electronic mapping is available on:
<https://www.mhsindiana.com/providers/resources/guides-and-manuals.html>
-  MHS website tools :
 - Reject code listing
 - Refer to top 10 rejection code help aid document
<https://www.mhsindiana.com/content/dam/centene/mhsindiana/medicaid/pdfs/0117-OS-P-WM-Top-10-Rejections-Education-Document-for-Portal-1-26-2018.pdf>

MHS Provider Claims Issue Resolution Process

Provider Claims Issue Resolution

PROCESS

-  Level 1: Informal Claims Dispute Online or with Medical Claim Dispute/Appeal form
-  Level 2: Formal Claim Dispute –Administrative Claim Appeal Online or with Medical Claim Dispute/Appeal form
-  Level 3: Arbitration

-  Please note, this is different than an Authorization appeal. A claim appeal cannot change a denied authorization status. To change authorization status, you must appeal the denied authorization.

Claim Dispute/Appeal Form – Medical and Behavioral Health



Medical Claims Address:
 Managed Health Services
 PO Box 3000
 Attn: Appeals Department
 Farmington, MO 63640-3800



Behavioral Health Claims
 Address:
 Managed Health Services BH
 Appeals
 PO Box 6000
 Attn: Appeals Department
 Farmington, MO 63640-3809

<https://www.mhsindiana.com/content/dam/centene/mhsindiana/medicaid/pdfs/MHS-Dispute-Appeal-form.pdf>



DO NOT USE THIS FORM FOR MEDICAL NECESSITY APPEALS.

Medical Claim Dispute/Appeal Form

This form is not required but available to assist in submitting an informal dispute/appeal.

____ 1st Level (Informal Dispute/Reconsideration)
 ____ 2nd Level (Appeal) – if you are not satisfied with resolution of informal dispute

This form must be completed in its entirety. In order to consider your request, you must provide an explanation of your appeal and submit supporting documentation for the dispute/appeal. Without sufficient documentation, the request cannot be reviewed and the original determination will be upheld.

Provider Name	Provider Tax ID
Provider NPI	Date of last Explanation of Payment
MHS Claim Number *	Dates of Service *
Member Name *	Member ID *

* Required fields

Where more than one of claim number, DOS, member name, or member ID applies for the same appeal reason, please include this information as an attachment.

Reason for the appeal:

- Claim was denied for no authorization, but authorization number _____ was obtained.
- Claim was denied for no authorization, but no authorization is required for this service.
- Claim was denied for no authorization, however authorization was not obtained due to member's eligibility or medical condition.
- Claims was denied for Member not eligible, but member was eligible on DOS (attach eligibility information).
- Claim was not paid per the terms of my contract with Managed Health Services (attach relevant reimbursement section).
- Claim denied as non-covered benefit (attach supporting documentation as proof the service is a covered benefit).
- Claim was denied "Past Timely Filing" (attach proof of timely filing).
 - o Note: if the past timely filing deadline denials falls on a weekend or a holiday, the provider may request a reconsideration (see Reconsideration Request Form)
- Claim was paid the incorrect amount (include calculation of expected payment and supporting information).
- Claim denied based on Managed Health Services Payment policy (attach medical records to support services provided).
 - o Note: Payment policies can be found at <https://www.mhsindiana.com/providers/resources/clinical-payment-policies.html>
- Other. Please explain (and provide supporting documentation): _____

Please ensure sufficient detail is provided to assist us in the review of your appeal.

Preferred submission via the Provider Portal: Informal disputes – currently available; 2nd level appeal – available online beginning in early 2021

Paper copies of the completed form and all attachments can be sent to:



Medical Claims:
 Managed Health Services
 PO Box 3000
 Farmington, MO 63640-3800

Behavioral Health Claims
 Managed Health Services BH Appeals
 PO Box 6000
 Farmington, MO 63640-3809






Informal Claims Dispute or Objection Form

Level 1:

-  Submit all documentation supporting your objection.
-  Must be submitted via the Secure Web Portal or in writing within **60 calendar days** of receipt of the MHS Explanation of Payment (EOP) by using the Medical Claim Dispute/Appeal form.
 - **Requests received after day 60 will not be considered.**
 - Copies of original MHS EOP showing how the claims in question were processed.
 - Copies of any subsequent MHS EOPs or other determinations on the claim(s) in question.
 - Documentation of any previous attempt you have made to resolve the issue with MHS.
 - Other documentation that supports your request for reprocessing or reconsideration of the claim(s).

Informal Claims Dispute or Objection Form


Level 1:


-  MHS will make all reasonable efforts to review your documentation and respond to you within 30 calendar days.
-  If you do not receive a response within 30 calendar days, consider the original decision to have been upheld.
-  At that time (or upon receipt of our response if sooner), you will have up to 60 calendar days from date of dispute response to initiate a formal claim appeal (Level 2).

Informal Claims Dispute or Objection Form


Level 1:

Helpful Tips:





-  Disputing multiple claim denials:
 - Submit separate Informal Claims Dispute Forms for each member/patient experiencing the denial;
 - Provide additional information such as:
 - The MHS denial code and description found on the EOP/remit;
 - Briefly describe why you are disputing this denial;
 - For multiple claims please either list all claim numbers or in the “Reason for Dispute” section state that “**member is experiencing denial reason ____ for all claims DOS ____ to ____; Please review all associated claims**”;

-  Save copies of all submitted informal claims dispute forms.

Provider Services Phone Requests & Web Portal Inquiries

 After the informal claims dispute (Level 1) has been submitted, for assistance or questions the provider can access the Provider Service Phone line, or Web Portal.

Provider Services Phone Requests & Web Portal Inquiries

-  This is not considered a formal notification of provider dispute.
-  Claim issues presented by providers to the Provider Services phone line & Web Portal Inquiries for review will be logged and assigned a ticket number. Please keep this ticket number for your reference.
-  **Phone: 1-877-647-4848; Provider Services 8 a.m. to 8 p.m.**
-  **Provider Web Portal:**
<https://www.mhsindiana.com/providers/login.html>
 - Use the Messaging Tool.

Provider Services Phone Requests & Web Portal Inquiries





Helpful Tips:

Disputing multiple claim denials:

- Provide the provider services rep or web portal team member with one claim number as an example of the specific denial.
- **Communication is Key!**
 - Tell the rep you have a “claims research request” to review all claims for the specific denial reason.
 - State if this denial is happening for one or multiple practitioners within your group or clinic; (if multiple, provide your TIN)
 - Provide the MHS denial code and description found on the EOP.
 - Briefly describe why you are disputing this denial or seeking research.






Formal Claim Dispute - Administrative Claim Appeal

Level 2

-  Level 2 is a Formal Claim Dispute, Administrative Claim Appeal.
-  In the event the provider is not satisfied with the informal claim dispute/objection resolution, the provider may file an administrative claim appeal. The appeal must be filed within 60 calendar days from receipt of the informal dispute resolution notice.
-  An administrative claim appeal must be submitted via the Secure Portal or in writing by using the Medical Claim Dispute/Appeal form with an explanation including any specific details which may justify reconsideration of the disputed claim. The appeal clearly marked on the form as Level 2.
-  See the MHS Provider Manual Chapter 5 Claims Administrative Reviews and Appeals for more information.
<https://www.mhsindiana.com/content/dam/centene/mhsindiana/medicaid/pdfs/508-Provider-Manual-2021.pdf>

Arbitration





Level 3:

-  Level 3 is a part of the formal MHS Provider Claims dispute process.
-  In the event a provider is not satisfied with the outcome of the administrative claim appeal process (Level 2), the provider may request arbitration. Claims with similar issues from the same provider may be grouped together for the purpose of requesting arbitration.
-  To initiate arbitration, the provider should submit a written request to MHS on company letterhead. The request must be postmarked no later than 60 calendar days after the date the provider received MHS' decision on the administrative claim appeal.
-  Arbitration Requests need to be mailed to, MHS Arbitration, 550 N. Meridian Street, Suite 101, Indianapolis, IN 46204.
-  See the MHS Provider Manual Chapter 5 Claims Administrative Reviews and Appeals for more information.

<https://www.mhsindiana.com/content/dam/centene/mhsindiana/medicaid/pdfs/508-Provider-Manual-2021.pdf>


Additional Claim Assistance











Provider Relations Regional Mailboxes

-  This is not considered a formal notification of provider dispute.
-  If all claim denials are upheld after following the dispute processes and the Provider has not received resolution by calling Provider Services or utilizing the secure messaging on the portal, please contact the Provider Relations team through the claims issues mailbox assigned to your region.
-  Issues will be logged by the internal Provider Relations team and providers will receive a response email with next steps and any assigned reference numbers. Response to incoming email can take 2-4 weeks depending on workload.
-  Please do not email your Provider Partnership Associate directly as this may delay the time in getting a response due to their travel.

Provider Relations Regional Mailboxes









Helpful Tips:

 Please submit the following information to the provider relations regional mailbox (**attach spreadsheet if multiple claims but below fields must be included**)

-  Issue Reference Number(s)
-  TIN
-  Group/Facility Name
-  Practitioner Name & NPI
-  Member Name and RID Number
-  Product (Medicaid/Ambetter/Allwell)
-  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

Provider Relations Regional Mailboxes

Regional Mailboxes

-  Northeast Region: MHS_ProviderRelations_NE@mhsindiana.com
-  North Central Region: MHS_ProviderRelations_NC@mhsindiana.com
-  Central Region: MHS_ProviderRelations_C@mhsindiana.com
-  Northwest Region: MHS_ProviderRelations_NW@mhsindiana.com
-  Southwest Region: MHS_ProviderRelations_SW@mhsindiana.com
-  Southeast Region: MHS_ProviderRelations_SE@mhsindiana.com
-  South Central Region: MHS_ProviderRelations_SC@mhsindiana.com
-  Tier 1 Providers: IndyProvRelations@mhsindiana.com

Portal Functionality

Secure Web Portal Login or Registration

Login/Register is the same for **MHS, Ambetter from MHS, Allwell from MHS** and **Behavioral Health Providers**



FOR MEMBERS

FOR PROVIDERS

GET INSURED

FOR PROVIDERS

Login

Become a Provider

Prior Authorization

Dental Providers

Pharmacy

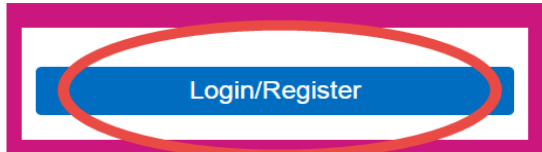
Behavioral Health

Provider Resources

QI Program

Provider News

Portal Login



[Click here for additional information and step by step guides.](#)

Behavioral Health Secure Portal

[Click here for the Cenpatico behavioral health portal.](#)

Registration Help

If you are having trouble with your registration, you may need to submit a non-par set-up form. Visit our [Become a Provider](#) page to get started. For further assistance, you can call our Secure Provider Portal Help Line at 1-866-912-0327.

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

Please note that Clear Claim Connection does not provide an all inclusive listing of claim edits. MHS does utilize additional prepayment review edits in keeping with NCCI procedures and guidelines.

Web Portal Training Documents








Documents Include:

- Registration Guide
- MHS Web Portal User Guides
- How To Complete Specific Tasks on the MHS Web Portal

FOR PROVIDERS

Login

Enrollment and Updates
Prior Authorization 
Dental Providers
Pharmacy 
Opioid Resources
Behavioral Health 
Provider Resources 
QI Program 
Provider News
Email Sign Up

Registration Help

If you are having trouble with your registration, you may need to submit a non-par set-up form. Visit our [Become a Provider](#) page to get started. For further assistance, you can call Provider Services at 1-877-647-4848 or see our [Account Registration Guide \(PDF\)](#).

PORTAL TRAINING GUIDES

- [Account Manager User Guide \(PDF\)](#)
- [Provider Secure Portal Brochure \(PDF\)](#)
- [Provider Secure Portal Flyer \(PDF\)](#)
- [Submit a Claim CMS 1500 \(PDF\)](#)
- [Submit a Claim CMS UB-04 \(PDF\)](#)
- [Submit a Corrected Claim \(PDF\)](#)
- [Update Portal Account Details \(PDF\)](#)
- [Utilize Member Management Forms \(PDF\)](#)
- [View Claim Status \(PDF\)](#)
- [View Payment History \(PDF\)](#)

Complete Registration or Login

The Tools You Need Now!
Our site has been designed to help you get your job done. For registration or secure website questions call (866) 912-0327. Manage all products with ease in one location.

Check Eligibility
Find out if a member is eligible for service.

Authorize Services
See if the service you provide is reimbursable.

Manage Claims
Submit or track your claims and get paid fast.

Login

User Name (Email)
name@domain.com

Password

[Forgot Password / Unlock Account](#)

[Login](#)

Need To Create An Account?
Registration is fast and simple, give it a try.

[Create An Account](#)

How to Register
Our registration process is quick and simple. Please click the button to learn how to register.

[Provider Registration Video](#)

[Provider Registration PDF](#)

Registration Complete! Your Progress

Thank you for completing your registration! A Superior HealthPlan provider services specialist will be sending you an email when your profile has been activated. Please allow up to 2 business days for processing.

If you do not receive an email within 2 business days, please log in and contact us using secure messaging or call 866-895-8443 for additional assistance.

[Login](#)

Quick Eligibility Check

Member ID or Last Name: 123456789 or Smith Birthdate: mm/dd/yyyy [Check Eligibility](#)

Recent Claims

STATUS	RECEIVED DATE	MEMBER NAME	CLAIM NO.
	08/19/2017	C	4
	08/19/2017	T	3
	08/19/2017	E	1
	08/19/2017	F	8

Welcome

- [Add a TIN to My ACCOUNT](#)
- [Manage Accounts](#)
- [Reports](#)
- [Patient Analytics](#)
- [Provider Analytics--Coming Soon](#)

Recent Activity

Date Activity

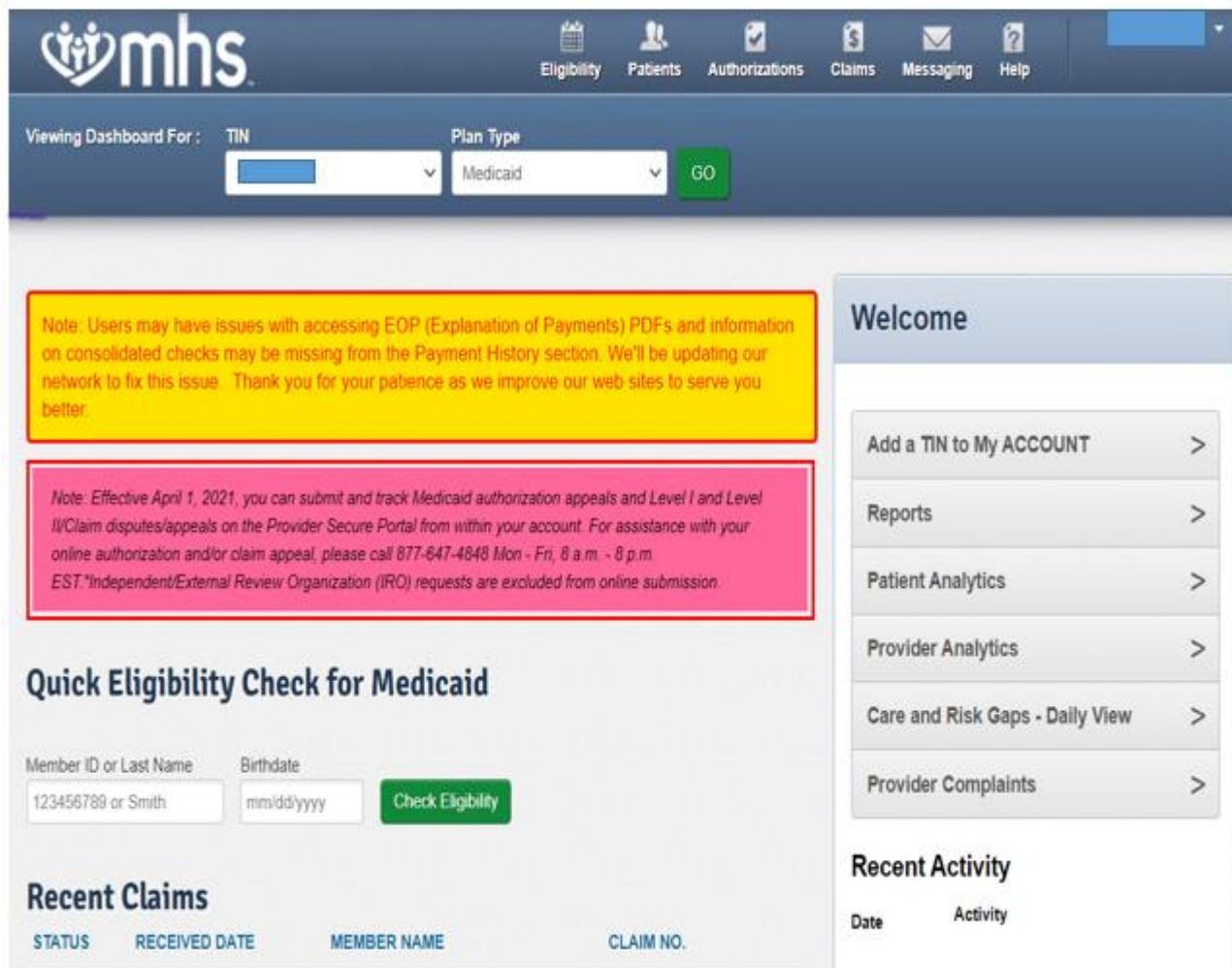
Quick Links

[Provider Resources](#)

- The Registration is complete and the Secure Portal homepage will be visible!

- An email will be sent to the provider when they have access to specific tools.

Homepage – MHS (Medicaid)

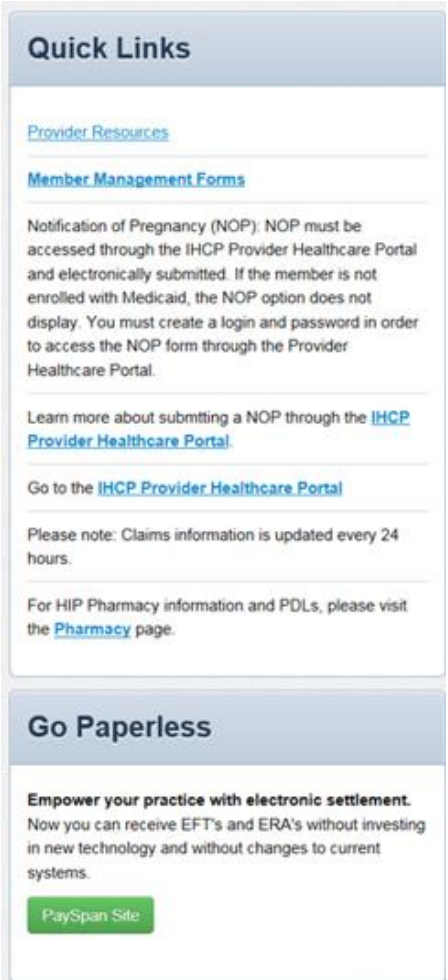


The screenshot shows the MHS Medicaid homepage dashboard. At the top, there is a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below this, a header section allows users to filter the dashboard by TIN and Plan Type (currently set to Medicaid). A green 'GO' button is next to the filters.

Two informational boxes are present: a yellow one with a note about EOP PDFs and a pink one with a note about Medicaid authorization appeals effective April 1, 2021.

The main content area is divided into three sections:

- Quick Eligibility Check for Medicaid:** A form with fields for Member ID or Last Name (123456789 or Smith) and Birthdate (mm/dd/yyyy), with a green 'Check Eligibility' button.
- Recent Claims:** A table with columns for STATUS, RECEIVED DATE, MEMBER NAME, and CLAIM NO.
- Welcome:** A central panel with a list of menu items: Add a TIN to My ACCOUNT, Reports, Patient Analytics, Provider Analytics, Care and Risk Gaps - Daily View, and Provider Complaints.



The right sidebar contains two main sections:

- Quick Links:** A list of links including Provider Resources, Member Management Forms, and information about NOP (Notification of Pregnancy) forms. It also includes a link to the IHCP Provider Healthcare Portal and a note about claims information being updated every 24 hours.
- Go Paperless:** A section titled 'Empower your practice with electronic settlement.' It states that users can now receive EFT's and ERA's without investing in new technology. A green 'PlaySpan Site' button is located at the bottom of this section.

Claims Audit Tool

The Clear Claim Connection screen appears, allowing you to enter the Procedure Code, Quantity, Modifiers, Date and Place of Service, and Diagnosis for a claim proactively before you submit or retroactively after you submit.

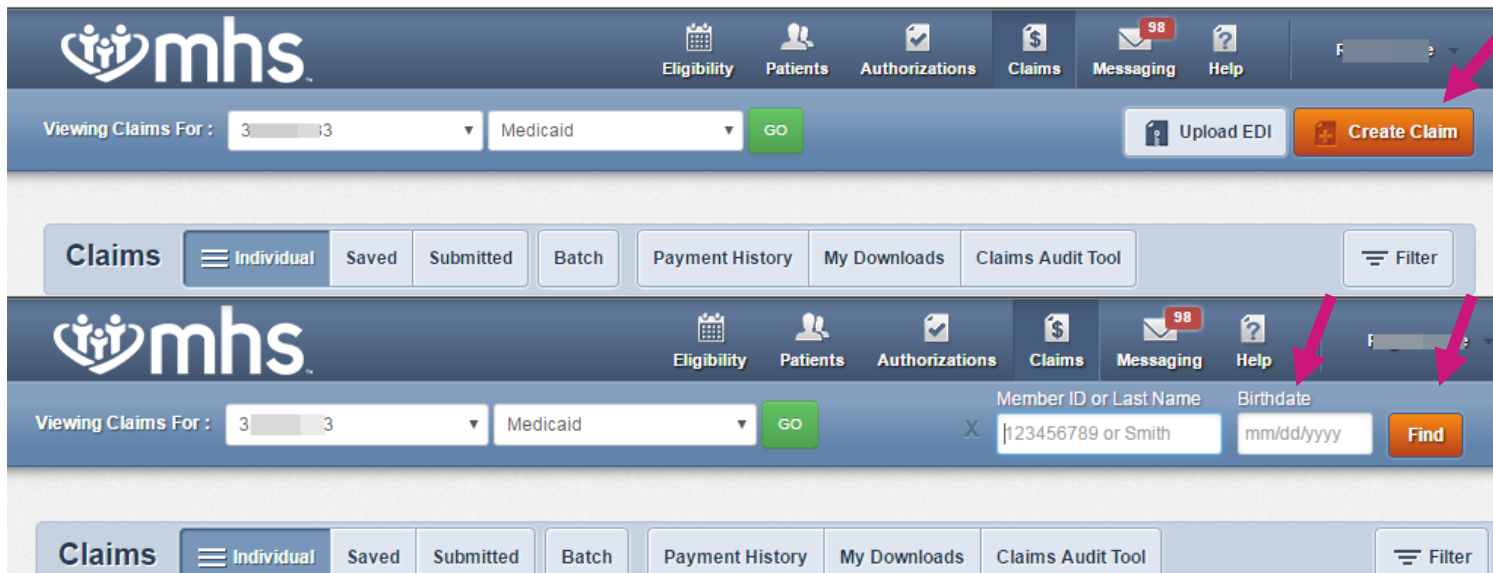
Claims

Web Portal Claims Functionalities:

- **Submit** new claim.
- **Review claims** information on file for a patient.
- **Correct** claims.
- **View payment history.**

Submit a New Claim:

- Click **Create Claim** and enter **Member ID** and **Birthdate**

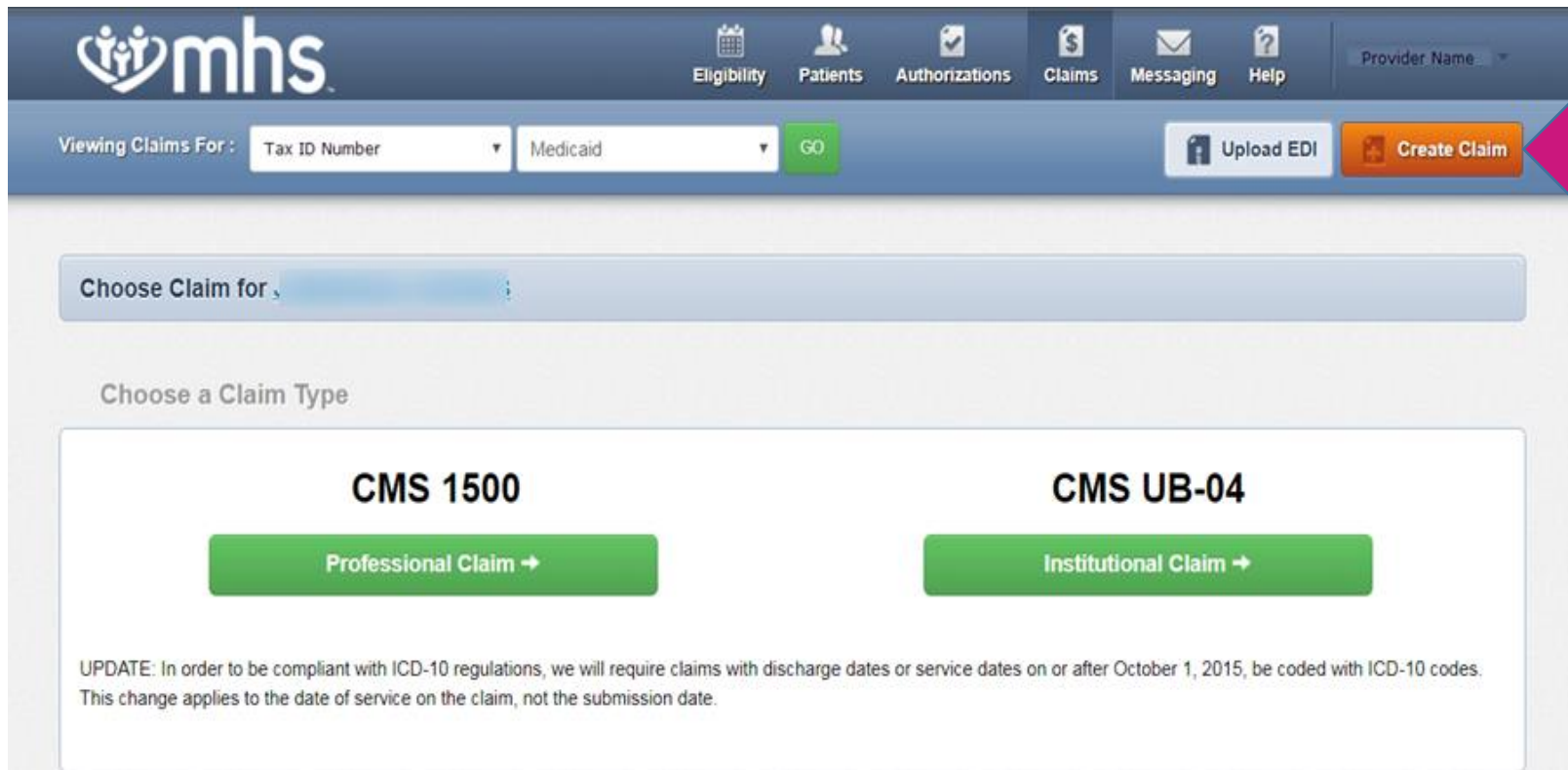


The screenshot displays the mhs web portal interface. At the top, there is a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, Messaging (with a notification badge of 98), and Help. Below this is a search bar with a dropdown menu and a 'GO' button. The main content area features a 'Claims' section with tabs for Individual, Saved, Submitted, Batch, Payment History, My Downloads, and Claims Audit Tool. A 'Filter' button is also present. Below the navigation bar, there is a search form with fields for 'Member ID or Last Name' (containing '|123456789 or Smith') and 'Birthdate' (containing 'mm/dd/yyyy'). A 'Find' button is located to the right of these fields. A red arrow points to the 'Create Claim' button in the top right corner, and two red arrows point to the search fields.

Claim Submission

Choose the Claim Type


- Professional or Institutional claim submission



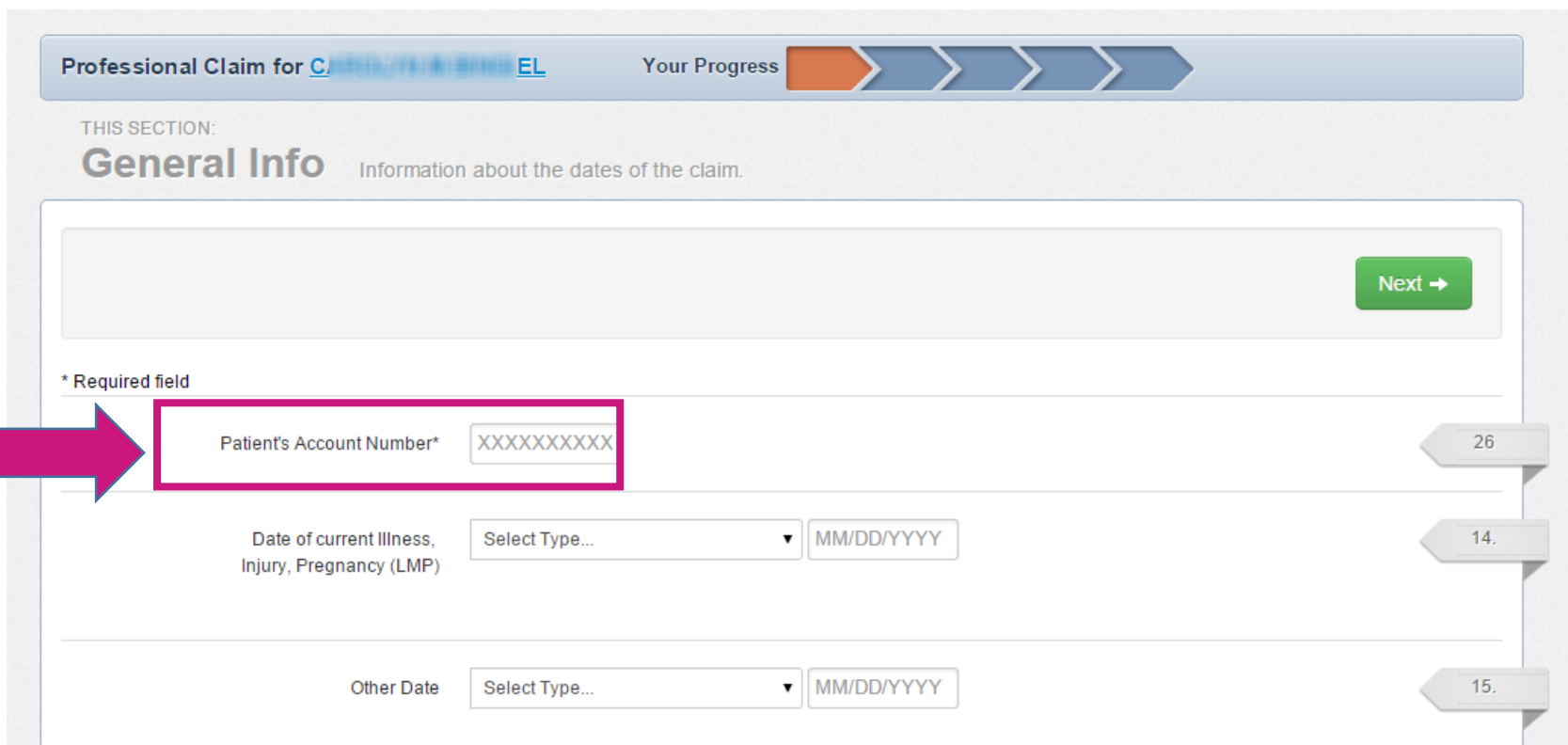
The screenshot shows the mhs Claims Submission interface. At the top, there is a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. A dropdown menu for 'Provider Name' is visible on the right. Below the navigation bar, there is a section for 'Viewing Claims For:' with two dropdown menus: 'Tax ID Number' and 'Medicaid', followed by a green 'GO' button. To the right of this section are two buttons: 'Upload EDI' and 'Create Claim'. A pink arrow points to the 'Create Claim' button. Below this section, there is a 'Choose Claim for' dropdown menu. Underneath, there is a section titled 'Choose a Claim Type' with two options: 'CMS 1500' and 'CMS UB-04'. Each option has a green button with a right-pointing arrow: 'Professional Claim →' for CMS 1500 and 'Institutional Claim →' for CMS UB-04. At the bottom of the page, there is an 'UPDATE' notice: 'UPDATE: In order to be compliant with ICD-10 regulations, we will require claims with discharge dates or service dates on or after October 1, 2015, be coded with ICD-10 codes. This change applies to the date of service on the claim, not the submission date.'


Professional Billing

Professional Claim Submission:

 In the **General Info** section, populate the **Patient's Account Number** and other information related to the patient's condition by typing into the appropriate fields.

 Click **Next**.



Professional Claim for [C. \[REDACTED\] EL](#) Your Progress 

THIS SECTION:
General Info Information about the dates of the claim.

[Next →](#)

* Required field

Patient's Account Number* 26


Date of current Illness, Injury, Pregnancy (LMP) 14.

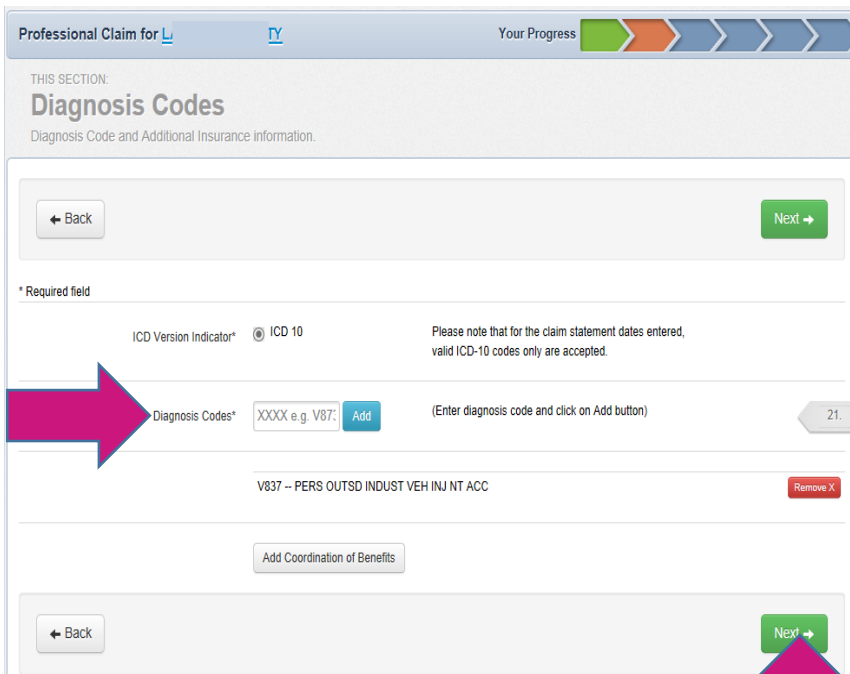
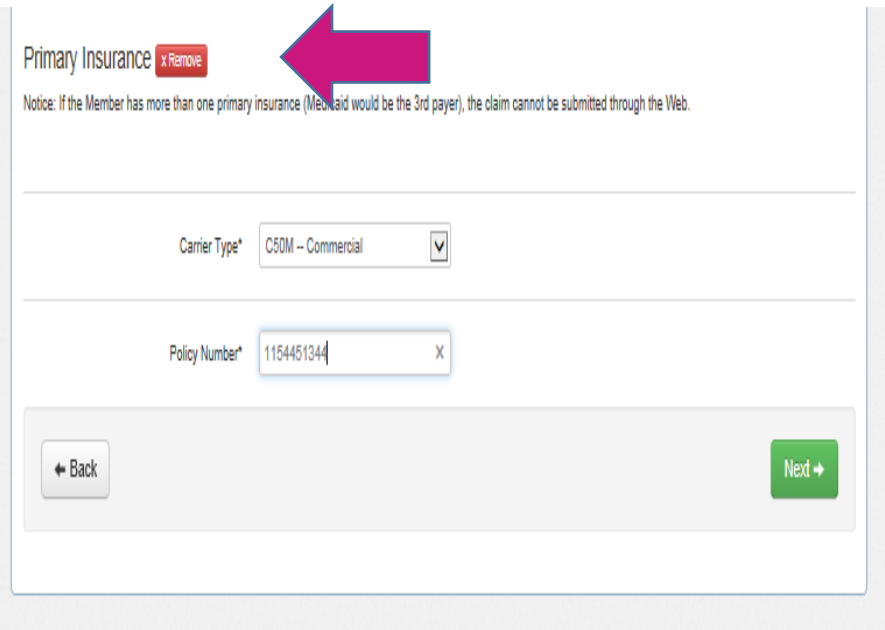
Other Date 15.

Professional Claim Submission:

 Add the **Diagnosis Codes** for the patient in Box 21.

 Click the **Add** button to save.

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

Professional Claim Submission:

Add Service Lines.

Professional Claim for [Member ID] Your Progress >>>>>

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

[Back](#) [Next](#)

Total: \$500.00 * Required field [Delete](#) [Save / Update](#)

[+ New Service Line](#)

PROCEDURE / CHARGES

1: 99213 / \$500.00

Now Viewing Line 1: 99213 / \$500.00

Dates of Service* From: 02/01/2018 To: 02/01/2018 24a

Place of Service* 11 - PROVIDER'S OFFICE 24b

Procedure Code* 99213 24c

Modifiers XX [Add](#) Please enter the modifier and click the ADD button.

Diagnosis Code(s)* M37 - PERD OUTSD INDUST VEH INJ NT ACC 24e

Charge* 500.00 24f

Units / Minutes / Days* 1 Type* UN - UP 24g

Family Planning Yes No EP007* Select... 24h

NDC NDC NDC

Supplemental Information Supplemental Information

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

Amount Allowed* 500.00

Deductible XXXXXX

Copy XXXXXX

Co-Insurance XXXXXX

Amount Paid 500.00

Service Line Denial Reasons
Select denied category, enter amount and click "Add Denied Reason" to add a denied amount to your claim.

Denied Category Select... 24i

Denied Amount XXXXXX

[Add Denied Reason](#)

[Delete](#) [Save / Update](#)

[Back](#) [Next](#)

Professional Claim Submission:


Enter Referring and Billing Provider information. Enter Service Facility Location.

Click Next.

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

Click Next.


Professional Claim Submission:

Professional Claim for L Your Progress 

THIS SECTION:
Review
Please review your claim and submit.

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

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

Claim Id: 8 

Member Record Number: 2 0
Member Claim Amount Paid:
Patient's Account Number: N

General Info [Edit](#)
Statement From Date: 03/16/2017
Statement To Date: 03/16/2017
Date of Current Illness, Injury, Pregnancy (LMP):
Other Date:
Hospitalized From:
Hospitalized To:
Additional Claim Information:
Outside Lab?: No
Outside Lab Amount:
Prior Authorization Number:
CLIA Number:

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

Service Lines [Edit](#)


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


Providers [Edit](#)

Provider Type	Name	Tax ID	NPI	Taxonomy	Address
Referring Provider	CARBUNARU , GOLDY		1366473456		
Rendering Provider					
Billing Provider	MOHAMMED S GHAZA,	200734793	1275540361	246W00000X	5107 N BEND DR, FORT WAYNE, IN, 468041753
Service Facility Location	LUTHERAN CHILDRENS HOSPITAL				7950 W JEFFERSON BLVD, FORT WAYNE, IN, 468049998

Attachments

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

 In the **Review** section, you can see if the claim is eligible for Real Time Editing and Pricing (RTEP).

 Click **Validate** for RTEP Claims and Click **Submit** for regular processed claims.



RTEP Claim Pricing View

COMPLETE!
You have successfully submitted your claim. Print

Web Reference No. 8
Claim No.

RefAcct No: 092851 DOS Range:
Member ID: Billed Amount: \$90.00
Member Name: Payment Amount: \$46.75
Servicing Provider: Status: APPROVED

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

The system has provided a response back to the you indicating amount to be paid on the claim. Any post adjudication processes can change the amount paid.


Close

RTEP Overview:

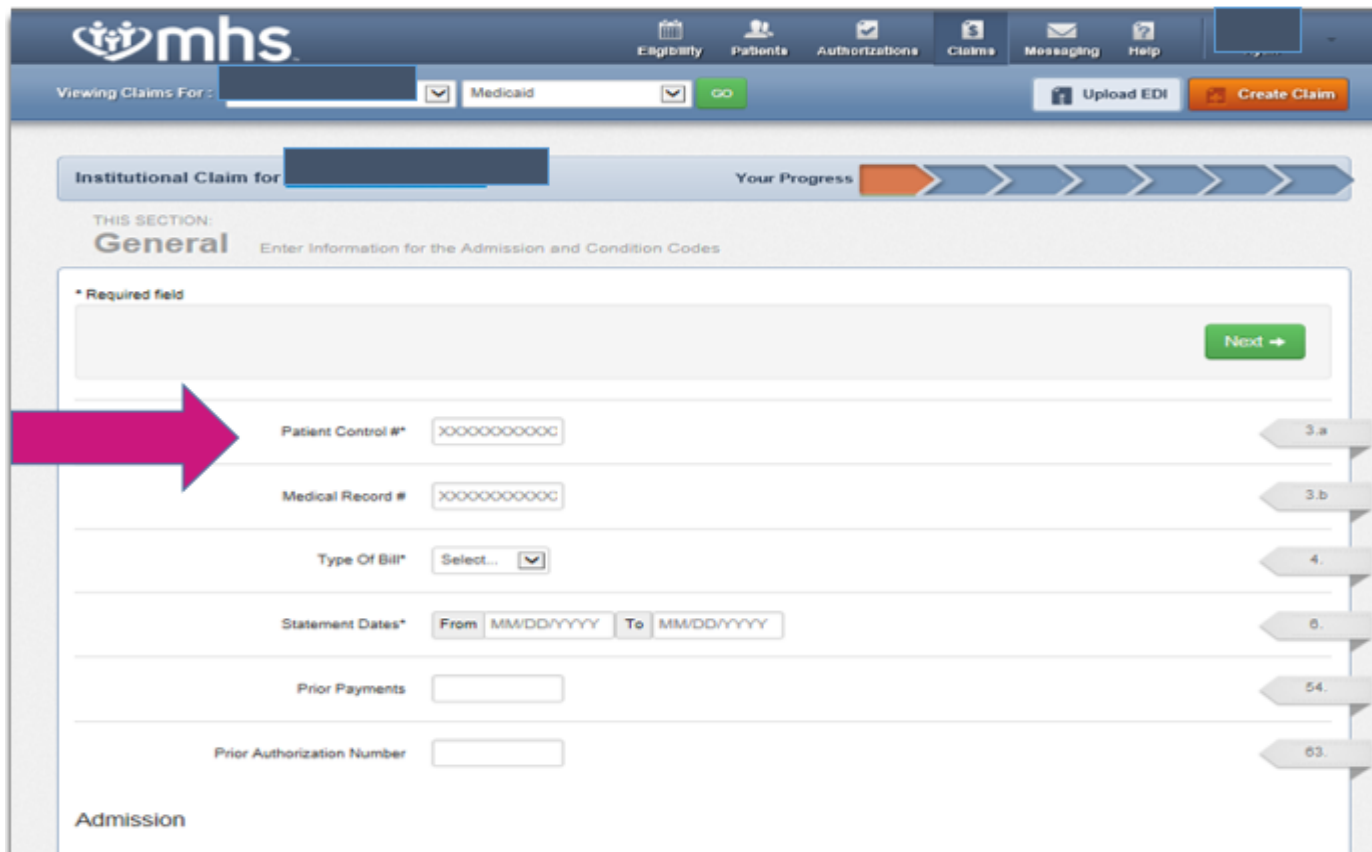
- On the final screen, each procedure code will receive a reimbursement estimate, pending claim explanation or denial reason.
- Claims with a reimbursement estimate or pend explanation may be impacted by final adjudication including a change to the reimbursement amount or a denial.
- Adjudication status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

Facility Billing

UB-04 Billing

 In the **General Info** section, populate the **Patient's Control Number** and other information related to the patient's condition by typing into the appropriate fields.

 Click **Next**.



The screenshot shows the mhs UB-04 Billing form. At the top, there is a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below this is a header area with "Viewing Claims For:" followed by a dropdown menu, a "Medicaid" dropdown, and a "GO" button. To the right are "Upload EDI" and "Create Claim" buttons. The main content area is titled "Institutional Claim for" followed by a redacted name. A "Your Progress" bar shows several steps, with the current step highlighted. Below this, the "General" section is active, with the instruction "Enter Information for the Admission and Condition Codes". A "Required field" label is present above a large empty text box. A green "Next" button is located to the right of this box. A large pink arrow points from the left side of the screen to the "Patient Control #" field, which contains "XXXXXXXXXX". Other fields include "Medical Record #", "Type Of Bill", "Statement Dates", "Prior Payments", and "Prior Authorization Number". A vertical sidebar on the right contains numbered steps: 3.a, 3.b, 4, 5, 5.a, and 5.b.

UB-04 Billing

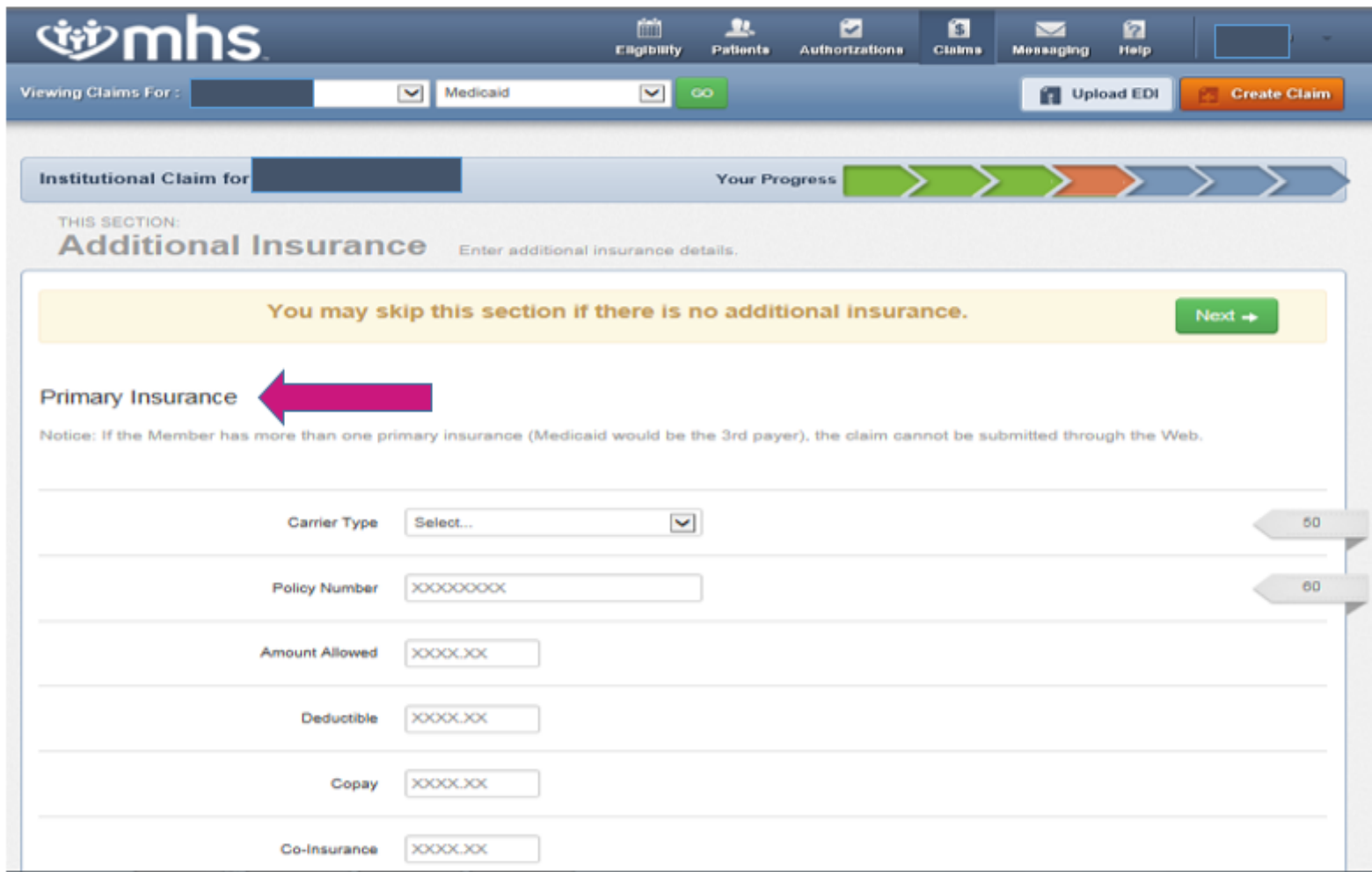
Add the **provider information**.

Click **save** and click **next** to proceed

Click **Add New Service Line** and enter the service lines information.


UB-04 Billing

Enter Additional Insurance (if applicable)



mhs Eligibility Patients Authorizations Claims Messaging Help

Viewing Claims For : Medicaid

Institutional Claim for Your Progress 

THIS SECTION:
Additional Insurance Enter additional insurance details.

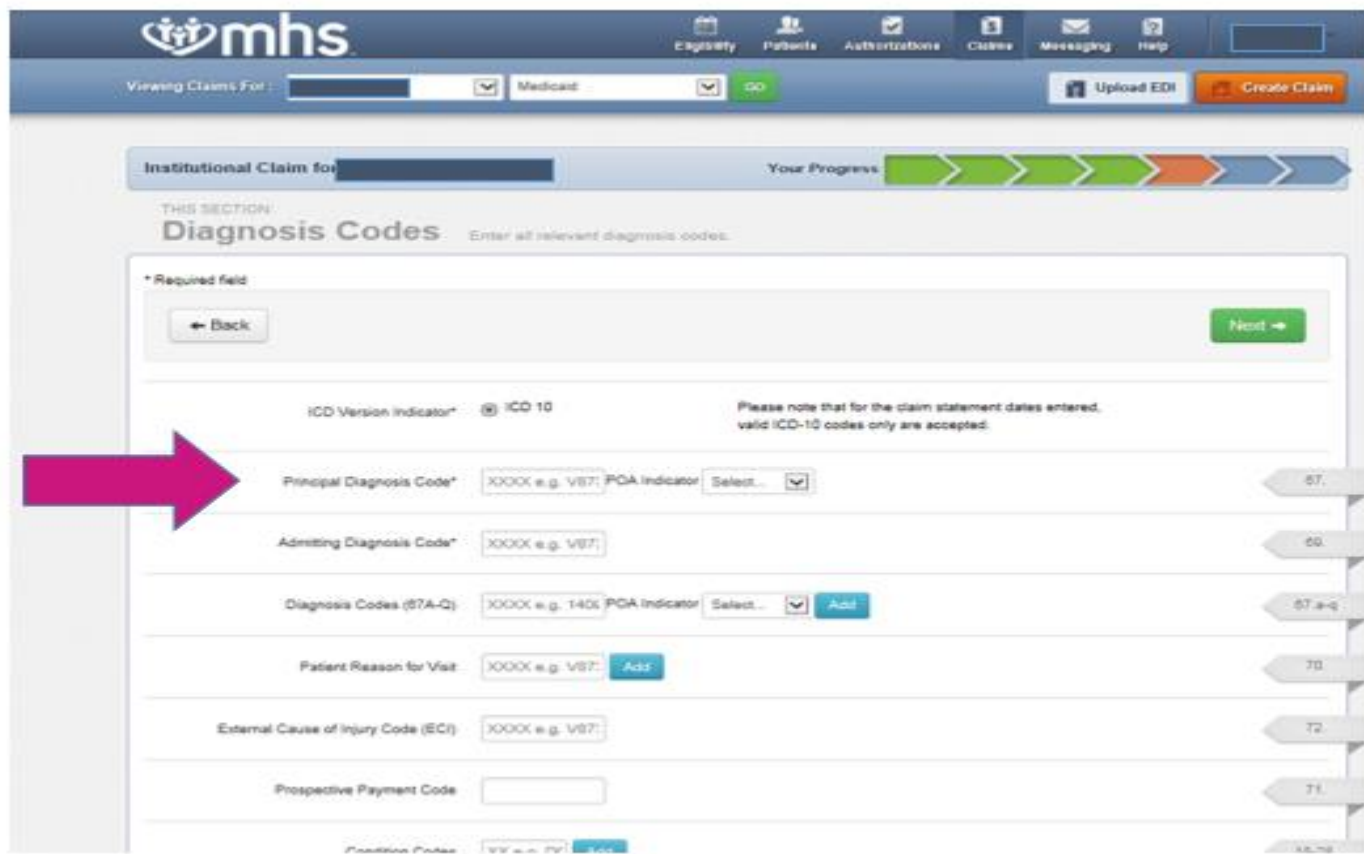
You may skip this section if there is no additional insurance.

Primary Insurance ←

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

Carrier Type	<input type="text" value="Select..."/>	60
Policy Number	<input type="text" value="XXXXXXXX"/>	60
Amount Allowed	<input type="text" value="XXXX.XX"/>	
Deductible	<input type="text" value="XXXX.XX"/>	
Copay	<input type="text" value="XXXX.XX"/>	
Co-Insurance	<input type="text" value="XXXX.XX"/>	

Enter Diagnosis Codes (use Add button)



The screenshot shows the mhs web application interface for entering diagnosis codes. The top navigation bar includes links for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below the navigation bar, there are dropdown menus for 'Viewing Claims For' and 'Medicaid', along with 'Upload EDI' and 'Create Claim' buttons. The main content area is titled 'Institutional Claim for' and features a 'Your Progress' progress bar. The 'Diagnosis Codes' section is highlighted, with a pink arrow pointing to the 'Principal Diagnosis Code' field. The form includes various input fields and buttons for adding and navigating through the codes.

THIS SECTION:
Diagnosis Codes Enter all relevant diagnosis codes.

* Required field

← Back Next →

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

Principal Diagnosis Code* POA Indicator 67

Admitting Diagnosis Code* 68

Diagnosis Codes (87A-Q) POA Indicator 67 a-q

Patient Reason for Visit 70

External Cause of Injury Code (ECI) 72

Prospective Payment Code 71

Position Codes 73-76

Add Attachments (if applicable)

Review Claim and Submit

Eligibility Patients Authorizations **Claims** Messaging Help

Viewing Claims For: [Redacted] Medicaid [GO] [Upload EDI] [Create Claim]

Institutional Claim for [Redacted] **Your Progress** [Progress Bar]

THIS SECTION:
Review and Submit Please review your claim before submitting.

Almost done! [Submit](#)

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

Claim ID: [Redacted]

General Info [Edit](#)

Patient Control #: 111111111
 Medical Record #: 111111111
 Type Of Bill: 110
 Statement From Date: 09/01/2017
 Statement To Date: 09/05/2017
 Prior Payments:
 Prior Authorization Number:
 Admission Date: 09/01/2017
 Admission Hour: 10
 Admission Type: 9
 Admission Source: 7
 Discharge Status: 01
 Discharge Hour: 09

Provider Details [Edit](#)

Provider Type	NPI	Taxonomy	Name	Tax ID	Address (1)	Address (2)	City	State	Zip
Billing Provider	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]
PayTo Provider	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]

Provider Type	NPI	Taxonomy	First Name	Last Name	IRS/Tax ID Num	Organization
[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]

Web Portal Claim and Payment Review

Submitted Claims

The **Submitted** tab will only display claims created via the MHS portal:

- **Paid** is a green thumbs up.
- **Denied** is an orange thumbs down.
- **Pending** is a clock.

RTEP claims also show if eligible (i.e. line 3 was submitted, but was not eligible for RTEP).

Viewing Claims For: Tax ID Number Medicaid Upload EDI Create Claim

Claims Individual Saved **Submitted** Batch Payment History My Downloads Claims Audit Tool Filter

SUBMITTED STATUS ↑	DATE SUBMITTED ↓	WEB #/ REF # ↑	CLAIM NUMBER ↑	CLAIM TYPE ↑	MEMBER NAME ↑	MEMBER ID ↑	ORIGINAL CLAIM # ↑	TOTAL CHARGES ↓	
🕒	08/16/2017	8		CMS-1500	S	1	6	\$150.00	
👍	08/10/2017		C	CMS-1500	C	1		\$150.00	RTEP 👍
👍	08/02/2017		C	CMS-1500	S	1		\$150.00	RTEP 🗑️
👍	07/24/2017	E	C	CMS-1500	S	1		\$150.00	RTEP 👍

4 items found, displaying all items. Page 1/1 1

Individual Claims

👤 On the **Individual** tab, submitted using paper, portal or clearing house:

- View the Claim No, Claim Type, Member Name, Service Date(s), Billed/Paid, and Claim Status

Viewing Claims For: 3 | Medicaid | GO | Upload EDI | Create Claim

Claims | **Individual** | Saved | Submitted | Batch | Payment History | My Downloads | Claims Audit Tool | Filter

CLAIM NO. ↑	CLAIM TYPE ↓	MEMBER NAME ↓	SERVICE DATE(S) ↓	BILLED/ PAID ↓	CLAIM STATUS ↓
3	CMS-1500	K R	07/24/2017 - 07/24/2017	\$65.00 / \$41.38	👍
31	CMS-1500	JE EN	07/24/2017 - 07/24/2017	\$171.00 / \$106.34	👍
36	CMS-1500	E R	07/24/2017 - 07/24/2017	\$253.00 / \$101.04	👍
1	CMS-1500	E R	07/24/2017 - 07/24/2017	\$2,783.00 / \$118.86	👍
2	CMS-1500	E	07/24/2017 - 07/24/2017	\$2,783.00 / \$0.00	👎

Paid is a green thumbs up, **Deny** is an orange thumbs down and a clock is **Pending**.

Saved Claims





To view **Saved** claims: Drafts, Professional, or Institutional:

1. Select **Saved**.
2. Click **Edit** to view a claim.
3. Fix any errors or complete before submitting.
- Or
4. Click **Delete** to delete saved claim that is no longer necessary.
5. Click **OK** to confirm the deletion.

The screenshot shows the mhs Claims management interface. At the top, there are navigation tabs for Eligibility, Patients, Authorizations, Claims, Messaging (with 88 notifications), and Help. Below this is a search bar for 'Viewing Claims For' with a dropdown set to 'Medicaid' and a 'GO' button. To the right are 'Upload EDI' and 'Create Claim' buttons. A pink arrow points to the 'Saved' tab in the 'Claims' section, which is highlighted with a pink box. Other tabs include 'Individual', 'Submitted' (with 11 notifications), 'Batch', 'Payment History', 'My Downloads', and 'Claims Audit Tool'. Below the tabs is a warning message: 'Claims listed below have missing information or contain errors. Click 'Edit' to view a claim, then fix any errors or complete it before submitting.' There are three filter tabs: 'Drafts', 'Professional Ready to be Submitted', and 'Institutional Ready to be Submitted'. The main table displays a list of claims with columns for Date Created, Claim Type, Claim ID, Member Name, Member ID, Original Claim #, and Total Charges. Each row includes 'Edit' and 'Delete' links.

DATE CREATED ↑	CLAIM TYPE ↓	CLAIM ID ↓	MEMBER NAME ↓	MEMBER ID ↓	ORIGINAL CLAIM # ↓	TOTAL CHARGES ↓		
08/10/2017	Institutional	8[redacted]0	R[redacted]N	1[redacted]9	Q[redacted]3	\$54,159.07	Edit	Delete
08/07/2017	Institutional	8[redacted]5	P[redacted]S	1[redacted]9	Q[redacted]1	\$461.75	Edit	Delete
08/02/2017	CMS-1500	8[redacted]0	A[redacted]N	1[redacted]9	Q[redacted]4	\$292.00	Edit	Delete
08/01/2017	Institutional	8[redacted]7	J[redacted]E	1[redacted]9	Q[redacted]6	\$461.75	Edit	Delete
08/01/2017	Institutional	8[redacted]1	F[redacted]	1[redacted]9	Q[redacted]1	\$461.75	Edit	Delete
07/17/2017	Institutional	8[redacted]3	[redacted]N	1[redacted]9		\$507.00	Edit	Delete

Tips to Remember

-  Clicking on items (claim numbers, check numbers, dates) that are highlighted **blue** will reveal additional information.
-  When **filtering** to find a claim or payment history, only a **30 day** span within the same month can be used.
-  Click on the **Saved Claims** tab to view claims that have been created but not Submitted. Claims in this queue can be edited for submission or deleted from this tab.
-  In order to utilize the **Correct Claim** feature, the claim needs to be in a **Paid** or **Denied** status.

Online Claim Reconsiderations on the MHS Secure Provider Portal

Summary Of Online Reconsiderations

Skip the phone call.

Providers can make their case directly on the portal.

Make the case.

Providers can submit informal dispute/reconsideration comments using expanded text fields.

Add context.

Providers can easily attach supporting documentation when filing an informal dispute/reconsideration.

Stay current.

- Providers may opt in/out for informal dispute/reconsideration status change emails.
- Providers may also view status online.





Online Reconsiderations

 Providers may now view denial code information.

 Providers will be able to:

- Submit informal disputes/reconsiderations on the secure portal
- Upload/view supporting documents
- View acknowledgement letters
- Track real time updates

Online Reconsiderations


-  It is important to note that all requests submitted via the online Portal for Level 1 will be considered an **informal dispute**. (secure messages are not considered reconsiderations/appeals)
-  Calling Provider Services **will not** pause the time frame for timely submissions for informal disputes.
-  Providers **do not** need to call prior to submitting an online claim reconsideration/information dispute.
-  Providers may include a dispute form, but it is not required, as they may include comments directly into the portal.

Level 1 Informal Claim Dispute and Level 2 Claim Appeals on the Secure Provider Portal

Back to Claims
Claim Details

Claim #T1234P1235: Denied

COPY
DISPUTE



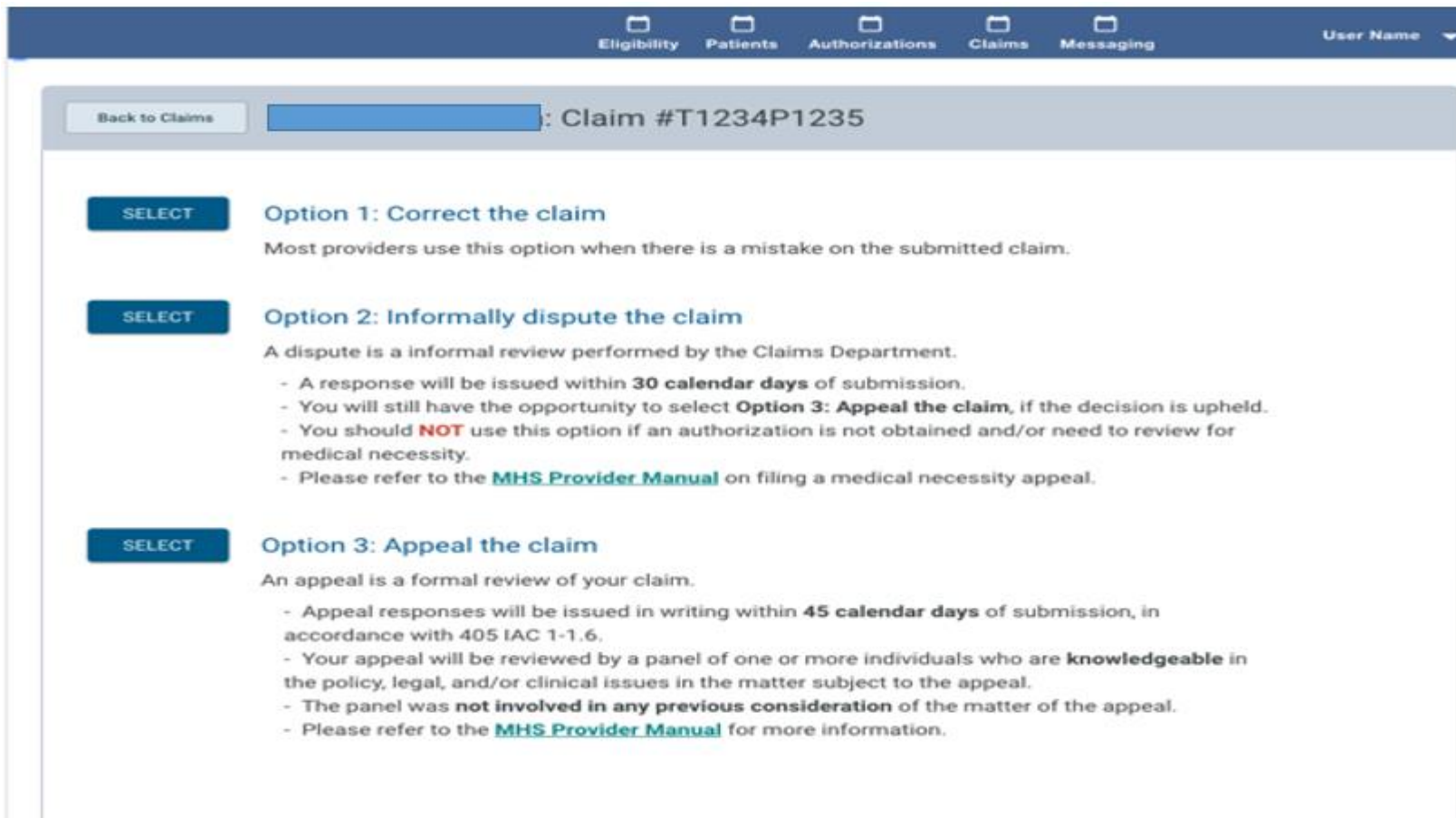
Claim Accepted In Process Denied

Participant	Provider	Claim	Most Recent Payment	
Participant Name [Redacted]	Ref./Acct No. 1234567890	DOS Range 08/12/2020 - 08/15/2020	Payment Date --	Paid Claim Amount \$0.00
Member ID ID123459	Servicing Provider [Redacted]	Received Date 09/12/2020	Check/EFT No. --	Total Check Amount --
Member DOB [Redacted]	Servicing NPI [Redacted]	Billed Amount \$6,1234.12	Check Dated --	

Service Lines

Label	Label	Label	Label	Label	Label	Label
-------	-------	-------	-------	-------	-------	-------

Level 1 Informal Claim Dispute and Level 2 Claim Appeals on the Secure Provider Portal



The screenshot shows the 'Claims' section of the Secure Provider Portal. At the top, there is a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, and Messaging, along with a 'User Name' dropdown. Below this, a breadcrumb trail shows 'Back to Claims' and a search bar containing 'Claim #T1234P1235'. The main content area lists three options for handling a claim:

- Option 1: Correct the claim**
Most providers use this option when there is a mistake on the submitted claim.
- Option 2: Informally dispute the claim**
A dispute is a informal review performed by the Claims Department.
 - A response will be issued within **30 calendar days** of submission.
 - You will still have the opportunity to select **Option 3: Appeal the claim**, if the decision is upheld.
 - You should **NOT** use this option if an authorization is not obtained and/or need to review for medical necessity.
 - Please refer to the [MHS Provider Manual](#) on filing a medical necessity appeal.
- Option 3: Appeal the claim**
An appeal is a formal review of your claim.
 - Appeal responses will be issued in writing within **45 calendar days** of submission, in accordance with 405 IAC 1-1.6.
 - Your appeal will be reviewed by a panel of one or more individuals who are **knowledgeable** in the policy, legal, and/or clinical issues in the matter subject to the appeal.
 - The panel was **not involved in any previous consideration** of the matter of the appeal.
 - Please refer to the [MHS Provider Manual](#) for more information.

Claim Reconsiderations

Enter your explanation for reconsideration and check email updates.

Reconsider Claim

Claim No:

For reconsiderations only. Not for appeals/Claim disputes
Example: If an authorization was not obtained and/or you need to review for medical necessity, submit an appeal.
Any submission on this form will be treated as a reconsideration.
Please refer to your Provider Manual.

Reconsideration Type

Notes
Brief Explanation

500 Character Limit

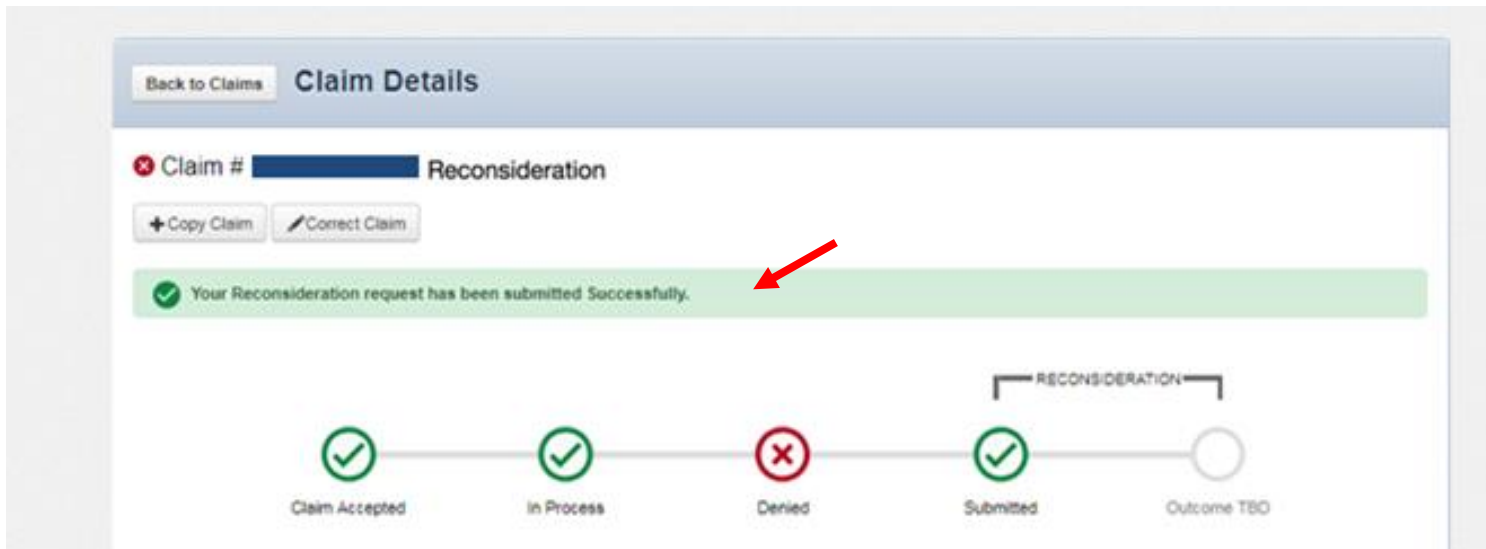
Upload Documents
*Proof of Timely Filing attachment **Required***

Uploaded Files

Email Updates
 Check here to receive email status updates for this reconsideration.
Please upload files less than 10MB each. Supported file formats are PDF, TIFF, TIF, JPEG, and JPG.


Online Reconsiderations

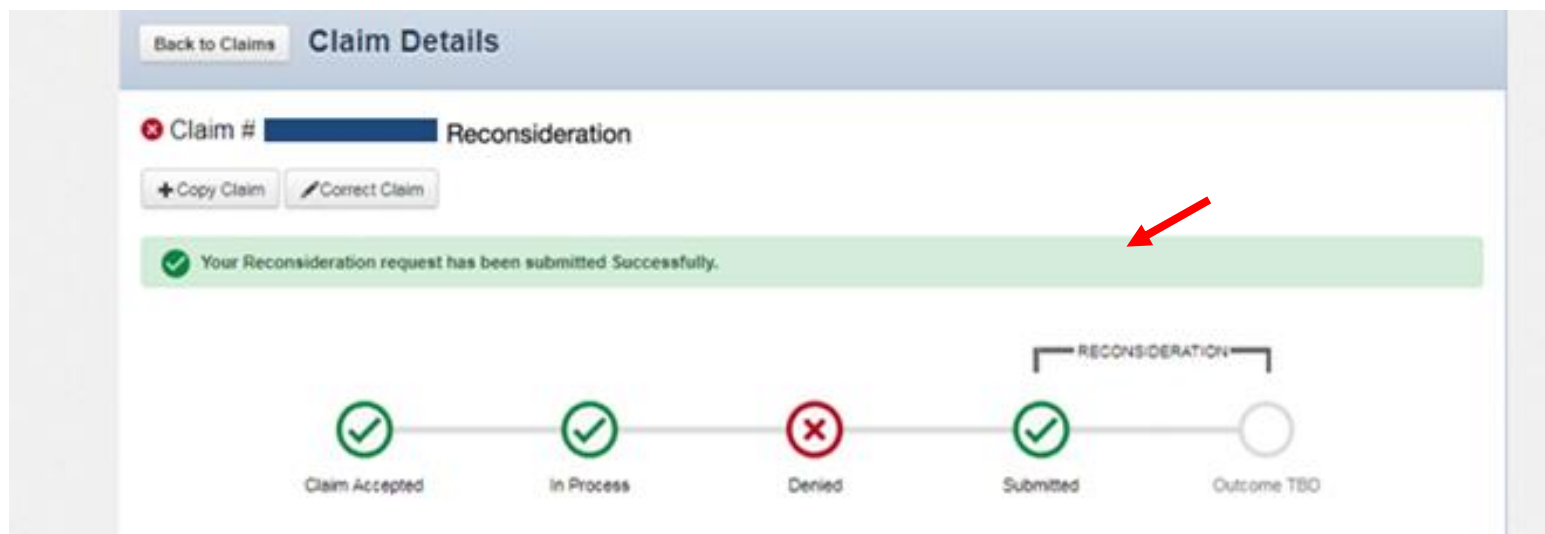
 Upon submission, a success banner will be displayed.



The screenshot displays the 'Claim Details' page for a 'Reconsideration' claim. At the top, there is a 'Back to Claims' button and the title 'Claim Details'. Below this, the claim number is redacted with a blue box, and the word 'Reconsideration' is displayed. There are two buttons: '+ Copy Claim' and 'Correct Claim'. A green success banner with a checkmark icon contains the text: 'Your Reconsideration request has been submitted Successfully.' A red arrow points to this banner. Below the banner is a process flow diagram with five steps: 'Claim Accepted' (green checkmark), 'In Process' (green checkmark), 'Denied' (red X), 'Submitted' (green checkmark), and 'Outcome TBD' (grey circle). A bracket labeled 'RECONSIDERATION' spans the 'Submitted' and 'Outcome TBD' steps.

Online Reconsiderations

 The tracker graphic will be updated to reflect that a reconsideration is in progress.



The screenshot displays the 'Claim Details' page. At the top, there is a 'Back to Claims' button and the title 'Claim Details'. Below this, the claim status is shown as 'Claim # [redacted] Reconsideration'. There are two buttons: '+ Copy Claim' and 'Correct Claim'. A green success message states: 'Your Reconsideration request has been submitted Successfully.' A red arrow points to this message. Below the message is a progress tracker with five steps: 'Claim Accepted' (green checkmark), 'In Process' (green checkmark), 'Denied' (red X), 'Submitted' (green checkmark), and 'Outcome TBD' (grey circle). A bracket labeled 'RECONSIDERATION' spans from the 'Submitted' step to the 'Outcome TBD' step.

Online Reconsiderations

Viewing Claims For: [dropdown] [dropdown] **GO** **Upload EDI** **Create Claim**

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

Claim # [redacted]: Reconsideration

+ Copy Claim / Correct Claim / Void/Recoup Claim

RECONSIDERATION

Claim Accepted (green check) → In Process (green check) → Denied (red X) → Submitted (green check) → Outcome TBD (grey circle)

Reconsideration Details

Created Date	Type	Current Status	Reference #
01/01/2019	General Correspondence	New	[redacted]
02/02/2019	COB Correspondence	Resolved	[redacted]

Member **Provider** **Claim** **Payment**

Member Name: [redacted]	Ref/Acct No.: [redacted]	DOS Range: 10/10/2018 - 10/10/2018	Payment Date: 10/11/2018	Granted Claim Amount: \$68.00
Member ID: [redacted]	Servicing Provider: [redacted]	Received Date: 10/10/2018	Check Number: [redacted]	Total Check Amount: \$75.00
Member DOB: [redacted]	Servicing NPI: [redacted]	Billed Amount: \$300.24	Check Dated: 10/10/2018	Included Claim Numbers View all



Online Reconsiderations Additional Attachments

RECONSIDERATION

Claim Accepted

In Process

Denied

In Process

Outcome TBD

Reconsideration Details

Created Date	Type	Current Status	Reference Number	Tools
06/05/2019	General Correspondence	OPEN	[Redacted]	

Member

Member Name: [Redacted]

Member ID: [Redacted]

Member DOB: [Redacted]

Provider

Ref/Acct No.: [Redacted]

Servicing Provider: [Redacted]

Servicing NPI: [Redacted]

Claim

DOS Range: [Redacted]

Received Date: [Redacted]

Billed Amount: [Redacted]

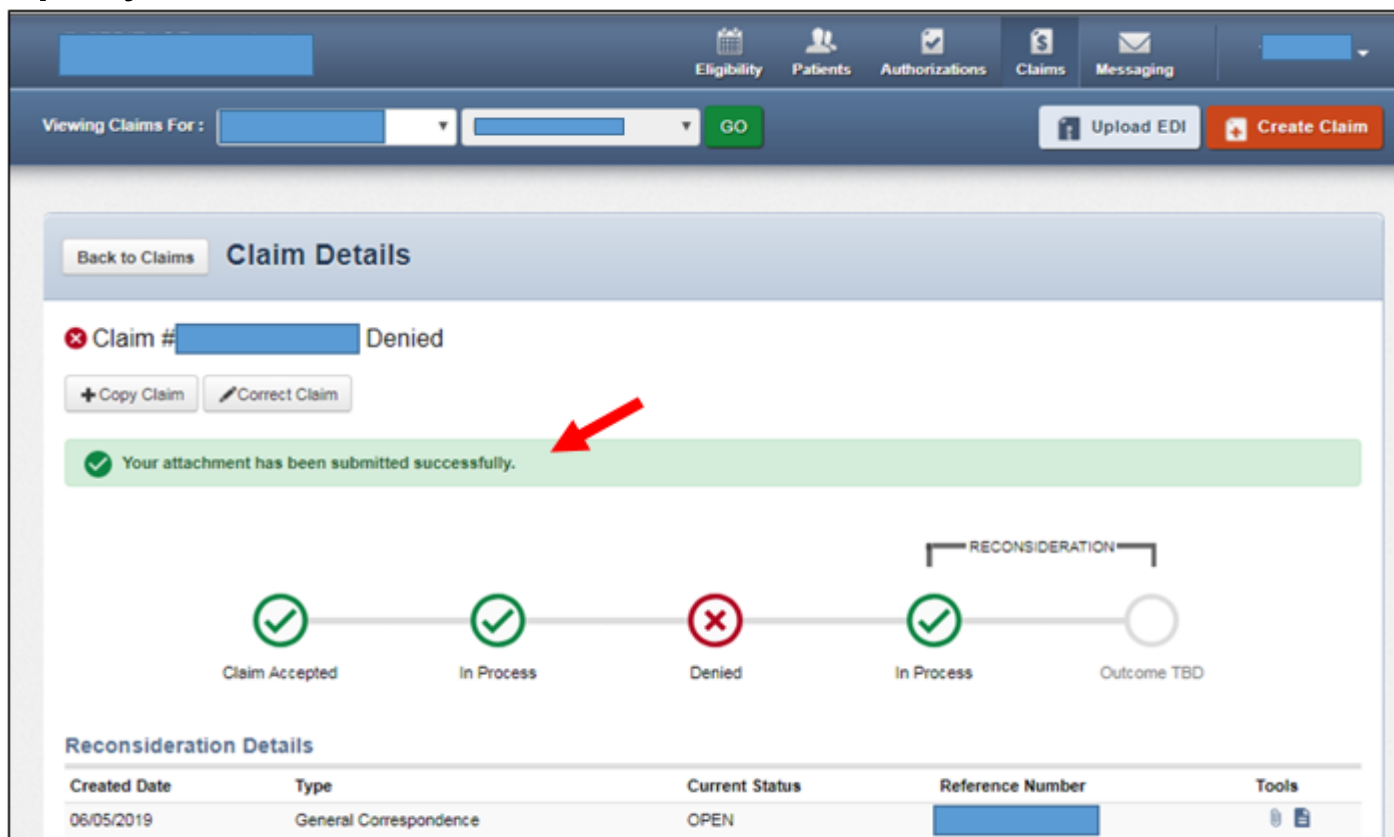
Service Lines

Line	DOS	Proc	Dx	Modifiers	Place of Service	Charged	Total Check Amount	Payment Date	Check Number	Status	Payment Codes
1	11/23/2018	J7620	J449		12	\$156.75	\$0.00	03/26/2019		DENY	6N,Ku
2	11/23/2018	Q0513	J449		12	\$33.00	\$0.00	03/26/2019		DENY	46,Ku



Additional Attachments – Success Banner

 Upon successful upload of files, a success banner is displayed.



The screenshot shows the 'Claim Details' page in the mhs system. At the top, there are navigation tabs for Eligibility, Patients, Authorizations, Claims, and Messaging. Below these are filters for 'Viewing Claims For' and buttons for 'Upload EDI' and 'Create Claim'. The main content area shows a claim status of 'Denied' with a red 'x' icon. Below this, there are buttons for '+ Copy Claim' and '/ Correct Claim'. A green success banner with a checkmark icon and the text 'Your attachment has been submitted successfully.' is displayed, with a red arrow pointing to it. Below the banner is a process flow diagram with five steps: 'Claim Accepted' (green checkmark), 'In Process' (green checkmark), 'Denied' (red x), 'In Process' (green checkmark), and 'Outcome TBD' (grey circle). A bracket labeled 'RECONSIDERATION' spans the last three steps. At the bottom, there is a 'Reconsideration Details' table.

Created Date	Type	Current Status	Reference Number	Tools
06/05/2019	General Correspondence	OPEN	[Redacted]	[Icons]

Level 1 Informal Claim Dispute and Level 2 Claim Appeals on the Secure Provider Portal

Back to Claims
Claim Details

Claim #T1234P1235: Denied

COPY
DISPUTE

Dispute/Appeal Details

Created Date	Type	Current Status	Reference No.	Tools
1/26/2021	Dispute - Claim Paid at the Incorrect Amount	Resolved	U026IA1234566	

Member

Participant Name
[Redacted]

Member ID
ID123459

Member DOB
[Redacted]

Provider

Ref/Acct No.
1234567890

Servicing Provider
[Redacted]

Servicing NPI
1234567890

Claim

DOS Range
08/12/2020 - 08/15/2020

Received Date
09/12/2020

Billed Amount
\$6,1234.12

Most Recent Payment

Payment Date	Paid Claim Amount
---	\$0.00
Check/EFT No.	Total Check Amount
---	---
Check Dated	

Service Lines

Label	Label	Label	Label	Label	Label	Label

Level 1 Informal Claim Dispute and Level 2 Claim Appeals on the Secure Provider Portal

Back to Claims
Claim Details

Claim #T1234P1235: Denied

COPY
DISPUTE

Claim Accepted

Claim Denied

Dispute Submitted

Claim Denied (Decision Upheld)

Appeal Submitted

Outcome TBD

Dispute

U026IA1234566

Appeal

ABCDE1234567

Dispute/Appeal Details

Created Date	Type	Current Status	Reference No.	Tools
2/15/2021	Appeal - Claim Paid at the Incorrect Amount	In Progress	ABCDE1234567	
1/26/2021	Dispute - Claim Paid at the Incorrect Amount	Resolved	U026IA1234566	

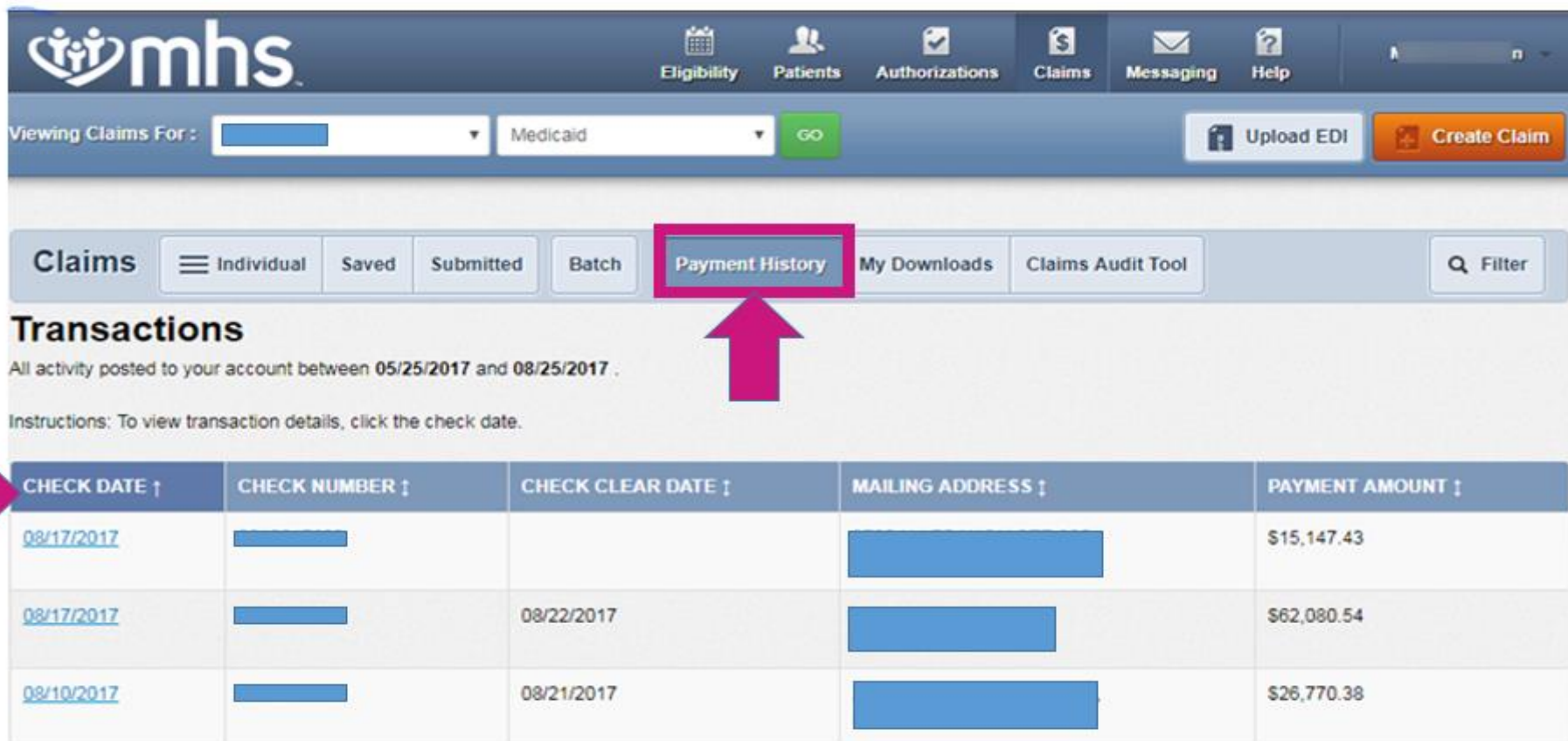
Member	Provider	Claim	Most Recent Payment
Participant Name [Redacted]	Ref/Acct No. 1234567890	DOS Range 08/12/2020 - 08/15/2020	Payment Date ---
Member ID ID123459	Servicing Provider [Redacted]	Received Date 09/12/2020	Paid Claim Amount \$0.00
Member DOB [Redacted]	Servicing NPI 1234567890	Billed Amount \$6,1234.12	Check/EFT No. ---
			Total Check Amount ---
			Check Dated ---

Service Lines

Label	Label	Label	Label	Label	Label	Label

Payment History

- Click on **Payment History** to view Check Date, Check Number, Check Clear Date, Mailing Address and Payment Amount
 - Click on **Check Date** to view Explanation of Payment



Viewing Claims For : Medicaid

Claims

Transactions

All activity posted to your account between 05/25/2017 and 08/25/2017 .


Instructions: To view transaction details, click the check date.

CHECK DATE ↑	CHECK NUMBER ↓	CHECK CLEAR DATE ↓	MAILING ADDRESS ↓	PAYMENT AMOUNT ↓
08/17/2017	<input type="text"/>		<input type="text"/>	\$15,147.43
08/17/2017	<input type="text"/>	08/22/2017	<input type="text"/>	\$62,080.54
08/10/2017	<input type="text"/>	08/21/2017	<input type="text"/>	\$26,770.38




Updated Provider EOPs (Explanation of Payment)

MHS has simplified the process for Providers to access claim summaries of claims paid.

Benefits

-  The new EOP is:
 - Cleaner
 - Easier to read
 - Matches what is sent in the mail
 - Can be saved and downloaded directly from the EOP screen
 - Includes negative balance if available

Change Overview

-  The 'payment history' check feature will take the Provider to a copy of the EOP they received directly from the check company versus the previous Portal data dump.
-  Currently negative balance is not shown on the portal EOP. By having the actual EOP, the negative balance data will now be included whenever it is present on the EOP the provider receives.
-  "My Download" feature will be retired as the new PDF file can be saved and downloaded directly from the EOP screen.

Updated Provider EOPs

The screenshot shows the mhs Claims system interface. At the top, there are navigation tabs for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below this, there are filters for 'Viewing Claims For : TIN' and 'Plan Type' (Medicaid), with a 'GO' button. To the right are buttons for 'Upload EDI' and 'Create Claim'. A secondary navigation bar includes 'Claims', 'Individual', 'Saved', 'Submitted', 'Batch', 'Recurring', 'Payment History', 'Claims Audit Tool', and a 'Filter' button.

The main section is titled 'Transactions' and shows activity between 06/20/2021 and 07/20/2021. A callout box with an information icon (i) contains the following text: "Instructions: Click on the Check Date to view the PDF of payment details from your payment provider. The PDF will open in a new window where you can save or print it. If there are any discrepancies on your payment details, please contact Provider Services." A pink arrow points to this callout box.

CHECK DATE ↑	CHECK NUMBER ↑	CHECK CLEAR DATE ↑	MAILING ADDRESS ↑	PAYMENT AMOUNT ↑
06/24/2021 (PDF)	[REDACTED]	06/23/2021	[REDACTED]	\$100.64
06/24/2021 (PDF)	[REDACTED]	06/23/2021	[REDACTED]	\$145.73
06/24/2021 (PDF)	[REDACTED]	06/23/2021	[REDACTED]	\$72.01
06/24/2021 (PDF)	[REDACTED]	EFT	[REDACTED]	\$0.00
06/24/2021 (PDF)	[REDACTED]	EFT	[REDACTED]	\$208.65
06/24/2021 (PDF)	[REDACTED]	EFT	[REDACTED]	\$578.92

Updated Provider EOPs

Old version of the EOP

Explanation of Payment Details

[Back to Payments List](#)
[Download \(Excel Format\)](#)
[Print](#)

Check/Trace Number: 0900195249 Check Date: 01/28/2021

Insured Name: ██████████

Patient Name: ██████████

Control Number: ██████████

Service Provider: ██████████

Group: ██████████

ID: ██████████

Account: ██████████

NPI: ██████████

[View Service Line Details](#)

Serv	Date	Proc#/ Proc2	Mod	Days/ Cnt Qty	Charged	Allowed	Deduct/ Copay	Coinsur	Discount/ Interest	Med Allow/ Med Paid	TPP	Denied	Remit Codes	Payment
10	01/21/2021	J1050		0/150	300.00	85.50	0.00/0.00	17.10	0.00/0.00	0.00/0.00	0.00	0.00	SR,21	68.40
Sub Total:					300.00	85.50	0.00/0.00	17.10	0.00/0.00	0.00/0.00	0.00	0.00		68.40

Remit Code Descriptions

SR
SEQUESTRATION WAIVED 05-01 TO 12-31-20 DATES OF SERVICE

21
PAID-CONSURANCE APPLIED

[View Service Line Details](#)

Serv	Date	Proc#/ Proc2	Mod	Days/ Cnt Qty	Charged	Allowed	Deduct/ Copay	Coinsur	Discount/ Interest	Med Allow/ Med Paid	TPP	Denied	Remit Codes	Payment
10	01/07/2021	90750		0/1	165.00	132.00	0.00/0.00	0.00	0.00/0.00	0.00/0.00	0.00	165.00	88,EC	0.00
Sub Total:					165.00	132.00	0.00/0.00	0.00	0.00/0.00	0.00/0.00	0.00	165.00		0.00

Updated Provider EOPs

New Version of the EOP

Electronic Service Requested

606 0-7648 AV 0-366 S-DIGIT 30374

RUN DATE: 07/09/20
 CHECK #: [REDACTED]
 PAYEE ID: [REDACTED]
 IRS#: [REDACTED]

STATEMENT TOTAL

Beginning Negative Services Balance: .00
 Beginning Prepayment Balance: .00
 Total Beginning Balance: .00
 Claims Paid This Run: [REDACTED]
 Check Amount: [REDACTED]

Remittance Advice and Explanation of Payment

Insured Name: [REDACTED] Member ID: [REDACTED] Claim No: [REDACTED]
 Patient Name: [REDACTED] PCN: [REDACTED] Carrier: DE Provider ID: [REDACTED]
 Service Provider: [REDACTED] LNPI: [REDACTED] Group: [REDACTED]

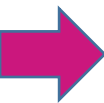
Serv	Dates	Procedure	Modifiers	Days Ctr/Qty	Charged	Allowed	Deduct/ Copay	Coinsur/ Discount	Interest	Med Allow/ Med Paid	TPP	Denied	Payment Codes	Payment
0100	[REDACTED]	[REDACTED]	G5	1.00	6388.16	263.75	.00	.00	.00	.00	.00	.00	A0 SR 30	258.47
0200	[REDACTED]	[REDACTED]	G5	1.00	6388.16	263.75	.00	.00	.00	.00	.00	.00	A0 SR 30	258.47
0300	[REDACTED]	[REDACTED]	G5	1.00	6388.16	263.75	.00	.00	.00	.00	.00	.00	A0 SR 30	258.47
0400	[REDACTED]	[REDACTED]	G5	1.00	6388.16	263.75	.00	.00	.00	.00	.00	.00	A0 SR 30	258.47
0500	[REDACTED]	[REDACTED]	G5	1.00	6388.16	263.75	.00	.00	.00	.00	.00	.00	A0 SR 30	258.47
0600	[REDACTED]	[REDACTED]	G5	1.00	6388.16	263.75	.00	.00	.00	.00	.00	.00	A0 SR 30	258.47
0700	[REDACTED]	[REDACTED]	G5	1.00	6388.16	263.75	.00	.00	.00	.00	.00	.00	A0 SR 30	258.47

Coordination of Benefits

 This screen shows if a member has other insurance.

[Back to Patient List](#) **Member Name**

Overview	Effective Date	Term Date	Policy Number	Group Number	Carrier Name	Coverage
Cost Sharing	06/01/2008	12/21/2013	██████████		AETNA	MEDICAL AND HOSPITAL
Assessments						
Health Record						
Care Plan						
Authorizations						
Coordination of Benefits						
Claims						



Prior Authorization

Authorizations

View previously submitted or **Create a New Authorization.**

Back to Patient List
Member Name

- Overview
- Cost Sharing
- Assessments
- Health Record
- Care Plan
- Authorizations**
- Referrals
- Coordination of Benefits
- Claims
- Document Resource Center
- Notes

Authorizations

STATUS	AUTH NBR	FROM DATE	TO DATE	DIAGNOSIS	AUTH TYPE	SERVICE
APPROVE	C-1	02/06/2018	05/06/2018	M51.36	OUTPATIENT	Office Visit
APPROVE	C-6	03/14/2017	01/05/2018	G89.4	OUTPATIENT	Office Visit

[Create a New Authorization](#)

Click on **AUTH NBR** above

Auth Status: APPROVE
 Auth Nbr: [C-1](#)
 Service: Office Visit
 Provider of Service(s):
 Diagnosis Code(s): M51.36

Explanation: Pay
 Auth Type: OUTPATIENT
 From Date: 02/06/2018
 To Date: 05/06/2018
 Procedure Code(s): 99214
 Notes & Attachments: [View](#)

Line Item	Service type	Start Date	End Date	Units Req.	Units Apprd	Servicing Provider	Location	Status	Medical Necessity	Decision Date
1	Office Visit	02/06/2018	05/06/2018	3	3	 	Office	APPROVE	Met as requested	01/31/2018

Authorization Considerations

Need to know what requires Authorization:

- Quick Reference Guides (QRG)
- Pre-Authorization tool

How to obtain Authorization:

- Online (excluding Home Health and Hospice requests)
- Phone
- Fax

Authorizations do not guarantee payment

Prior Authorization



Is Prior Authorization Needed?

- MHS website: [mhsindiana.com](https://www.mhsindiana.com)
- Quick reference guide <https://www.mhsindiana.com/content/dam/centene/mhsindiana/medicaid/pdfs/508-Provider-QRG-2021.pdf>
- Non-contracted provider services now align with PA requirements for contracted providers

PROVIDER Quick Reference Guide
effective August 1, 2020

Applies to all Hoosier Healthwise (HHW), Healthy Indiana Plan (HIP) and Hoosier Care Connect (HCC) packages.
For an Ambetter Provider Quick Reference Guide, please visit ambetter.mhsindiana.com. Coverage is subject to specific benefit package of member.

1-877-647-4848
TTY/TDD: 1-800-743-3333
[mhsindiana.com](https://www.mhsindiana.com)

GENERAL OFFICE HOURS:
8 a.m. to 5 p.m., EST, closed holidays

MEMBER SERVICES AND PROVIDER SERVICES:
8 a.m. to 8 p.m.

REFERRALS AND AUTHORIZATIONS:
8 a.m. to 5 p.m., closed 12 p.m. to 1 p.m.

CASE MANAGEMENT:
8 a.m. to 5 p.m.

AFTER-HOURS:
MHS' 24/7 Nurse Advice Line for members is available to answer calls for emergent authorization needs. Or, you may leave a message on our after-hours recording system. Messages are returned within one business day.

MANAGED HEALTH SERVICES (MHS)

ELECTRONIC PAYER ID: 68069	MEDICAL CLAIMS APPEALS ADDRESS: Managed Health Services P.O. Box 3000 Farmington, MO 63640-3800
BEHAVIORAL HEALTH PAYER ID: 68068	Providers have 67 calendar days from the date of the Explanation of Payment to file an adjustment, resubmit, or appeal a decision (effective March 1, 2021, 60 days).
MEDICAL CLAIMS ADDRESS: Managed Health Services P.O. Box 3000 Farmington, MO 63640-3800	Failure to do so within the specified timeframe will waive the right for reconsideration.
Claims sent to MHS' Indianapolis address will be returned to the provider.	MEDICAL CLAIMS REFUNDS: To refund claims over payment, please send check and documentation to: Coordinated Care Corporation 75 Renaissance Dr., Suite 6446 Chicago, IL 60675-6446
MEDICAL NECESSITY APPEALS ONLY ADDRESS: ATTN: APPEALS P.O. Box 441637 Indianapolis, IN 46244	

MHS FAX NUMBERS

MEDICAL APPEALS: 1-866-714-7993

CASE MANAGEMENT: 1-866-694-3653
Ex. Member Referrals to CM/DM

REFERRALS AND AUTHORIZATIONS: 1-866-912-4345

MHS WEBSITE: MHSINDIANA.COM

mhsindiana.com/providers	Latest MHS provider updates and news, as well as online provider enrollment, office and billing address change forms, quality and care gap tools, forms, manuals, guides, online PA tool and tutorials.
mhsindiana.com/health	MHS' Health Library. Click on "KRAMER Health Library" for free print-on-demand patient health fact sheets on over 4,000 topics, available in English and Spanish.
mhsindiana.com/login	MHS' Secure Provider Portal lets you submit prior authorization, claims, claim adjustments, and view your panel's medical records and care gaps.
mhsindiana.com/transactions	Information for electronic processing and payment of claims with MHS.
OTHER RESOURCES payparhealth.com	MHS is pleased to partner with PayPar to provide an innovative web based solution for Electronic Funds Transfers (EFT) and Electronic Remittance Advices (ERA). This service is provided at no cost to providers and allows online enrollment at payparhealth.com .

You can find out more about the information in this guide in the MHS Provider Manual, online at [mhsindiana.com/providers/resources](https://www.mhsindiana.com/providers/resources), or by contacting MHS at 1-877-647-4848.

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Prior Authorization



FOR MEMBERS

FOR PROVIDERS

GET INSURED

FOR PROVIDERS

Login

Enrollment and Updates +

Prior Authorization -

Medicaid Pre-Auth

Ambetter Pre-Auth

Medicare Pre-Auth

Dental Providers

Pharmacy +

Opioid Resources

Behavioral Health Providers +

Provider Resources +

QI Program +

Provider News

Email Sign Up

Coronavirus Information +

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 [Envolve Vision](#).
 Dental services need to be verified by [Envolve Dental](#).
 Ambulance and Transportation services need to be verified by [LCP Transportation](#).
 Musculoskeletal services need to be verified by [TurningPoint](#).
 Complex imaging, MRA, MRI, PET, CT scans, PT, ST, and OT need to be verified by [NIA](#).

Non-participating providers must submit Prior Authorization for all services.
 For non-participating providers, [join our network](#).

Are services being performed in the Emergency Department or Urgent Care Center or are these family planning services billed with a contraceptive management diagnosis?

Yes No

Types of Services	YES	NO
Is the member being admitted to an inpatient facility?	<input type="radio"/>	<input checked="" type="radio"/>
Are services other than lab, radiology, domiciliary visits DME, Orthotics, or Prosthetics being rendered in the home?	<input type="radio"/>	<input checked="" type="radio"/>
Are anesthesia services being rendered for pain management?	<input type="radio"/>	<input checked="" type="radio"/>
Are services for infertility?	<input type="radio"/>	<input checked="" type="radio"/>

Enter the code of the service you would like to check:

58270

Check








Yes


58270 - VAG HYST UTRUS 250 GM/¢;REP ENTROCL
 Pre-authorization required for all providers.

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

EFTs and ERAs

PaySpan Health

- 
 Web based solution for:
 - Electronic Funds
 - Transfers (EFTs) and Electronic Remittance Advices (ERAs)
- 
 One year retrieval of remittance advice.
- 
 Provided at no cost to providers and allows online enrollment.
- 
 Register at payspanhealth.com
- 
 For questions call 1-877-331-7154 or email providersupport@payspanhealth.com

PaySpan® Health


FOLLOW THESE INSTRUCTIONS TO GET STARTED WITH PAYSAN® 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) <input type="text"/> <small>Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)</small> <input type="text"/> <small>Billing Tax Code (Optional)</small> <input type="text"/>	Reg Code <input type="text"/> <small>What is a Reg Code?</small>
OR	
<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>

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

Account Name <input type="text"/> <small>This is the name that will be used to identify this banking account throughout the PaySpan system.</small>
Financial Institution Routing Number <input type="text"/>
Provider's Account Number with Financial Institution <input type="text"/>
Confirm Provider's Account Number with Financial Institution <input type="text"/>
Type of Account at Financial Institution <input type="text"/>
<input checked="" type="checkbox"/> Enable Electronic Payment <small>The Paper does not allow paper remittance.</small>
<input checked="" type="checkbox"/> Assign new or additional Paper to this Banking account
<input type="button" value="Back"/> <input type="button" value="Next"/>

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

Provider Contact Name <input type="text"/> <small>Administrative Full Name</small>	Username <input type="text"/> <small>Minimum 8 characters and may include letters (a-z), numbers (0-9), dashes (-), or underscores (_). Symbols are not allowed.</small>
Email Address <input type="text"/> <small>Verification will be sent to this address.</small>	Password <input type="text"/> <small>Minimum 8 characters and may include letters (a-z), numbers (0-9), dashes (-), or underscores (_). Symbols are not allowed.</small>
Confirm Email Address <input type="text"/>	Confirm Password <input type="text"/>
Telephone Number <input type="text"/> <small>Please call us like 800-800-0000 format.</small>	Challenge Question <input type="text"/>
Title <input type="text"/>	Challenge Answer <input type="text"/>
<input type="button" value="Cancel"/>	<input type="button" value="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

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MHS Team

MHS Provider Network Territories

Indiana

NORTHEAST REGION

For claims issues, email:
 MHS_ProviderRelations_NE@mhsindiana.com
 Chad Pratt, Provider Partnership Associate
 1-877-647-4848, ext. 20454

NORTHWEST REGION

For claims issues, email:
 MHS_ProviderRelations_NW@mhsindiana.com
 Candace Ervin, Provider Partnership Associate
 1-877-647-4848, ext. 20187

NORTH CENTRAL REGION

For claims issues, email:
 MHS_ProviderRelations_NC@mhsindiana.com
 Natalie Smith, Provider Partnership Associate
 1-877-647-4848, ext. 20127

CENTRAL REGION

For claims issues, email:
 MHS_ProviderRelations_C@mhsindiana.com
 Mona Green, Provider Partnership Associate
 1-877-647-4848, ext. 20080

SOUTH CENTRAL REGION

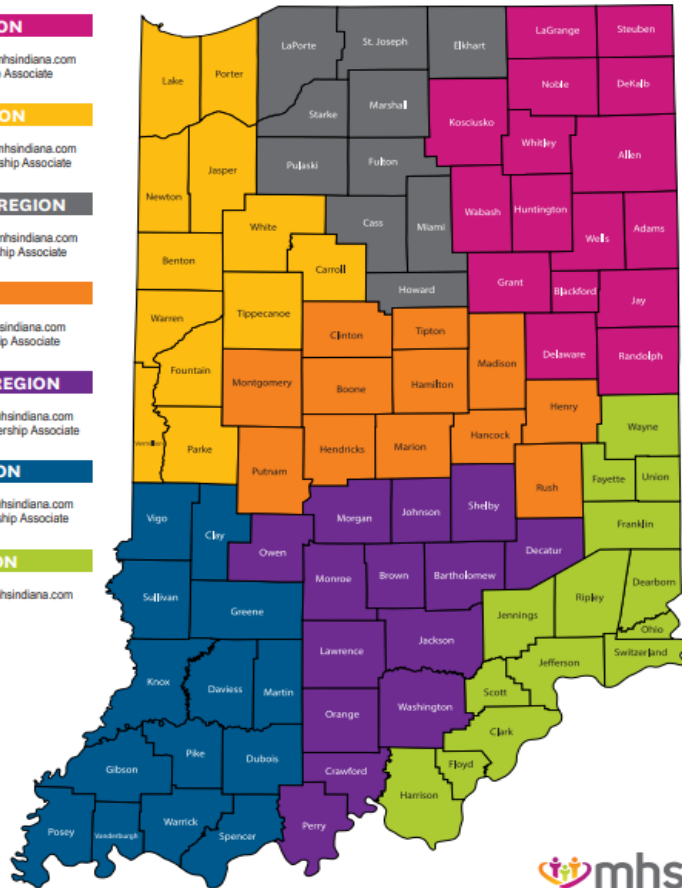
For claims issues, email:
 MHS_ProviderRelations_SC@mhsindiana.com
 Dalesia Denning, Provider Partnership Associate
 1-877-647-4848, ext. 20026

SOUTHWEST REGION

For claims issues, email:
 MHS_ProviderRelations_SW@mhsindiana.com
 Dawn McCarty, Provider Partnership Associate
 1-877-647-4848, ext. 20117

SOUTHEAST REGION

For claims issues, email:
 MHS_ProviderRelations_SE@mhsindiana.com
 Carolyn Valachovic Monroe
 Provider Partnership Associate
 1-877-647-4848, ext. 20114



550 N. Meridian Street, Suite 101 • Indianapolis, IN 46204 • 1-877-647-4848 • mhsindiana.com
 All well from MHS • Ambetter from MHS • Healthy Indiana Plan (HIP) • Hoosier Care Connect • Hoosier Healthwise

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Available online:

https://www.mhsindiana.com/content/dam/centene/mhsindiana/medicaid/pdfs/ProviderTerritory_map_2021.pdf

NORTHEAST REGION

For claims issues, email:
 MHS_ProviderRelations_NE@mhsindiana.com
 Chad Pratt, Provider Partnership Associate
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NORTHWEST REGION

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MHS Provider Network Territories

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Provider Partnership Associate II
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PROVIDER GROUPS

Beacon Medical Group
Franciscan Alliance
HealthLinc
Heart City Health Center
Indiana Health Centers
Lutheran Medical Group
Parkview Health System
South Bend Clinic

JENNIFER GARNER

Program Manager,
Provider Engagement
1-877-647-4848 ext. 20149
jgarner@mhsindiana.com

PROVIDER GROUPS

American Health Network of Indiana
Columbus Regional Health
Community Physicians of Indiana
HealthNet
Health & Hospital Corporation of
Marion County
Indiana University Health
St. Vincent Medical Group

ENVOLVE DENTAL, INC.

ANTWAN PEREZ-ALVAREZ

Antwan.Perez-Alvarez@EnvolveHealth.com
Tyneshia James
Tyneshia.James@EnvolveHealth.com
Dental Provider Services: 1-855-609-5157
Questions: ProviderRelations@EnvolveHealth.com

ENVOLVE VISION, INC.

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Network Leadership

NETWORK LEADERSHIP

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Questions?

**Thank you for being our
partner in care.**