



# Claims update and dispute process

2023 Indiana Health Coverage  
Programs (IHCP) works seminar



# Agenda

- Acronyms
- Provider manual
- Eligibility
- Managed care model
- Prior authorization (PA)
- Claims
- Dispute process
- Contact information

# Acronyms

- **COB** — Coordination of Benefits
- **EDI** — Electronic Data Interchange
- **IHCP** — Indiana Health Coverage Programs
- **MCE** — Managed Care Entity
- **MID** – Member Identification Number
- **PMP** — Primary Medical Provider
- **RCP** — Right Choices Program
- **UM** — Utilization Management

# Provider manual

<https://providers.anthem.com/indiana-provider/resources/manuals-and-guides>

- Resources ▾
- Claims ▾
- Patient Care ▾
- Eligibility & Pharmacy ▾
- Communications ▾
- Our Network ▾
- Members

## Provider manuals and guides



Anthem Blue Cross and Blue Shield (Anthem) is committed to supporting you in providing quality care and services to the members in our network. Here you will find information for assessing coverage options, guidelines for Clinical Utilization Management (UM), practice policies and support for delivering benefits to our members.



### Provider manual

Anthem's provider manual provides key administrative information, including the quality improvement program, the UM program, quality standards for participation, claims appeals, and reimbursement and administration policies.



Documents

- [Provider Manual](#)
- [Credentialing Program Summary Guide](#)

# Eligibility



# Eligibility

Always verify a member's eligibility prior to rendering services. Anthem Blue Cross and Blue Shield (Anthem) recommends a two-step verification process.

## **Providers can access this information by visiting:**

- [IHCP Provider healthcare portal](#): Use to verify eligibility, assigned Managed Care Entity (MCE), and Medicaid product
- [Availity Essentials](#): use for PMP verification, benefit limitations, COB, and much more

# Eligibility (cont.)

Hoosier Healthwise:

- Anthem assigns the YRH prefix with the member ID (MID).



- It is no longer required to include the YRH prefix before the MID.

# Eligibility (cont.)

## Hoosier Care Connect:

- Anthem assigns the YRH prefix with the Member ID.

MEMBER ID		Primary Medical Provider:	
Group Plan	631	Providers: Call MCE to confirm copays*	
RxBIN	003858	Prescriptions	\$3.00
RxPCN	MA	Transportation	\$1.00
RxGroup	WKXA	Non-emergent ER	\$3.00
		*Exempt: Under age 18, pregnant members.	

Possession of this card does not guarantee eligibility for benefits.	Customer Care Center: 1-844-284-1797
Providers: Please file claims with the local Blue Cross and Blue Shield plan in the state where services are provided.	TTY: 711
Anthem Medical Claims Address: Anthem, PO Box 6144 Indianapolis, IN 46206-6144	24/7 Nurse Line: 1-866-800-8780
	Provider Helpline: 1-844-284-1798
	Med. & RX Precart: 1-888-468-7187
	Pharmacy Help Desk: 1-844-520-2680
	Vision Service Plan*: 1-877-478-7561
	DentaQuest™: 1-888-291-3762
	LCP Transportation†: 1-800-508-7230
	†Contracts directly with group
	Anthem Blue Cross and Blue Shield is the trade name of Anthem Insurance Companies Inc., an independent licensee of the Blue Cross and Blue Shield Association.
	00/00/0000

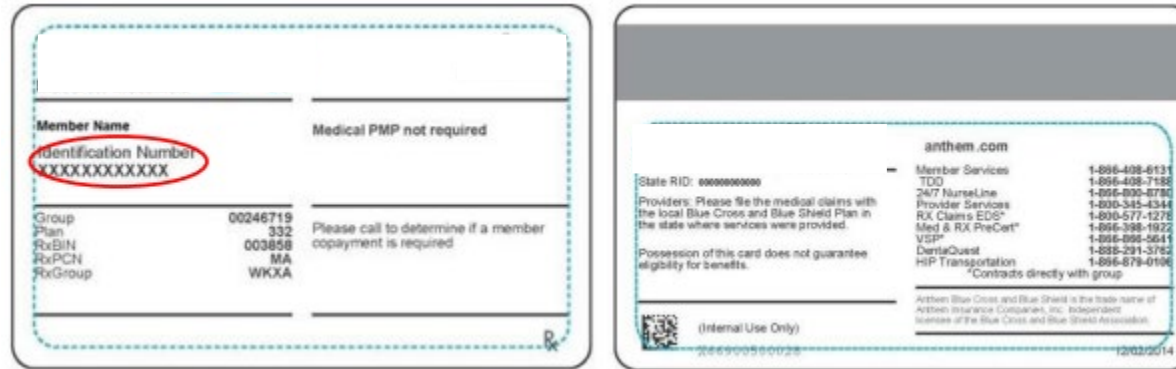
- It is no longer required to include the YRH prefix before the MID.



# Eligibility (cont.)

## Healthy Indiana Plan (HIP):

- Anthem assigns the YRK prefix with the member ID.



- It is no longer required to include the YRK prefix before the MID.

# Right Choices Program (RCP)

- RCP is a program for Indiana Medicaid members who may need assistance learning how to properly use their health insurance.
- The program provides members with a lock-in provider who acts as a safeguard against the unnecessary or inappropriate use of benefits.



# RCP (cont.)

- Members enrolled in RCP must see the providers who are assigned per CoreMMIS.
- The member's PMP may call **866-902-1690 option 1** to add new providers to the member's list of authorized providers.
- Refer to pages 65 to 68 of the Anthem provider manual for more information.
- RCP members are no longer required to be locked into a single hospital:
  - **Although members are no longer locked into a single hospital, they will still be locked into one primary medical provider to coordinate their care and one pharmacy to fill prescriptions.**



## Managed Care Model (Assigned PMP)

# Managed Care Model (Assigned PMP)

All members must see their assigned PMP. Please view the Availity PMP assignments.

Specialty providers must have a referral from the PMP:

- Include the individual (type one) national provider identifier (NPI) of the member's assigned referring PMP when you submit the *CMS-1500* claim form or electronic data interchange (EDI) claim.
- If one physician is on call or covering for another, the billing provider must complete Box 17b of the *CMS-1500* claim form to receive reimbursement.

If you are a non-contracted provider, you need to obtain prior authorization (PA) from Anthem before you provide services to our members.

Note: Out-of-network behavioral health and routine dental services do not require PA.

# Managed Care Model (Assigned PMP) (cont.)

Exceptions to this policy include:

- Self-referrals. Members may self-refer for certain services provided by an IHCP-enrolled provider:
  - **Note:** Refer to the provider manual for a listing of self-referral services.
- A PMP not yet assigned to the member.
- A provider in the same provider group, with the same tax ID, or group NPI as the referring physician (and is an approved provider type).
- Emergency services (services performed in place of service 23).
- Family planning services.

# Managed Care Model (Assigned PMP) (cont.)

Exceptions to this policy include (cont.):

- Services provided after hours (codes 99050 – Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed and 99051 – Service(s) provided in the office during the regularly scheduled evening, weekend, or holiday office hours).
- Diagnostic specialties (such as lab and X-Ray services).
- The billing or referring physician is an Indian health provider or is providing services at a federally qualified health center (FQHC) or urgent care center.

# Prior authorization





# Precertification lookup tool

Visit the provider website to utilize the precertification lookup tool at <https://providers.anthem.com/indana-provider/home> > Claims >

Precertification Lookup Tool

Providers can quickly determine PA requirements for outpatient services. If a PA is required, we strongly recommend utilizing our Availity Authorization tool to request PA.

**Note:** All inpatient services require PA.

All authorization requests can be submitted via the [Availity](#) Authorization Tool.

# Claims



# Initial claim submission

For participating providers, the claim filing limit is 90 calendar days from the date of service.

Claim submission methods:

- Electronically via electronic data interchange (EDI) - Preferred
- Availity
- By mail to:

Anthem Blue Cross and Blue Shield  
Claims Department  
Mail Stop: IN999  
P.O. Box 61010  
Virginia Beach, VA 23466

Note: Nonparticipating providers have 180 days from the date of service to submit claims.

# Claim turnaround

Processing time:

- 21 days for electronic clean claims
- 30 days for paper clean claims

If the claim isn't showing in our processing system, ask the Provider Services representative to verify if the claim is in imaging. **Do not resubmit if the claim is on file in the processing or image system.**

# COB

COB is when a member shows to have primary insurance:

- Claims must be filed to Anthem within 90 days of the date on the primary *Explanation of Payment (EOP)*.

If the primary carrier pays more than the Medicaid allowable, no additional money will be paid.

- **Example one:** Primary pays \$45 for a 99213 and you bill Medicaid as secondary. The Medicaid fee schedule is \$31.96. No additional reimbursement would be made.
- **Example two:** Primary allows \$45 for a 99213 but applies it all towards a deductible and you bill Medicaid as secondary. Medicaid will pay the \$31.96 since primary applied all to the deductible.

**Note:** Bill all secondary claims, even if we will not pay additional money; this will assist in the HEDIS® data review.

# Identifying denials on the *EOP*



Anthem Blue Cross and Blue Shield is the trade name of Anthem Insurance Companies, Inc. Independent licensee of the Blue Cross and Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.

[REDACTED]

CHECK/EFT:

SERVICE DATE(S)	SERVICE CODES	POS	CHARGE	ALLOWED	DEDUCTIBLE	CO-PAY	CO-INSURANCE	CONTRACTUAL DIFFERENCE	PROVIDER RESP. AMOUNT	EXPL/ANSI CODE(S)	INSURED RESPONSIBILITY AMOUNT	EXPL/ANSI CODE(S)	WHAT WE WILL PAY
INSURED'S NAME: [REDACTED]													
PATIENT ACCOUNT#: [REDACTED]													
SERVICE PROVIDER NAME: [REDACTED]													
NETWORK: IN NETWORK      RELATIONSHIP TO INSURED: [REDACTED]													
	87210			0.00	0.00	0.00	0.00	0.00	23.00	GLI 16	0.00		0.00
	872100W			0.00	0.00	0.00	0.00	0.00	23.00	GLI 16	0.00		0.00
	TOTAL:			68.99	0.00	0.00	0.00	0.00	118.75		0.00		68.99
INTEREST													0.00
	TOTAL NET PAID												68.99

EXPL CODES	EXPLANATION
TFO	This claim was submitted after the claim filing limit.
PXN	<u>Paid per your contract or Out Of Network rates</u>
GLI	A valid CLIA number must be submitted for this service

GLI 16
GLI 16

EXPL CODES	EXPLANATION
TFO	This claim was submitted after the claim filing limit.
PXN	Paid per your contract or Out Of Network rates
GLI	A valid CLIA number must be submitted for this service

# Identifying denials on the EOP (cont.)

SERVICE DATE(S)	SERVICE CODES	POS	CHARGE	ALLOWED	DEDUCTIBLE	CO-PAY	CO-INSURANCE	CONTRACTUAL DIFFERENCE	PROVIDER RESP. AMOUNT	EXPL/ANSI CODE(S)	INSURED RESPONSIBILITY AMOUNT	EXPL/ANSI CODE(S)	WHAT WE WILL PAY
INSURED'S NAME:		INSURED'S ID:		PATIENT NAME:		FOR INQUIRIES CALL:							
PATIENT ACCOUNT#:		CLAIM NUMBER:		RECEIVED DATE:									
SERVICE PROVIDER NAME:		SERVICE PROVIDER ID:		EXPL CD:									
NETWORK:		RELATIONSHIP TO INSURED:		PLAN TYPE:									
	0250	13		0.00	0.00	0.00	0.00	0.00		Y97 252	0.00		0.00
	S1015	13		0.00	0.00	0.00	0.00	0.00		Y97 252	0.00		0.00
	0272	13		0.00	0.00	0.00	0.00	0.00		Y97 252	0.00		0.00
	8830STC	13		0.00	0.00	0.00	0.00	0.00		Y97 252	0.00		0.00
	58661	13		0.00	0.00	0.00	0.00	0.00		Y97 252	0.00		0.00
	0370	13		0.00	0.00	0.00	0.00	0.00		Y97 252	0.00		0.00
	J3010	13		0.00	0.00	0.00	0.00	0.00		Y97 252	0.00		0.00
	J2250	13		0.00	0.00	0.00	0.00	0.00		Y97 252	0.00		0.00
	J0690	13		0.00	0.00	0.00	0.00	0.00		Y97 252	0.00		0.00
	J7120	13		0.00	0.00	0.00	0.00	0.00		Y97 252	0.00		0.00
	J2795	13		0.00	0.00	0.00	0.00	0.00		Y97 252	0.00		0.00
	J2405	13		0.00	0.00	0.00	0.00	0.00		Y97 252	0.00		0.00
	J7642	13		0.00	0.00	0.00	0.00	0.00		Y97 252	0.00		0.00
	J2710	13		0.00	0.00	0.00	0.00	0.00		Y97 252	0.00		0.00
	0710	13		0.00	0.00	0.00	0.00	0.00		Y97 252	0.00		0.00
	0710	13		0.00	0.00	0.00	0.00	0.00		Y97 252	0.00		0.00
	TOTAL:			0.00	0.00	0.00	0.00	0.00			0.00		0.00
INTEREST													
TOTAL NET PAID													

SP. EXPL/ANSI CODE(S) F

NAME: I

DATE:

PL CD:

Y97 252

Y97 252

Y97 252

Y97 252

Y97 252

Y97 252

Y97 252

Y97 252

Y97 252

Y97 252

Y97 252

Y97 252

Y97 252

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Y97 252

Y97 252

EXPL CODES	EXPLANATION
PXN	Paid per your contract or Out Of Network rates
G18	The submitted service is not allowed per your contract
INC	Included in per diem/case rate
G22	Paid in accordance to the provider contracted rates or Out Of Network rates
G37	The charges for this service have been combined into the primary procedure.
ER3	Triage rate. Request PLP w/1 120 days @Anthem BCBS-Provider Disputes- PO Box 61599-Virginia Beach-VA-23466. See www.Anthem.com/INMedicaidDoc
M62	ER visit approved after medical record review, paid at level billed
Y97	<b>Valid consent form required</b>
ST	This service was not paid because the member's coverage was not in effect at the time of the service.
PPC	Exceeds the Ambulatory Payment Classification (APC) rate
45	CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED/LEGISLATED FEE ARRANGEMENT. USAGE: THIS ADJUSTMENT AMOUNT CANNOT EQUAL THE TOTAL SERVICE OR CLAIM CHARGE AMOUNT; AND MUST NOT DUPLICATE PROVIDER ADJUSTMENT AMOUNTS (PAYMENTS AND CONTRACTUAL REDUCTIONS) THAT HAVE RESULTED FROM PRIOR PAYER(S) ADJUDICATION.
256	SERVICE NOT PAYABLE PER MANAGED CARE CONTRACT.
97	THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT, IF PRESENT.
94	PROCESSED IN EXCESS OF CHARGES.
252	<b>AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE.</b>
27	EXPENSES INCURRED AFTER COVERAGE TERMINATED.

# Top five denials

## **Professional claims:**

- Billing NPI not registered with the state – Z33
- Submitted after plan filing limit – TF0
- Deny – prior auth not obtained – Y40
- *EOB* required from the primary carrier – QA0
- Rendering NPI not registered with the state – Z34

## **Institutional claims:**

- Submitted after plan filing limit – TF0
- *EOB* required from the primary carrier - CBP
- Prior Authorization not obtained – Y40
- Billing NPI not registered with the state – Z33
- Definite duplicate claim - CDD



# Billing NPI not registered with the state – Z33 – Professional claim

- Z33 refers to the provider NPI in field 33a of the *CMS-1500/837P* claim form.
- Billing providers must be actively enrolled with the state to receive reimbursement from Anthem.
- There must be a one-to-one match between the data submitted on the claim and the State Assigned Provider ID file received from the state:
  - NPI, taxonomy, ZIP+4 = 1 State provider ID = Match
  - NPI, taxonomy, ZIP+4 = 2+ State provider IDs = No match, Z33 denial

33. BILLING PROVIDER INFO & PH # ( )

a. NPI	b.
--------	----

APPROVED OMB-0938-1197 FORM 1500 (02-12)

# Claims resolution process

## Follow-up guidelines

Use the Availity Essentials to check claim status online. You can also call the appropriate helpline:

Plan	Phone number
HIP	844-533-1995
Hoosier Care Connect	844-284-1798
Hoosier Healthwise	866-408-6132

It is the provider's responsibility to follow up timely and ensure claims are received and accepted.

# Claims resolution process (cont.)

## **Corrected claims submission guidelines**

Submit a corrected claim when the claim is denied or only paid in part due to an error on the original claim submission.

When submitting corrected claims, follow these guidelines:

- Submit the corrected claim no later than 60 calendar days from the date of our letter or remittance advice (RA).
- Corrected claims can be submitted by paper, electronically through your clearinghouse, or through the Availity Essentials.

# Claims resolution process (cont.)

Send corrected paper claims to:

Anthem Blue Cross and Blue Shield  
Corrected Claims and Correspondence  
Department  
P.O. Box 61599  
Virginia Beach, VA 23466

The [Claim Follow-Up Form](https://providers.anthem.com/indiana-provider/home) is available at <https://providers.anthem.com/indiana-provider/home> > Resources > Forms > Claims and Billing.

Anthem Blue Cross and Blue Shield  
Serving Hoosier Healthwise, Healthy Indiana Plan  
and Hoosier Care Connect

**Claim Follow-Up Form**

**Provider information**

Sent by _____	Date sent _____
Hospital/facility/physician _____	Phone number _____
NPI number _____	Provider TIN _____

**Member information**

Patient name _____	Date of service _____
Member ID number _____	Medicaid ID number _____

**Instructions:** Please attach the proper documentation, including a copy of any applicable correspondence received from Anthem Blue Cross and Blue Shield.

After completing this form, place it on top of all documentation and mail to:

Claims  
P.O. Box 61010  
Virginia Beach, VA 23466

A copy of the claim should not be submitted with the documentation requested unless otherwise denoted by an asterisk (\*).

Returned claim follow-up (Check all that apply):

- Coordination of benefits/Medicaid information
- Corrected billing\*
- Explanation of Medicare Benefits/Explanation of Benefits of primary insurance carrier
- Hard copy of itemized bill for a previously submitted claim
- Medical records
- Patient eligibility verified (Provider Services, Interactive Voice Response, provider access)
- Other: \_\_\_\_\_

Claim adjustment request:

- Additional charges\*

**HMO use only (Consult your HMO agreement if you are uncertain which choice applies.)**

- Eligibility guarantee claims
- Enrollment protection claims
- Noncap discrepancies
- Other: \_\_\_\_\_

# Claims resolution process (cont.)

## **Claims dispute and appeal process**

The dispute process is used if a provider disagrees with full or partial denial on the claim:

- There is a 60-calendar day filing limit from the date on the remittance advice (RA) in which to dispute any claim.
- Disputes and appeals that are not filed within the defined time frames will be denied without a review for merit.

# Claims resolution process (cont.)

The claims dispute process is as follows:

- 1. Claims reconsideration** — must be received within 60 calendar days from the date on the RA. Disputes can be done verbally through provider services, in writing, or online through the Availity Essentials. Submit a claims reconsideration if you disagree with full or partial claim rejection or denial, or the payment amount.
- 2. Claim payment appeal** — if you are not satisfied with the reconsideration, you may submit a claim payment appeal. We must receive this appeal within 60 calendar days from the date of the claim reconsideration. This can be done via the Availity Essentials or by mail.



## Filing a dispute in Availity

# Claims disputes in Availity

- Login and select **Claim Status** on your Dashboard.

The screenshot displays the Availity user interface. At the top, there is a navigation bar with the Availity logo, user profile information (Indiana, Help & Training, Matthew's Account, Logout), and a search bar. Below the navigation bar, the dashboard is divided into several sections:

- Notification Center:** A section with a header 'N Notification Center' and a message: "You have no notifications."
- My Top Applications:** A row of four application tiles:
  - PC Professional Claim:** Represented by a green square with 'PC'.
  - FC Facility Claim:** Represented by a green square with 'FC'.
  - A&R Authorizations & Referrals:** Represented by an orange square with 'A&R'.
  - CS Claim Status:** Represented by a green square with 'CS'. A large green arrow points to this tile.
- My Account Dashboard:** A sidebar on the right containing:
  - My Account
  - Manage My Organization
  - 'How To' Guide for Dental Providers
  - Enrollments Center
  - EDI Companion Guide
  - User profile for Matthew Swingendorf (matthew.swingendorf@anthem.com, My Job Title)
- News and Announcements:** A list of recent news items with dates, including:
  - Join Our Webinar: Navigating Challenges for Atypical Service Providers Without an NPI (08/04/2023)
  - Live Training for RCV - The App for Managing Risk Adjustment Requests (07/31/2023)
  - Humana Dental Providers: Did You Miss Our Training for Your Enhanced Claim Status Search? (07/26/2023)
  - VA CCN Providers (06/29/2023)
  - 1756 News testing (10/20/2021)
  - Clone-1756 News testing (10/20/2021)



# Claims disputes in Availity (cont.)

- Select your **Organization** and **Payer**.

The screenshot shows the Availity web interface for 'Claim Status'. The top navigation bar includes 'Availity', 'essentials', 'Home', 'Notifications', 'My Favorites', 'Indiana', 'Help & Training', 'Matthew's Account', and 'Logout'. A secondary navigation bar contains 'Patient Registration', 'Claims & Payments', 'Clinical', 'My Providers', 'Reporting', 'Payer Spaces', 'More', and a 'Keyword Search' field. The main content area has a breadcrumb 'Home > Select' and a link 'Need Help? Watch a demo for Claim Status'. The title 'Claim Status' is displayed with a 'Give Feedback' button. Two dropdown menus are present: 'Organization' with 'Anthem QA's' selected, and 'Payer' with 'Select...' selected. A red border highlights the 'Payer' dropdown, and a red error message below it reads: 'Select a payer from the dropdown above.'

# Claims disputes in Availity (cont.)

- Fill out the required information as indicated by a red asterisk(\*).

Availity | essentials | Home | Notifications | My Favorites | Indiana | Help & Training | Matthew's Account | Logout

Patient Registration | Claims & Payments | Clinical | My Providers | Reporting | Payer Spaces | More | Keyword Search

Home > Select > Search | Need Help? Watch a demo for Claim Status | Give Feedback

### cs Claim Status

Organization: Anthem QA's | Payer: ANTHEM - IN

HIPAA Standard

Fields marked with an asterisk \* are required.

#### Provider Information

\* Is the provider the same as the organization name?  Yes  No

Select a Provider: Select... | \* Provider NPI: [Text Field]

#### Patient Information

Select a Patient: Q Select... | clear | \* Member ID: [Text Field]

\* Patient Last Name: [Text Field] | \* Patient First Name: [Text Field]

\* Patient Date of Birth: MM/DD/YYYY | Patient Gender: Select...

Patient Account Number: [Text Field] | Patient's Relationship to Subscriber: Self

#### Claim Information

\* Service Dates: From Date [Text Field] - To Date [Text Field]

Claim Number: [Text Field] | Claim Amount: [Text Field]


Institutional Bill Type: [Text Field]

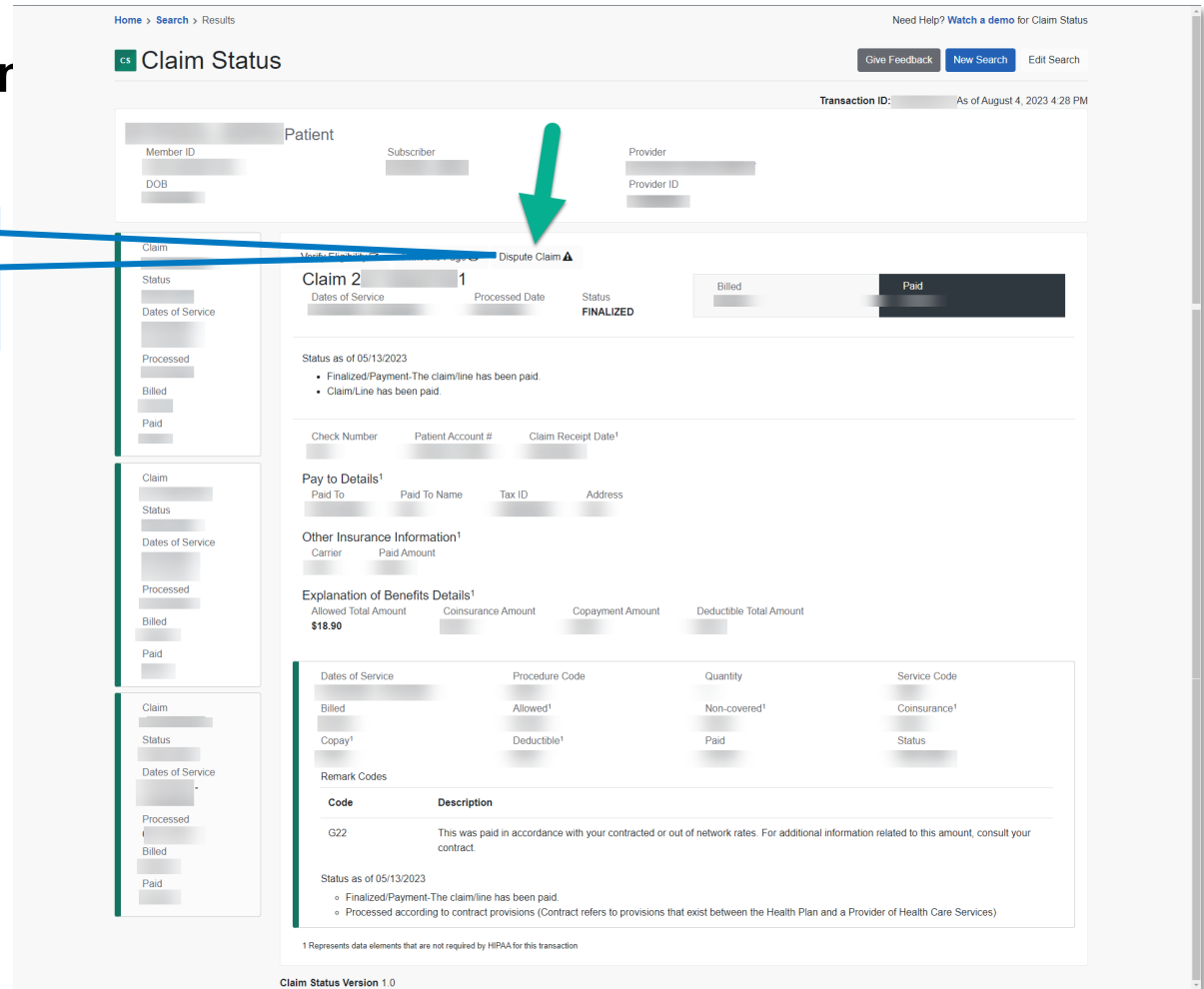
Submit | Clear Form

Claim Status Version 1.0

# Claims disputes in Availity (cont.)

- Select the **Dispute Claim**

Dispute Claim 




Home > Search > Results Need Help? [Watch a demo](#) for Claim Status

## Claim Status Give Feedback New Search Edit Search

Transaction ID: [REDACTED] As of August 4, 2023 4:28 PM

**Patient**

Member ID [REDACTED] Subscriber [REDACTED] Provider [REDACTED]  
DOB [REDACTED] Provider ID [REDACTED]

**Claim** Dispute Claim 

Status [REDACTED] **Claim 2** [REDACTED] 1 Billed [REDACTED] Paid [REDACTED]

Dates of Service [REDACTED] Processed Date [REDACTED] Status **FINALIZED**

Status as of 05/13/2023

- Finalized/Payment-The claim/line has been paid.
- Claim/Line has been paid.

Check Number	Patient Account #	Claim Receipt Date <sup>1</sup>
[REDACTED]	[REDACTED]	[REDACTED]

**Pay to Details<sup>1</sup>**

Paid To	Paid To Name	Tax ID	Address
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]

**Other Insurance Information<sup>1</sup>**

Carrier	Paid Amount
[REDACTED]	[REDACTED]

**Explanation of Benefits Details<sup>1</sup>**

Allowed Total Amount	Coinsurance Amount	Copayment Amount	Deductible Total Amount
<b>\$18.90</b>	[REDACTED]	[REDACTED]	[REDACTED]

Dates of Service	Procedure Code	Quantity	Service Code
Billed [REDACTED]	Allowed <sup>1</sup>	Non-covered <sup>1</sup>	Coinsurance <sup>1</sup>
Copay <sup>1</sup>	Deductible <sup>1</sup>	Paid	Status

**Remark Codes**

Code	Description
G22	This was paid in accordance with your contracted or out of network rates. For additional information related to this amount, consult your contract.

Status as of 05/13/2023

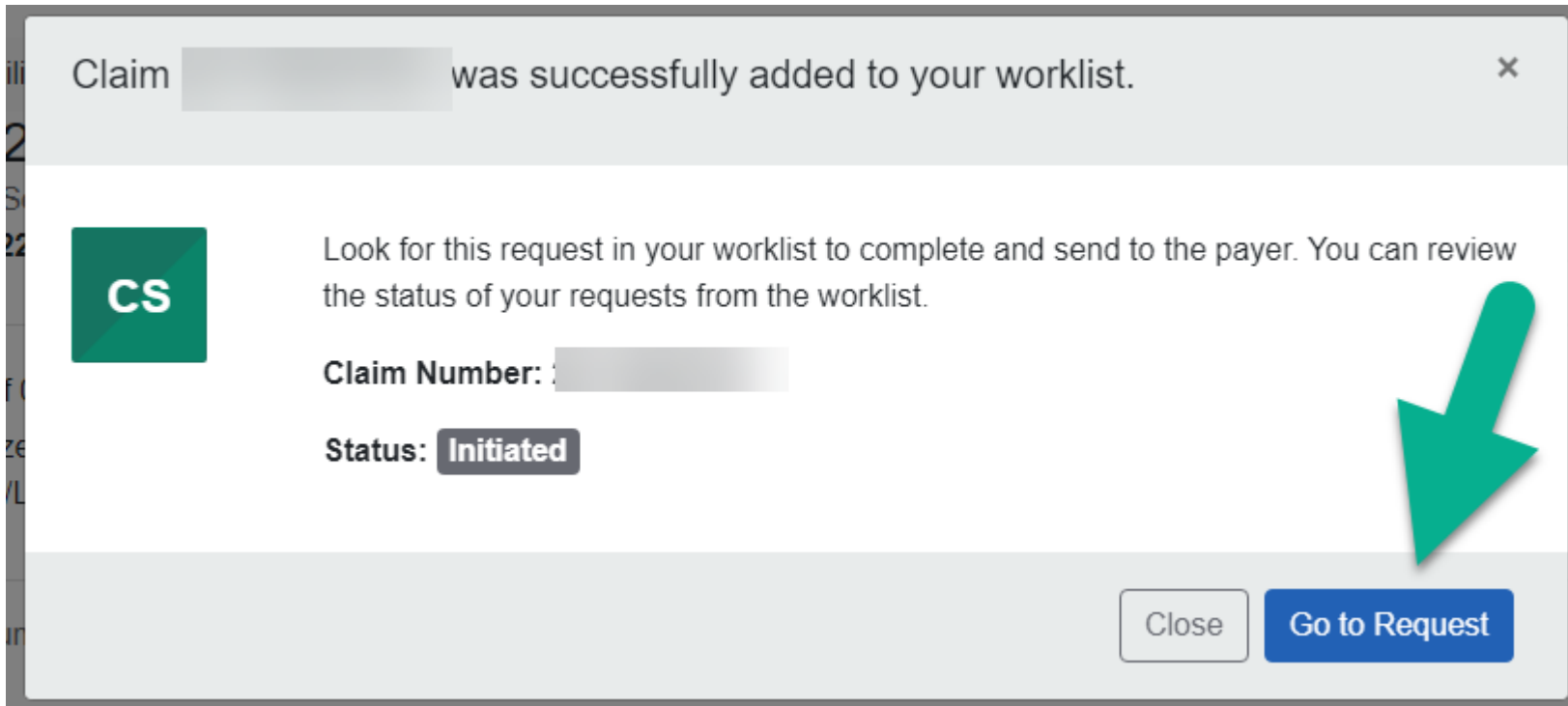
- Finalized/Payment-The claimline has been paid.
- Processed according to contract provisions (Contract refers to provisions that exist between the Health Plan and a Provider of Health Care Services)

<sup>1</sup> Represents data elements that are not required by HIPAA for this transaction

Claim Status Version 1.0

# Claims Disputes in Availity (cont.)

- The claim will go to your Worklist. You can add more claims and then select **Go to Request**.



Claim [redacted] was successfully added to your worklist. ×

**CS**

Look for this request in your worklist to complete and send to the payer. You can review the status of your requests from the worklist.

Claim Number: [redacted]

Status: **Initiated**

[Close](#) [Go to Request](#)

# Claims Disputes in Availity (cont.)

- The claim will be in your worklist and show Initiated. Select the three lines and then select **Complete Dispute Request**.

The screenshot displays the 'Appeals' section of the Availity interface. At the top left, there is a green square with the letter 'A' followed by the text 'Appeals'. On the top right, there is a 'Give Feedback' button. Below this, the Anthem logo is visible on the left, and the status 'Initiated' is shown in the center, with 'Created: 08/04/2023 • Updated 08/04/2023' below it. A table of claims is shown with columns for Claim Number, Payment Information, Patient Name, Service Begin Date, Billed Amount, Method of Receipt, Payment Date, Patient Account Number, Service End Date, and Payment Amount. A dropdown menu is open on the right side of the table, containing three options: 'Complete Dispute Request', 'Delete Initiated Appeal', and 'Return to Worklist'. A large green arrow points to the 'Complete Dispute Request' option. A hamburger menu icon is visible on the far right of the table header.

# Claims Disputes in Availity (cont.)

- Select **Request Reason**.
- Explain your supporting rationale.
- Select if the issue has impacted claims for other members.
- Select how you want to be contacted.
- Select if there are additional claims numbers for the appeal.
- Select **Next**.

The screenshot shows a web form for filing a claim dispute. At the top, a progress bar has four steps: 1. Request Reason (highlighted in green), 2. Add Additional Claims, 3. Attach Documents, and 4. Request Submitted. Below the progress bar, the text reads: "This Anthem - Indiana request was initiated on 08/04/2023". A note states: "Fields marked with \* are required." The form includes a dropdown menu for "Request Reason" with "Claim Payment Issue" selected. Below this is a large text area for "Please explain the supporting rationale for your request", which is currently empty. A red warning icon and text indicate "Message to payer is required." with a character count of "0/2000". There is a checked checkbox for "This issue has impacted claims for other members. Please re-evaluate claims on file." with a sub-note: "Please provide date range in the supporting rationale box above." Under "Contact Information", a dropdown menu shows "Web" selected. At the bottom, there are radio buttons for "Are there additional claim numbers related to this appeal?", with "Yes, I DO want to add additional claim numbers to this appeal" selected. Finally, "Cancel" and "Next" buttons are located at the bottom right of the form.

1 **Request Reason** 2 Add Additional Claims 3 Attach Documents 4 Request Submitted

This Anthem - Indiana request was initiated on 08/04/2023

Fields marked with \* are required.

\* Request Reason  
Claim Payment Issue

\* Please explain the supporting rationale for your request

▲ Message to payer is required.  
0/2000

This issue has impacted claims for other members. Please re-evaluate claims on file.  
Please provide date range in the supporting rationale box above.

Contact Information  
Web

\* Are there additional claim numbers related to this appeal?  
 No, I do NOT want to add additional claims  
 Yes, I DO want to add additional claim numbers to this appeal

Cancel Next

# Claims Disputes in Availity (cont.)

Complete Dispute Request Claim# 227188287901

1 Request Reason    2 **Add Additional Claims**    3 Attach Documents    4 Request Submitted

Enter up to 24 additional claim numbers related to this appeal. Claim must be for same member, provider, and request reason.

Additional Claim #1  
   
[Remove](#)

Additional Claim #2  
   
[Remove](#)

Additional Claim #3  
   
[Remove](#)

[+ Add more claims to this request](#)

- If you said yes to adding additional claim numbers, you would do that here.

# Claims Disputes in Availity (cont.)

Attach documents for claim(s):

Upload Supporting Documentation

**IMPORTANT:** Individual file size cannot exceed **50 MB**.

Supported file types include: .csv, .doc, .docx, .jpg, .jpeg, .pdf, .tiff, .txt, .xls, .xlsx

**NOTE:** File names cannot contain spaces or special characters with the exception of "\_" and "-".

+ Add File

Cancel

Submit Request

- Finally, you have the option to upload your supporting documentation:
  - Select: **Add File** to upload your supporting documentation.
- Select **Submit Request** to complete your dispute.



# Important contact information



# Important contact information

## **Provider Services:**

- Hoosier Healthwise: **866-408-6132**
- HIP: **844-533-1995**
- Hoosier Care Connect: **844-284-1798**

## **Member Services and 24/7 NurseLine:**

- Hoosier Healthwise and HIP: **866-408-6131**
- Hoosier Care Connect: **844-284-1797**

# Important contact information (cont.)

## PA requests:

- HIP: **844-533-1995**
- Hoosier Care Connect: **844-284-1798**
- Hoosier Healthwise: **866-408-6132**
- Fax: **866-406-2803**

# Physical health Provider Relationship Account Managers

## Provider Relationship Account Management physical health zone map

**Zone 1/Beacon Health Systems, St. Joseph Regional Medical Center**

Jessi Earls  
 Jessica.Wilkerson-Earls@anthem.com  
 317-452-2568

**Zone 2**

Whit'ney McTush  
 Whitney.McTush@anthem.com  
 317-519-1089

**Zone 3/Lutheran**

Ashley Holmes  
 Ashley.Holmes@anthem.com  
 317-315-0623

**Zone 4**

Jamaal Wade  
 Jamaal.WadeSr@anthem.com  
 317-409-7209

**Zone 5/Eskenazi, Home Health and Hospice, Skilled Nursing Facilities**

Matt Swingendorf  
 Matthew.Swingendorf@anthem.com  
 317-306-0077

**Zone 6**

Jonathan Hedrick  
 Jonathan.Hedrick@anthem.com  
 317-601-9474

**Zone 7/Baptist Health, Cincinnati Children's Hospital Medical Center, Norton Healthcare**

Sophia Brown  
 Sophia.Brown@anthem.com  
 317-775-9528

**Zone 8/Out-of-state providers**

Angelique Jones  
 Angelique.Jones@anthem.com  
 317-619-9241



<b>Indiana University Health, Parkview Regional Health, Ascension</b> David Tudor David.Tudor@anthem.com 317-447-7008	<b>Community Health Network, Franciscan Health, Deaconess</b> Nicole Bouye Nicole.Bouye@anthem.com 317-517-8862
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**Director, Provider Relationship Account Management**  
 Jacquie Marsalis  
 Jacqueline.Marsalis@anthem.com  
 317-431-2439

# Provider Relationship Account management behavioral health subject matter experts

## Statewide behavioral health (BH) subject matter experts (SME)

### Acute care hospitals

Tish Jones, Provider Relationship Account Manager  
Latisha.Willoughby@anthem.com  
317-617-9481

### Community mental health centers/Federally qualified health centers/Rural health clinics

Matthew McGarry, Provider Relationship Account Manager  
Matthew.McGarry@anthem.com  
463-202-3579

### Substance use disorder (SUD)/Opioid treatment program (OTP)

Alisa Phillips, Provider Relationship Account Manager, Sr.  
Alisa.Phillips@anthem.com  
317-517-1008

Michele Weaver, Provider Relationship Account Manager  
Michele.Weaver@anthem.com  
317-601-3031



# Questions?

Thank you for your participation in serving our members enrolled in Hoosier Healthwise, HIP, and Hoosier Care Connect!



Serving Hoosier Healthwise, Healthy Indiana Plan  
and Hoosier Care Connect

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Providers who are contracted with Anthem Blue Cross and Blue Shield to serve Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect through an accountable care organization (ACO), participating medical group (PMG) or Independent Physician Association (IPA) are to follow guidelines and practices of the group. This includes but is not limited to authorization, covered benefits and services, and claims submittal. If you have questions, please contact your group administrator or your Anthem network representative.

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