



Claims CMS-1500

2023 Annual IHCP Works Seminar

Presenter: Natalie Smith, Provider
Engagement Administrator

Agenda

- MHS Overview
- Claim Submission Process
- MHS Provider Claims Issue Resolution Process
- Additional Claims Assistance
- Portal Functionality
- Professional 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 (HHW), the Healthy Indiana Plan (HIP) and Hoosier Care Connect (HCC).
- **MHS is your choice for better healthcare.**

MHS Products



Claim Submission Process

Medical Claims Submission

- **Electronic Data Interchange Submission:**
 - Preferred method of claims submission
 - Faster and less expensive than paper submission
 - MHS Electronic Payor ID **68069**
- **Online through the MHS Secure Provider Portal at <https://www.mhsindiana.com/providers/login.html>**
 - Provides immediate confirmation of received claims and acceptance
 - Institutional and Professional
 - Batch Claims
 - Claim Adjustments/Corrections
 - Claim review/Adjustments request
- **Paper Claims:**

Managed Health Services
P.O. Box 3002
Farmington, MO 63640-3802

Behavioral Health Claims 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 through the MHS Secure Provider Portal at <https://www.mhsindiana.com/providers/login.html>**
 - Provides immediate confirmation of received claims and acceptance
 - Institutional and Professional
 - Batch Claims
 - Claim Adjustments/Corrections
 - Claim review/Adjustments request
- **Paper Claims:**

MHS Behavioral Health
P.O. Box 6800
Farmington, MO 63640-3818

Claims Billing with Ease

- **NPI, Tax ID, Zip +4**
- This information is necessary for the system to make a one-to-one match based on the information provided on the claim and the information on file with Indiana Medicaid.
 - Member Information
 - Newborn's Member ID (MID) is required for payment
- **Attachment Forms:**
 - Required forms need to accompany the claim form
- **Secondary Claims (TPL):**
 - Accepted electronically from vendors or via the MHS Secure Provider Portal

Claim Submission

- In-Network providers: 90 calendar days from the date of service or discharge date. Out-of-Network providers: 180 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 Member ID (MID).
 - 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 EOP is received after the 365 days, providers have *60 days* from date of primary EOP 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.

Paper Claim Corrections

- A corrected claim can be submitted following Indiana Health Coverage Program (IHCP) claim adjustment processes.
- A claim adjustment code is required on all claims, based on the type of claim submitted.
 - Example: Frequency 7 entered in Box 22 of the *CMS-1500* form.
- The original claim number must also be listed on the corrected claim.
- Box 22 on the *CMS-1500*
 - Remember: a rejection must be submitted as 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 standard paper claim form with the following sections and annotations:

- Box 14:** DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) (MM DD YY) QUAL: [Redacted]
- Box 15:** OTHER DATE (QUAL) (MM DD YY) [Redacted]
- Box 16:** DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (FROM MM DD YY TO MM DD YY)
- Box 17a:** [Redacted]
- Box 17b:** NP [Redacted]
- Box 18:** HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM MM DD YY TO MM DD YY)
- Box 19:** ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
- Box 20:** OUTSIDE LAB? YES NO \$ CHARGES [Redacted]
- Box 21:** DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Raise ALL to service line below) (ICD-9) [Redacted]
- Box 22:** RESUBMISSION CODE: 1
- Box 23:** PRIOR AUTHORIZATION NUMBER [Redacted]
- Box 24:** TABLE with columns: A. DATE(S) OF SERVICE (From MM DD YY To MM DD YY), B. PLACE OF SERVICE, C. PROCEDURE, SERVICES, OR SUPPLIES (CPT/HCPCS), D. DIAGNOSIS POINTER, E. \$ CHARGES, F. DAYS OR UNITS, G. STATE (FSA#), H. ICD-9 QUAL, I. RENDERING PROVIDER ID # [Redacted]
- Box 25:** FEDERAL TAX I.D. NUMBER (SSN EIN) [Redacted]
- Box 26:** PATIENT'S ACCOUNT NO. [Redacted]
- Box 27:** ACCEPT ASSIGNMENT? [Redacted]
- Box 28:** TOTAL CHARGE [Redacted]
- Box 29:** AMOUNT PAID [Redacted]
- Box 30:** Reserved for NUCC Use
- Box 31:** SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE(S) OR CREDENTIALS (Verify that the statements on the reverse is a part thereof.) [Redacted]
- Box 32:** SIGNATURE OF PHYSICIAN OR SUPPLIER [Redacted]

Annotations:

- An orange arrow points from the text "Original claim number" to box 23.
- A blue arrow points from the text "Resubmission code is '7'" to box 22.

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)**

MHS 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

- 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 Transportation Module: [transportation-services.pdf](#) ([in.gov](#))
- **Claim Inquiries:**
 - Check status online
 - Call Provider Services at 1-877-647-4848

Claim Rejections

- A rejection is an unclean claim that contains invalid or missing data elements required for acceptance of the claim in the claim process system.
- Timely filing is not substantiated.
- Rejected claims need corrected and submitted as a new claim.

Claim Rejections

Medical

- **07** Invalid Subscriber/Member ID
- **02** Invalid Provider ID-Rendering Physician (Provider State Crosswalk File)
- **09** Member Invalid on Date of Service
- **01** Invalid Provider ID Billing Physician (Provider State Crosswalk File)
- **08** Invalid Member Date of Birth
- **76** Original claim number required
- **90** Invalid or Missing Modifier
- **40** Diagnosis code is missing
- **B5** Missing/incomplete/Invalid CLIA

Behavioral Health

- **02** Invalid Provider ID-Rendering Physician (Provider State Crosswalk File)
- **09** Member Invalid on Date of Service
- **07** Invalid Subscriber/Member ID
- **01** Invalid Provider ID Billing Physician (Provider State Crosswalk File)
- **08** Invalid Member Date of Birth
- **76** Original claim number required
- **40** Diagnosis code is missing
- **31** Invalid Service Procedure code

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/508-Top-10-Rejections-Edu-Doc.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
P.O. Box 6000
Attn: Appeals Department
Farmington, MO 63640-3809

<https://www.mhsindiana.com/content/dam/cenene/mhsindiana/medicaid/pdfs/508-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 denial 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



1-877-647-4546 | TTY: 1-800-743-3333 | mhsindiana.com
 Affiliated from MHS | Ambassador from MHS | Healthy Indiana Plan (HIP) | Hoosier Care Connect | Hoosier HealthWise

1220 08.P.LT 1/21



Informal Claims Dispute or Objection Form

Level 1:

- Submit all documentation supporting your objection.
 - 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).
- 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.

Informal Dispute or Objection Form

Level 1:

- MHS will make all reasonable efforts to review your documentation and respond to you within 30 calendar days.
- 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 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 and 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. The inquiries 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 and Web Inquiries

- 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!**
 - Inform 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 Claims 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. [MHS - Provider Manual 2023 \(mhsindiana.com\)](https://www.mhsindiana.com)

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-2023.pdf>

Additional Claim Assistance

Provider Relations Regional Mailboxes

- 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 claim 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.
- 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 and NPI
 - Member Name and MID Number
 - Product (Medicaid/Ambetter/Wellcare by 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

The screenshot shows the MHS website's navigation and main content area. At the top left is the MHS logo. The top navigation bar includes links for Home, Find a Provider, Portal Login, Events, Careers, and Contact Us, along with a search bar. On the right, there are options for Contrast (On/Off) and language settings. Below the navigation bar are three main tabs: FOR MEMBERS, FOR PROVIDERS, and GET INSURED. The FOR PROVIDERS tab is active, displaying a sidebar with various service categories and a main content area titled 'Portal Login'. The sidebar includes 'Login', 'Enrollment and Updates', 'Prior Authorization', 'Dental Providers', 'Pharmacy', 'Opioid Resources', 'Behavioral Health Providers', 'Provider Resources', 'QI Program', 'Provider News', 'Email Sign Up', and 'Coronavirus Information'. The main content area features a 'Portal Login' heading, a 'Create your own online account today!' call to action, and a 'Secure Provider Portal' button. Below this is a 'Provider Email Sign Up' button. A section titled 'PORTAL TRAINING GUIDES' lists several PDF guides: Account Manager User Guide, Provider Secure Portal Brochure, Submit a Claim CMS 1500, Submit a Claim CMS UB-04, Update Portal Account Details, and Utilize Member Management Forms. A note mentions that Clear Claim Connection does not provide an all-inclusive listing of claim edits. There is also a 'Registration Help' section with a link to the 'Become a Provider' page and a 'Registration Guide' PDF. At the bottom, there are links for 'Vision Provider Portal Login' and 'Dental Provider Portal Login', followed by a list of services: 'Verify member eligibility' and 'View member benefits'.

Home Find a Provider Portal Login Events Careers Contact Us

Contrast On Off a a a language-

FOR MEMBERS **FOR PROVIDERS** **GET INSURED**

FOR PROVIDERS

Login

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

Portal Login

Create your own online account today!

MHS offers you many convenient and secure tools to assist you. To enter our secure portal, click on the login/register button. A new window will open. You can login or register for a new account.

Creating an account is free and easy.

By creating a MHS account, you can:

- Verify member eligibility
- Submit and check claims
- Submit and confirm authorizations
- View detailed patient list

PORTAL TRAINING GUIDES -

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

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.

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 \(PDF\)](#).

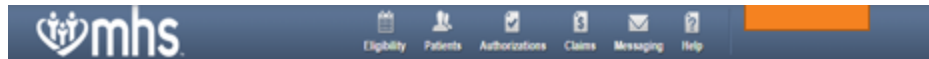
Vision and Dental Providers

[Vision Provider Portal Login](#)

[Dental Provider Portal Login](#)

- Verify member eligibility
- View member benefits

Homepage-MHS (Medicaid)



Eligibility Patients Authorizations Claims Messaging Help

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

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

Please Note
Claims information is updated every 24 hours.

Welcome, Kimberly!

Get summaries of claims data at a glance and easy access to the options you use most.

Admin Settings

Add and manage user access and information.

[Add User](#) [Edit User Access](#) [Add a TIN](#)

Quick Actions

Do a quick eligibility check, find patient benefits information, create a new claim or recurring claim or an authorization.

Member ID or Last Name *

Member Date of Birth 
MM/DD/YYYY

Select Action Type *

[SUBMIT](#)

Authorization Overview

[Inpatient Authorizations](#) [View All](#)

[Outpatient Authorizations](#) [View All](#)

Useful Links

[Reports](#)
This repository contains reports that are uploaded and maintained by the health plan.

[Patient Analytics](#)
This is a PHM tool that supports providers in the delivery of timely, efficient, and evidence-based care to our members.

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

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 98 notification), and Help. Below the navigation bar, there are filters for 'Viewing Claims For' (3/3) and 'Medicaid'. A 'Create Claim' button is visible. The main content area shows a search form for 'Member ID or Last Name' and 'Birthdate' with a 'Find' button.

Claims Submission

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

The screenshot displays the mhs Claims Submission interface. At the top, the mhs logo is on the left, and navigation icons for Eligibility, Patients, Authorizations, Claims, Messaging, and Help are on the right. A 'Provider Name' dropdown is also present. Below the navigation bar, there is a 'Viewing Claims For:' section with dropdown menus for 'Tax ID Number' and 'Medicaid', and a 'GO' button. To the right of this section are 'Upload EDI' and 'Create Claim' buttons. The main content area features a 'Choose Claim for' dropdown and a 'Choose a Claim Type' section. This section contains two large green buttons: 'CMS 1500 Professional Claim →' and 'CMS UB-04 Institutional Claim →'. At the bottom of the main content area, there is an 'UPDATE' notice regarding ICD-10 regulations.

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

Choose Claim for

Choose a Claim Type

CMS 1500
Professional Claim →

CMS UB-04
Institutional Claim →

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

Professional Billing

Professional Claims Submission:

- In the **General Info** section, populate the **Patient's Account Number** 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.

* Required field

Patient's Account Number* 26

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

Other Date 15.

Professional Claims 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 for L TY Your Progress

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

[← Back](#) [Next →](#)

* Required field

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

Diagnosis Codes* [Add](#) (Enter diagnosis code and click on Add button) 21

V837 -- PERS OUTSD INDUST VEH INJ NT ACC [Remove X](#)

[Add Coordination of Benefits](#)

[← Back](#) [Next →](#)

Primary Insurance [x Remove](#)

Notice: If the Member has more than one primary insurance (the 2nd paid would be the 3rd payer), the claim cannot be submitted through the Web.

Carrier Type*

Policy Number* [X](#)

[← Back](#) [Next →](#)

Professional Claims Submission

- Add **Service Lines**.

The screenshot displays the 'Professional Claims Submission' interface. The top section is titled 'Service Lines' and includes a 'Back' button and a 'Next' button. Below this, there is a 'Total: \$500.00' and a 'New Service Line' button. A list of 'PROCEDURE / CHARGES' is shown, with the first entry '1: 99213 / \$500.00' highlighted by a pink arrow. The 'Now Viewing Line 1: 99213 / \$500.00' section contains various fields for service details, including 'Dates of Service', 'Place of Service', 'Procedure Code', 'Modifiers', 'Diagnosis Code(s)', 'Charge', 'Units / Minutes / Days', 'Family Planning', and 'NDC'. A pink arrow points to the 'New Service Line' button. The 'Primary Insurance' section is also visible, with fields for 'Amount Allowed', 'Deductible', 'Copay', 'Co-Insurance', and 'Amount Paid'. Below this is the 'Service Line Denial Reasons' section, which includes a 'Denied Category' dropdown, a 'Denied Amount' field, and an 'Add Denied Reason' button. At the bottom of the interface, there are 'Back' and 'Next' buttons, with a pink arrow pointing to the 'Next' button.

Professional Claims Submission

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

Professional Claim for L... Y... Your Progress

THIS SECTION: **Providers**
Providers on this claim.

← Back Next →

*Required

Referring Provider

NPI: 1 73 Find Provider
Last Name or Organizational Name: FARRELL Find Provider First Name: ERN

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

NPI: 1 73 Tax ID: 2 04 Find Provider
Specialty #: 2 0X Last Name or Organizational Name: FARRELL First Name: ERN Save X

Billing Provider

Tax ID: 3 14
Name: Farrell NPI: 11 073 Specialty #: 2 0X
Address: 230 SIMPSON, City: ELKHART State: Indiana Zip: 45518

Service Facility Location Same as Billing Provider

Name: Farrell NPI: 190 073
Address: 230 SIMPSON AVENUE, City: ELKHART State: Indiana Zip: 45518

← Back 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 for L... Y... Your Progress

THIS SECTION: **Attachments**
Add attachments to the claim (5MB limit). Supported types are .jpg, .tif, .pdf and .tif

← Back If there are no attachments, click Next. Next →

Attachments

*Do NOT send password protected files. You must click ATTACH for each file being submitted.

File* No file chosen Attachment Type* Select Type... Attach

There are no attached files.

← Back If there are no attachments, click Next. Next →

Professional Claims Submission

Professional Claim for **L** Your Progress

THIS SECTION:
Review
Please review your claim and submit.

[← Back](#) Validate →

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

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

Claim Id: 8 [REDACTED]

Member Record Number: 2 [REDACTED] 0
Member Claim Amount Paid: [REDACTED]
Patient's Account Number: M [REDACTED]

General Info [Edit](#)

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

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

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

RTEP Claim Pricing View

COMPLETE!
You have successfully submitted your claim. [Print](#)

Web Reference No. 8
Claim No.

RefAcct No: 002851 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 pending explanation may be impacted by final adjudication, including a change to the reimbursement amount or a denial.
- Adjudication status may be affected by Code Editing or other payment rules.

Web Portal Claim and Payment Review

Submitted Claims

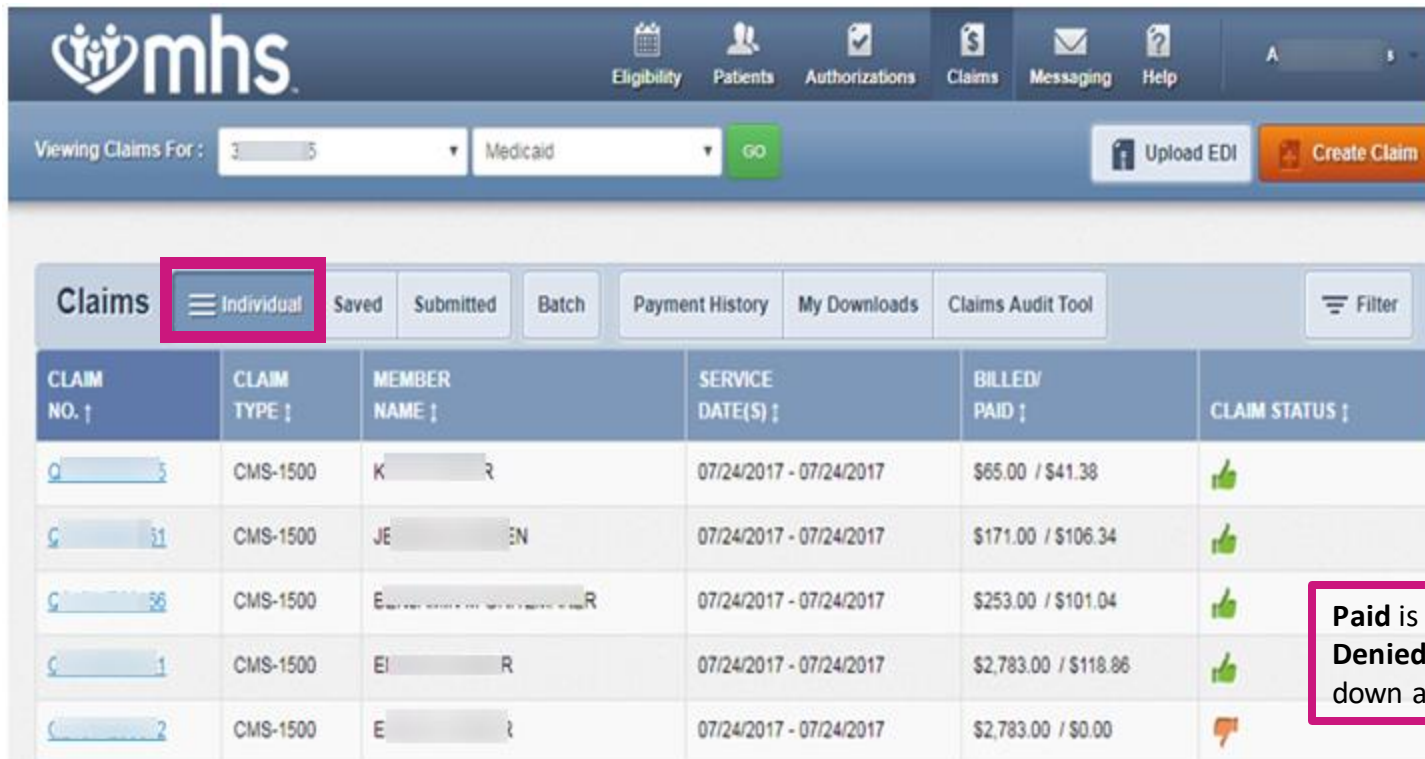
- The **Submitted** tab will only display claims created via the MHS portal:
 - Paid** is a **green** thumbs up.
 - Denied** is an **orange** thumbs down.
 - Pending** is a clock.
- RTEP** claims also show if eligible (i.e., line 3 was submitted but was not eligible for RTEP).

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... J...	1...	6	\$150.00	
👍	08/10/2017	{...}	C...	CMS-1500	C... F...	1...		\$150.00	RTEP 👍
👍	08/02/2017	{...}	C...	CMS-1500	S... M...	1...		\$150.00	RTEP 🗑️
👍	07/24/2017	{...}	(...)	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



The screenshot shows the mhs Claims portal 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' (set to 3) and 'Medicaid'. A 'GO' button and 'Upload EDI' and 'Create Claim' buttons are also visible. The main content area shows a 'Claims' section with a sub-tab 'Individual' highlighted in red. Below this are buttons for 'Saved', 'Submitted', 'Batch', 'Payment History', 'My Downloads', and 'Claims Audit Tool', along with a 'Filter' button. A table of claims is displayed with the following columns: CLAIM NO., CLAIM TYPE, MEMBER NAME, SERVICE DATE(S), BILLED/PAID, and CLAIM STATUS. The table contains five rows of data. A red arrow points to the 'CLAIM STATUS' column. A red box contains a legend: 'Paid is a green thumbs up, Denied is an orange thumbs down and a clock is Pending.'

CLAIM NO. ↑	CLAIM TYPE ↑	MEMBER NAME ↑	SERVICE DATE(S) ↓	BILLED/PAID ↓	CLAIM STATUS ↓
Q 5	CMS-1500	K R	07/24/2017 - 07/24/2017	\$65.00 / \$41.38	👍
C 11	CMS-1500	JE EN	07/24/2017 - 07/24/2017	\$171.00 / \$106.34	👍
C 36	CMS-1500	E R	07/24/2017 - 07/24/2017	\$253.00 / \$101.04	👍
C 1	CMS-1500	EI R	07/24/2017 - 07/24/2017	\$2,783.00 / \$118.86	👍
C 2	CMS-1500	E	07/24/2017 - 07/24/2017	\$2,783.00 / \$0.00	👎

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.
4. Click **Delete** to delete saved claim that is no longer necessary.
5. Click **OK** to confirm the deletion.

Viewing Claims For : 3 Medicaid GO Upload EDI Create Claim

Claims Individual **Saved** Submitted 11 Batch Payment History My Downloads Claims Audit Tool

Claims listed below have missing information or contain errors. Click 'Edit' to view a claim, then fix any errors or complete it before submitting.

Drafts Professional Ready to be Submitted Institutional Ready to be Submitted

DATE CREATED ↑	CLAIM TYPE ↓	CLAIM ID ↓	MEMBER NAME ↓	MEMBER ID ↓	ORIGINAL CLAIM # ↓	TOTAL CHARGES ↓		
08/10/2017	Institutional	8000	R...	1009	Q003	\$54,159.07	Edit	Delete
08/07/2017	Institutional	8005	P...	1009	Q001	\$461.75	Edit	Delete
08/02/2017	CMS-1500	8000	AI...	1009	Q004	\$292.00	Edit	Delete
08/01/2017	Institutional	8007	J...	1009	Q006	\$461.75	Edit	Delete
08/01/2017	Institutional	8001	F...	1009	Q001	\$461.75	Edit	Delete
07/17/2017	Institutional	8003	...	1009		\$507.00	Edit	Delete

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 : TIN [] Plan Type Medicaid [] GO [] Upload EDI [] Create Claim []

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

Transactions

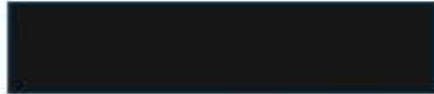
All activity posted to your account between 06/20/2021 and 07/20/2021 .

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.

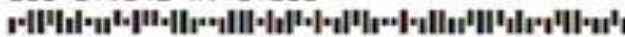

CHECK DATE ↑	CHECK NUMBER ↑	CHECK CLEAR DATE ↓	MAILING ADDRESS ↑	PAYMENT AMOUNT ↑
06/24/2021 (PDF)	[]	06/23/2021	[]	\$100.64
06/24/2021 (PDF)	[]	06/23/2021	[]	\$145.73
06/24/2021 (PDF)	[]	06/23/2021	[]	\$72.01
06/24/2021 (PDF)	[]	EFT	[]	\$0.00
06/24/2021 (PDF)	[]	EFT	[]	\$208.65
06/24/2021 (PDF)	[]	EFT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

Provider EOP

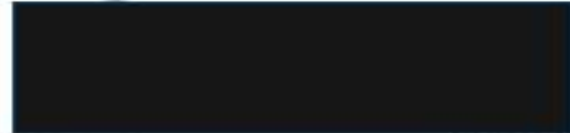
FORMERLY



Electronic Service Requested



606 D.7648 AV D.386 S-DIGIT 30374



3000706111


























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

STATEMENT TOTAL

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

Remittance Advice and Explanation of Payment

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


Serv	Dates	Procedure	Modifiers	Days Ct/Qty	Charged	Allowed	Deduct / Copay	Coinsur/ Discount	Interest	Med Allow/ Med Paid	TPP	Denied	Payment Codes	Payment
0100			G5	1.00	6388.16	263.75	.00	.00	.00	.00	.00	.00	A0 SR 30	258.47
								5.28						
0200			G5	1.00	6388.16	263.75	.00	.00	.00	.00	.00	.00	A0 SR 30	258.47
								5.28						
0300			G5	1.00	6388.16	263.75	.00	.00	.00	.00	.00	.00	A0 SR 30	258.47
								5.28						
0400			G5	1.00	6388.16	263.75	.00	.00	.00	.00	.00	.00	A0 SR 30	258.47
								5.28						
0500			G5	1.00	6388.16	263.75	.00	.00	.00	.00	.00	.00	A0 SR 30	258.47
								5.28						
0600			G5	1.00	6388.16	263.75	.00	.00	.00	.00	.00	.00	A0 SR 30	258.47
								5.28						
0700			G5	1.00	6388.16	263.75	.00	.00	.00	.00	.00	.00	A0 SR 30	258.47
								5.28						

EFT 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 [Payspan | Healthcare Payment Reimbursement Solutions](#)
- For questions call 1-877-331-7154.

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**.
- 4** Populate the requested Personal Information. Click **Next**.
- 5** Designate an account for fund transfers by completing the required fields. Click **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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0221.PR.P.FL 2/21

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 are able to:

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

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

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

The screenshot displays the 'Claims' section of the Secure Provider Portal. At the top, a navigation bar includes icons and labels for 'Eligibility', 'Patients', 'Authorizations', 'Claims', and 'Messaging', along with a 'User Name' dropdown. Below this, a breadcrumb trail shows 'Back to Claims' and the current claim identifier 'Claim #T1234P1235'. The main content area presents three options for handling a claim, each with a 'SELECT' button:

- 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 Reconsideration

- Enter your explanation for reconsideration and check email updates.

Reconsider Claim

Claim No. [REDACTED]

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
Denied for Untimely Filing

Notes
Brief Explanation

500 Character Limit

Upload Documents
Proof of Timely Filing attachment Required

Choose Files

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.


Cancel →

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)

Dispute
U026IA1234566

Dispute/Appeal Details

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

Member	Provider	Claim	Most Recent Payment
Participant Name <div style="background-color: #0056b3; height: 15px; width: 100%;"></div>	Ref/Acct No. 1234567890	DOS Range 08/12/2020 - 08/15/2020	Payment Date ---
Member ID ID123459	Servicing Provider <div style="background-color: #0056b3; height: 15px; width: 100%;"></div>	Received Date 09/12/2020	Check/EFT No. ---
Member DOB <div style="background-color: #0056b3; height: 15px; width: 100%;"></div>	Servicing NPI 1234567890	Billed Amount \$6,1234.12	Check Dated ---
			Paid Claim Amount \$0.00
			Total Check Amount ---

Service Lines

Label	Label	Label	Label	Label	Label	Label

Coordination of Benefits

- This screen shows if a member has other insurance.

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

Effective Date	Term Date	Policy Number	Group Number	Carrier Name	Coverage
06/01/2008	12/21/2013	W [REDACTED]		AETNA	MEDICAL AND HOSPITAL

Overview

Cost Sharing

Assessments

Health Record

Care Plan

Authorizations

Coordination of Benefits

Claims

Prior Authorization

Authorization Considerations

- **Need to know what requires Authorization:**

- Pre-Authorization tool

<https://www.mhsindiana.com/providers/prior-authorization/medicaid-pre-auth.html>

- **How to obtain Authorization:**

- Online: <https://www.mhsindiana.com/providers/prior-authorization.html>
- Phone: 1-877-647-4848
- Fax: 1-866-912-4245

- **Authorizations do not guarantee payment.**

Prior Authorization

The screenshot shows the MHS website's Prior Authorization tool for providers. The top navigation bar includes links for Home, Find a Provider, Portal Login, Events, Careers, and Contact Us, along with a search bar. A contrast control is set to 'Off'. The main navigation has three tabs: 'FOR MEMBERS', 'FOR PROVIDERS', and 'GET INSURED'. The 'FOR PROVIDERS' tab is active, showing a sidebar with various service categories and a main content area for 'Medicaid Pre-Auth'. The sidebar includes links for 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, and Coronavirus Information. The main content area features a disclaimer, verification links for various services, a question about emergency services, a table of service types, a service code input field, and a result for code 58270.

Home Find a Provider Portal Login Events Careers Contact Us

Contrast On Off a a a language-

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:

Y
Yes

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

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

MHS Team

MHS Team

MHS Provider Network Territories

Indiana

NORTHEAST REGION

For claims issues, email:
MHS_ProviderRelations_NE@mhsindiana.com
 Chad Pratt, Provider Partnership Associate II
 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 II
 1-877-647-4848, ext. 20080

SOUTH CENTRAL REGION

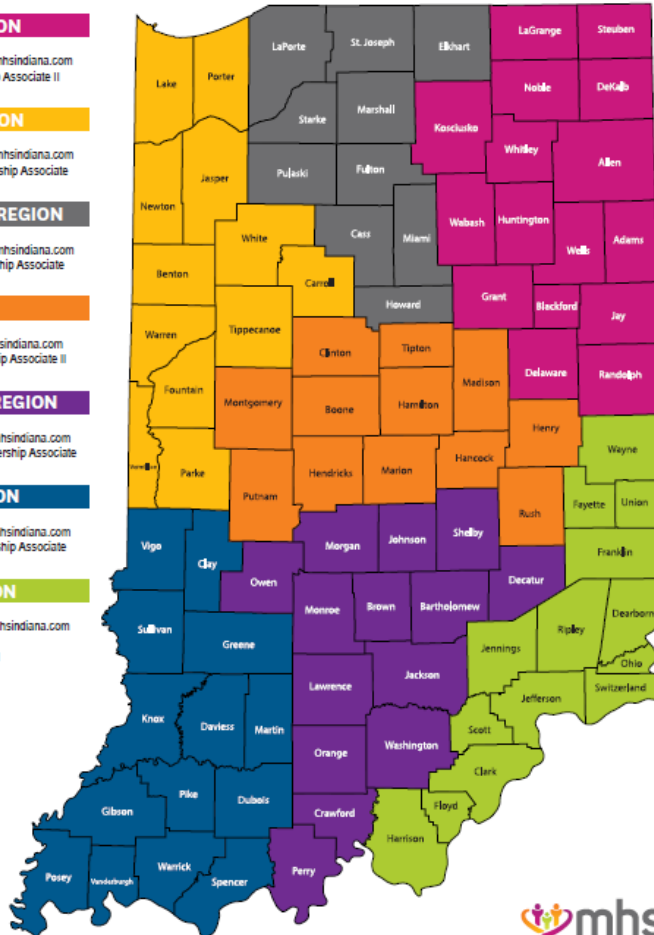
For claims issues, email:
MHS_ProviderRelations_SC@mhsindiana.com
 Dalesia Denning, Provider Partnership Associate
 1-877-647-4848, ext. 20026

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 II
 1-877-647-4848, ext. 20114



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

NORTHEAST REGION

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

NORTHWEST REGION

For claims issues, email:
MHS_ProviderRelations_NW@mhsindiana.com
 Candace Ervin, Provider Partnership Associate
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NORTH CENTRAL REGION

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 Natalie Smith, Provider Partnership Associate
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CENTRAL REGION

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MHS_ProviderRelations_C@mhsindiana.com
 Mona Green, Provider Partnership Associate II
 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 II
 1-877-647-4848, ext. 20114

MHS Team

MHS Provider Network Territories

NETWORK LEADERSHIP

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PROVIDER GROUPS

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PROVIDER GROUPS

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PROVIDER GROUPS

American Health Network

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PROVIDER GROUPS

Community Health Network
Indiana University Health
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PROVIDER GROUPS

HealthLinc

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PROVIDER GROUPS

St. Vincent Medical Group
Ascension Complete
Franciscan Health

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PROVIDER GROUPS

Lutheran Medical Group
Parkview Health System
Beacon Medical Group
Heart City Health Center



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Allwell from MHS - Ambetter from MHS - Healthy Indiana Plan (HIP) - Hoosier Care Connect - Hoosier Healthwise

Questions?
Thank you for being our
partner in care.
