



DENTAQUEST INDIANA

2019 IHCP Annual Provider Seminar
October 16, 2019

Agenda

1. How and When?
2. Claims – we want to help!
3. How to contact us

How and When

Peer Review
Managed Care
HIP Appeal
Anthem
Provider Engagement
Corrected Claim
Representative
Portal
DentaQuest
Hoosier Care Connect
Benefit Effective Date
Hoosier Health Wise
MDwise
Prior Authorization
CoreMMIS
Indiana Medicaid
Claim



Member Eligibility

Member Eligibility

- Always view member eligibility on CoreMMIS on the Date of Service.

Eligibility Verification Request ?

* Indicates a required field.
Enter the member information. If Member ID is not known, enter SSN and Birth Date, or Last Name, First Name, and Birth Date.

Member ID Last Name First Name

SSN Birth Date

*Effective From Effective To

Coverage Details for First Name, Last Name from 07/19/2018 to 07/19/2018

Member ID 19999999999 Birth Date 01/01/2001 [Expand All](#) | [Collapse All](#)

Verification Response ID 18200066GY

Benefit Details			
Coverage	Description	Effective Date	End Date
Package A-Standard Plan - CHIP	Package A-Standard Plan	07/19/2018	07/19/2018

Limit Details

Member Eligibility (cont.)

- Select Expand All
 - Review Managed Care Assignment Details, MCE:
 - ✓ Anthem Blue Cross and Blue Shield (Anthem) - claim is sent to DentaQuest (*use Anthem ID#*)
 - ✓ MDwise - claim is sent to DentaQuest
 - If there is not a Managed Care assignment, the member's claim should be sent to IHCP/DXC Technology.

Finding Managed Care Entity on CoreMMIS

- If the Managed Care Entity is MDwise, use the Medicaid ID as their patient ID.

Managed Care Assignment Details			
Managed Care Program		Primary Medical Provider	Provider Phone
→ Hoosier Healthwise Managed Care		First Name Last Name	1-812-254-4650
Effective Date	End Date	MCO / CMO Name	MCO / CMO Phone
08/01/2018	08/01/2018	→ MDWISE/EXCEL NETWORK	1---

Finding Managed Care Entity on CoreMMIS

- If the Managed Care Entity is Anthem you must also use the Medicaid ID as their patient ID.

Managed Care Assignment Details			
Managed Care Program		Primary Medical Provider	Provider Phone
Hoosier Healthwise Managed Care		First Name Last Name	1-812-485-7240
Effective Date	End Date	MCO / CMO Name	MCO / CMO Phone
07/19/2018	07/19/2018	ANHEM	1-866-408-6132
Demographic Details			
Street Address 111 E Main St.			
City Sample		State Indiana	ZIP Code 44444

Anthem ID Numbers

- As of April 1, 2017, all Anthem members enrolled in Healthy Indiana Plan, Hoosier Care Connect and Hoosier Healthwise have a nine-digit ID number.
- When looking up a member on our portal or calling our Customer Service department, you will need to use the nine-digit Anthem ID number to locate the member.
- When looking up the member on CoreMMIS, you will need to use the 12-digit Medicaid ID number to locate the member.

How To Locate an Anthem ID Number on the DentaQuest Portal?

Select Patient, then select Member Eligibility. Search by the member's first and last name along with date of birth only.

DentaQuest Dentist

Welcome Home | FAQ | Sign Out

Member Eligibility Search

This functionality will allow you to perform member eligibility checks. To check eligibility, please enter a Service Date, Date of Birth and either Member Number or Member's complete last Name and at least a partial first name.

If you feel a member is eligible for service but a check indicates the member is non-eligible or it is a non-participating provider, please contact a service representative.

You no longer have to enter slashes to enter date, but you must enter must enter the 2 digit month, 2 digit day and the 4 digit year. Example: Please enter 11182012 and it will become 11/18/2012. To navigate through the screen, please use the Tab Key, not the Enter Key.

Please note this information does not guarantee or imply payment and is contingent upon other factors, including but not limited to eligibility changes, covered services and benefit limitations.

Select a Location and Provider:

Search	Service Date	Date of Birth *	Member Number	Member Last Name	Member First Name	
1	<input type="text" value="07/19/2018"/>	<input type="text" value="01/01/2001"/>	<input type="text"/>	<input type="text" value="Last Name"/>	<input type="text" value="First Name"/>	Delete
2	<input type="text" value="07/19/2018"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Delete
3	<input type="text" value="07/19/2018"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Delete
4	<input type="text" value="07/19/2018"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Delete
5	<input type="text" value="07/19/2018"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Delete

*Required Fields Search

Both the Anthem ID and Medicaid ID will show up. Make sure you use the Anthem ID on all Anthem Patient claims.

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[Home](#) > [Member Eligibility Search](#)

Member Eligibility List

This page displays the Members meeting the search criteria. You can conduct another search by clicking search again, view Member detail by clicking a Member name link, and print the results by using the Printer Friendly Format button.

Please note this information does not guarantee or imply payment and is contingent upon other factors, including but not limited to eligibility changes, covered services and benefit limitations.

Printer Friendly Format

Order Entered	Service Date	Member Number	Date of Birth	Member Name	Plan	Benefit	Client Number	Network Name	Paid Through Date	Dentist/Office Name	Dentist Effective Date
1	07/19/2018	IN0999999	01/01/2001	First Name, Last Name	- IN Anthem BCBS HHW Package A Usage	- Child	6001421034	IN HHW Medicaid			
1	07/19/2018	1019999999999 (IN0999999)	01/01/2001	First Name, Last Name	- IN Anthem BCBS HHW Package A Usage	- Child	6001421034	IN HHW Medicaid			

Ineligible

Order Entered	Service Date	Member Number	Date of Birth	Member Name
No Results Found				

Note: If you wish to search again, the information you originally entered for these members will be retained allowing you to correct any information you previously entered.



Claims

Claim Submission



Welcome Oral Surgery

Administration
Claims/Pre-Authorizations/ Referrals

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Select	Last Name	First Name	Member ID	Ac
<input type="text" value="select"/>	Doe	John	123456789123	67 Me
<input type="text" value="select"/>	Doe	John	123456789	67 Me

- Claims/Pre-Authorizations
 - Claim/Pre-Authorization Status Search
 - Explanation of Benefits
 - Dental Claim Entry
 - Dental Pre-Auth Entry

Dental Clai

If you will be sending an attachment via regular mail, do not submit the request electronically. Submit a 2012 ADA form with the attachment through the mail. Submitting electronically will result in duplicate authorization requests. We are only able to accept only 10 attachments per claim

Note the following:

How to Locate A Patient's Service History

Once you find the patient, click on their name and the below screen will appear. Click on View Service History. This is the same for a MDwise patient and an Anthem patient.

[Home](#) > [Member Eligibility Search](#) > [Member Eligibility List](#)

Member Detail

This page displays member-specific information. The drill-down options may vary depending on permissions set up by the health plan. Among options for members are the ability to edit their their address, add dependents, select PCPs, view their eligibility history, and others. If a user account has been defined, its information will be displayed. Members may also elect to share information with family or the subscriber.

Search

*Service Date (mm/dd/yyyy)

*Required Fields

Client: **IN Anthem Blue Cross Blue Shield Hoosier Healthwise - 6001421034**

Family

Member Name	Member Number
▶ First Name Last Name	19999999999
▶ First Name Last Name	IN099999

First Name Last Name

Member Number 19999999999

Date of Birth 01/01/2001 ?

Address 111 Main St. Sample, Indiana 44444 Home

Phone (812) 000-1234

Work Phone

Fax

View Of Service History

[Home](#) > [Member Eligibility Search](#) > [Member Eligibility List](#) > [Member Detail](#)

Personal Health General Info

Member Information Download File Printer Friendly Format

Member Name First Name, Last Name

Date of Birth 01/01/2001

Member ID IN0999999, 199999999999

Member Service History

Procedure Code	Procedure Code Description	Tooth/Quad/Arch	Place of Service	Service Date
D0150	comprehensive oral evaluation - new or established patient		Office	12/26/2017
D1120	prophylaxis - child		Office	12/26/2017
D1206	topical application of fluoride varnish		Office	12/26/2017

1

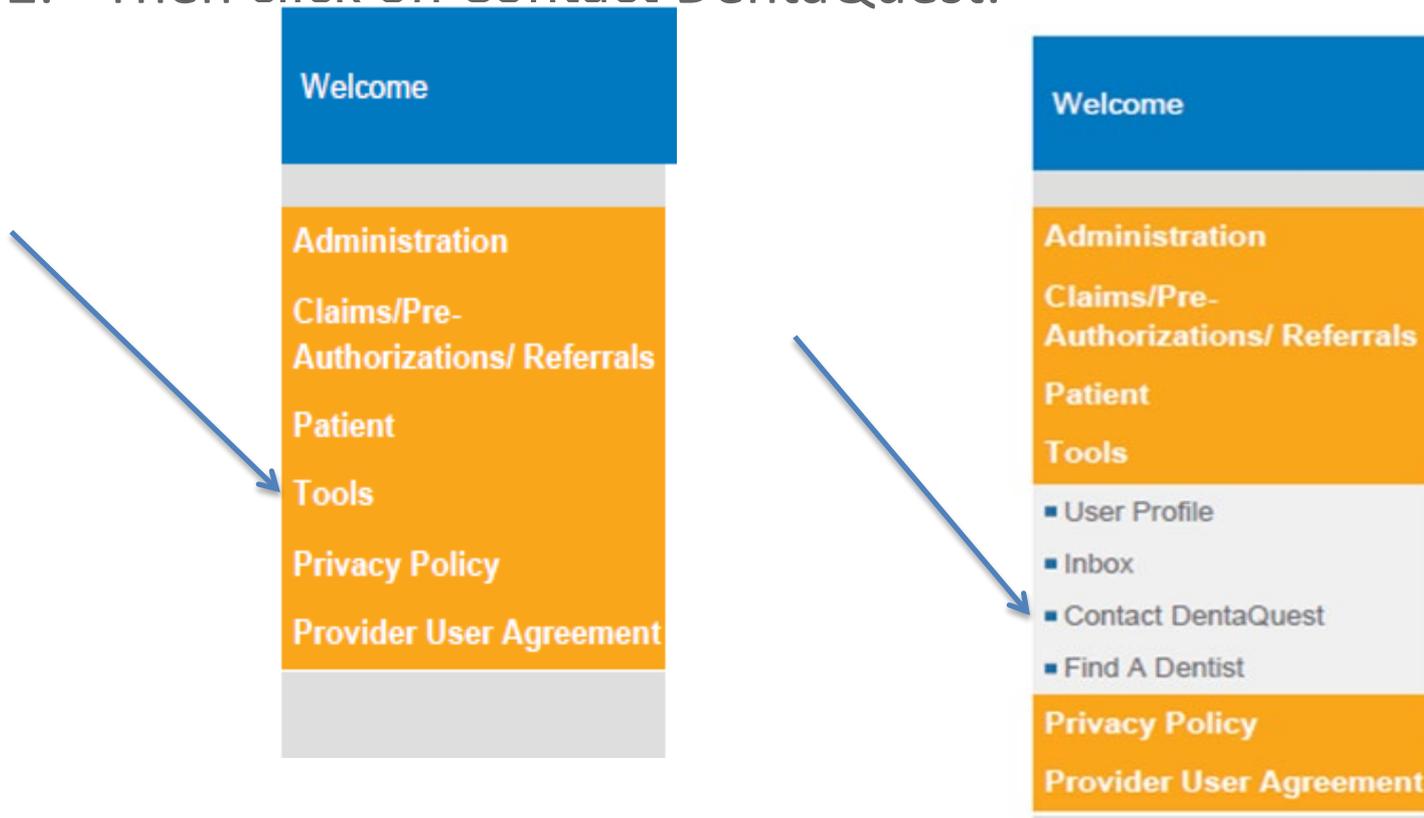
Done

When Should An Appeal Be Filed?

- Providers that disagree with determinations made by the DentaQuest dental directors may submit a written Notice of Appeal to the member's MCE that specifies the nature and rationale of the disagreement.
- An Appeal can only be determined by a Dental Director if the service was previously clinically denied.
- Eligibility issues should not go to appeals.

How To File An Appeal Through The DentaQuest Portal

1. On home screen of portal click on Tools.
2. Then click on Contact DentaQuest.



How To File An Appeal Through The DentaQuest Portal (cont.)

In the Message Type, choose Appeals.

DentaQuest **Dentist**

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Contact DentaQuest
Find A Dentist
Privacy Policy
Provider User Agreement

Contact DentaQuest

All peer to peer requests are to be discussed Dentist to Dentist regarding clinical criteria This page enables you to send secure messages to DentaQuest. Select the type of inquiry from the dropdown menu and type your question, comment, or suggestion in the comments text box. If desired, add an attachment to your message. If you need to attach more than one file, please zip up the files and upload the zip file. Clicking submit sends the message.
Please note that All peer to peer requests are to be discussed Dentist to Dentist regarding clinical criteria

Message

Your Name

* Message Type **Appeals** ?

Attachment
[Upload](#) [View](#) [Clear](#)

Claim/Pre-Authorization Number Pending Claim/Pre-Authorization Number Search

Member Name Member Number Search

Dentist Name Dentist Number Search

* Description

*Required Fields

How to File An Appeal Through The DentaQuest Portal cont.

Include attachments by clicking the upload link. Then search for the claim number by clicking on the spyglass.

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 - User Profile
 - Inbox
 - Contact DentaQuest
 - Find A Dentist
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Contact DentaQuest

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Please note that All peer to peer requests are to be discussed Dentist to Dentist regarding clinical criteria

Message

Your Name

*Message Type ?

Attachment

[Upload](#) [View](#) [Clear](#)

Claim/Pre-Authorization Number

Member Name

Dentist Name

* Description

Pending Claim/Pre-Authorization Number

Search

Member Number

Search

Search

*Required Fields

How to File An Appeal Through The DentaQuest Portal cont.

After you click on the spyglass it expands out and you can search for the claim by First and Last name and Date of Birth



Dentist

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Claim/Pre-Authorization Status Search

This page allows you to perform a Claim/Pre-Authorization Status Search. At least 1 field must be used in order to perform a search. To narrow down search results, enter as much information as possible.

You can search for old Claims and Pre-Authorizations using their old number format.
Old Claim numbers are 14 digits, Old Pre-Authorizations are 7 digits. Please enter Old Claims/Pre-Authorization numbers in the field called 'Old Claim/Pre-Authorization Number'.
This is located in in the Claim Information section below.

Search

Patient/Subscriber Information

Member First Name ?

Member Last Name ?

Member Number ? (123456)

Date of Birth ? (mm/dd/yyyy)

Claim Information

Servicing Treating Dentist

Claim/Pre-Authorization Number ? Show Related Claims

Old Claim/Pre-Authorization Number ?

Type

Claim Status

Date From ? to ?

Claim Received Date From ? to ?

How to File An Appeal Through The DentaQuest Portal cont.

Complete the rest of the searches, and then if you need to add a narrative, type it in the Description box and hit Submit.

DentaQuest

Dentist

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Administration [Home](#)

Claims/Pre-Authorizations/ Referrals

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Please note that All peer to peer requests are to be discussed Dentist to Dentist regarding clinical criteria

Message

Your Name

*Message Type ?

Attachment [Upload](#) [View](#) [Clear](#)

Claim/Pre-Authorization Number

Member Name

Dentist Name

Description

*Required Fields

Pending Claim/Pre-Authorization Number

Member Number

When and How A Claim Should Be Voided

Incomplete Claims should be voided by selecting Void in the Message Type box. The process is the same as an appeal but instead you select “Void”.

The screenshot shows the DentaQuest user interface. At the top right, there is a blue header with the DentaQuest logo and a user role indicator 'Dentist'. Below the header is a navigation bar with 'Welcome', 'Home | EAQ |', and 'Sign Out'. A left sidebar contains navigation links: Administration, Claims/Pre-Authorizations/ Referrals, Patient, Tools, User Profile, Inbox, Contact DentaQuest, Find A Dentist, Privacy Policy, and Provider User Agreement. The main content area is titled 'Contact DentaQuest' and contains instructions: 'All peer to peer requests are to be discussed Dentist to Dentist regarding clinical criteria This page enables you to send secure messages to DentaQuest. Select the type of inquiry from the dropdown menu and type your question, comment, or suggestion in the comments text box. If desired, add an attachment to your message. If you need to attach more than 1 file, please zip up the files and upload the zip file. Clicking submit sends the message. Please note that All peer to peer requests are to be discussed Dentist to Dentist regarding clinical criteria'. The 'Message' form includes a 'Your Name' field, a 'Message Type' dropdown menu with 'Void' selected, an 'Attachment' section with 'Upload View Clear' links, and search fields for 'Claim/Pre-Authorization Number', 'Pending Claim/Pre-Authorization Number', 'Member Name', 'Member Number', and 'Dentist Name', each with a 'Clear' button. A large text area for 'Description' is at the bottom, followed by 'Submit' and 'Cancel' buttons. A note at the bottom left indicates '*Required Fields'.

When To Submit A Corrected Claim

- A corrected claim is a claim that is submitted to correct an error(s) on a previously submitted claim.
- A corrected claim is different than an appeal or a void because there is no clinical or administrative disagreement or services that were not provided with the original claim.
- The sole purpose of a corrected claim is to correct a recognized error on a previously submitted claim.

How To Submit A Corrected Claim

- For example, if D2140 is submitted without a tooth number specified, the claim will be denied because a tooth number is required for that code. A new claim should be created with the proper tooth number identified and submitted with the words “Corrected Claim.” The previous claim number should be in Box 35 of the ADA claim form. The remarks might be “Corrected claim for 201812345678999 to provide missing tooth number for D2140.”
- It is imperative that a corrected claim includes either the word “Corrected” or the word “Adjusted.” Place the original claim number in Box 35 so that the DentaQuest system will recognize the claim as a corrected claim.

Example of Corrected Claim

When: If an incorrect code or fee was entered on a claim, a corrected claim can be submitted to make adjustments to the incorrect code or fee that was originally submitted.

How: In the note section of the claim, add “corrected claim” with the original claim number. Please only enter procedures that need to be corrected.

Optional Information

Accident Type

Accident State Accident Date

Office Ref# Referral #

COB EPSDT

Corrected claim # 2018000000000000

33. Missing Teeth Information (Place an 'X' on each missing tooth)	34. Diagnosis Code List Qualifier <input type="checkbox"/> <input type="checkbox"/> (ICD-9 = B; ICD-10 = AB)	31a. Other Fee(s)	\$0.00
Permanent	34a. Diagnosis Code(s) A _____ B _____	32. Total Fee	\$115.00
Primary	(Primary Diagnosis Code in 'A') C _____ D _____		
35. Remarks Corrected claim # 2018000000000000			
AUTHORIZATIONS		ANCILLARY CLAIM/TREATMENT INFORMATION	

What Does HIP Maternity Cover?

HIP Maternity has the same coverage as a HIP State Plan Plus member.

Benefit Details 			
Coverage	Description	Effective Date	End Date
HIP Maternity	HIP Maternity	04/19/2018	04/19/2018

Managed Care Assignment Details 			
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Sending a Secondary Insurance Claim

- When a patient has a primary insurance, the office has 90 days from the date the primary paid to submit the secondary claim.
- When submitting the secondary claim make sure you submit the primary EOB as well as the page that shows the denial descriptions. If this is not included we will deny the claim.
- Mark in box 35 “See Primary INS EOB attached.”

33. Missing Teeth Information (Place an 'X' on each missing tooth)	34. Diagnosis Code List Qualifier <input type="checkbox"/> <input type="checkbox"/> (ICD-9 = B; ICD-10 = AB)	31a. Other Fee(s)	\$0.00
Permanent	34a. Diagnosis Code(s) A _____ B _____	32. Total Fee	\$115.00
Primary	(Primary Diagnosis Code in 'A') C _____ D _____		
35. Remarks See Primary INS EOB attached			
AUTHORIZATIONS		ANCILLARY CLAIM/TREATMENT INFORMATION	

How Are Claims Reviewed?

There are three levels of claim review:

1. Automatic review of claims that ensure basic information is correct such as verifying the eligibility of the member.
2. If a claim requires clinical review, it is reviewed by a Clinical Review Specialist (CRS).
 - All Clinical Review Specialists are certified dental assistants or registered dental hygienists. They receive rigorous training in claims adjudication.

How Are Claims Reviewed? (cont.)

3. If a Clinical Review Specialist determines that a claim should be denied based on a clinical interpretation, the claim is sent to a licensed dentist for further review.
 - The decision to deny a claim for clinical purposes can only be made by a dentist.
 - All DentaQuest personnel involved in reviewing claims, CRSs and dentists, take quarterly examinations called Inter-Rater Reliability (IRR) tests to ensure that claims are being adjudicated in a consistent manner.

Authorization versus Prior Authorization

Authorization Required	
Yes	The service will be reviewed either before <u>or after</u> the submission of a claim.
No	The service is not routinely reviewed.
Prior Authorization Required	The service must be approved with a prior authorization before treatment begins.

Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations
D4355	full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit	21 and older		Yes	One of (D4355) per 36 Month(s) Per patient. Only one of D4355 allowed per date of service. Not billable in conjunction with D1110, D4341, D4342
D4910	periodontal maintenance procedures	21 and older		No	One of (D4910) per 6 Month(s) Per patient ages 3 to 20. One of (D4910) per 12 Month(s) Per patient ages 21 and above.

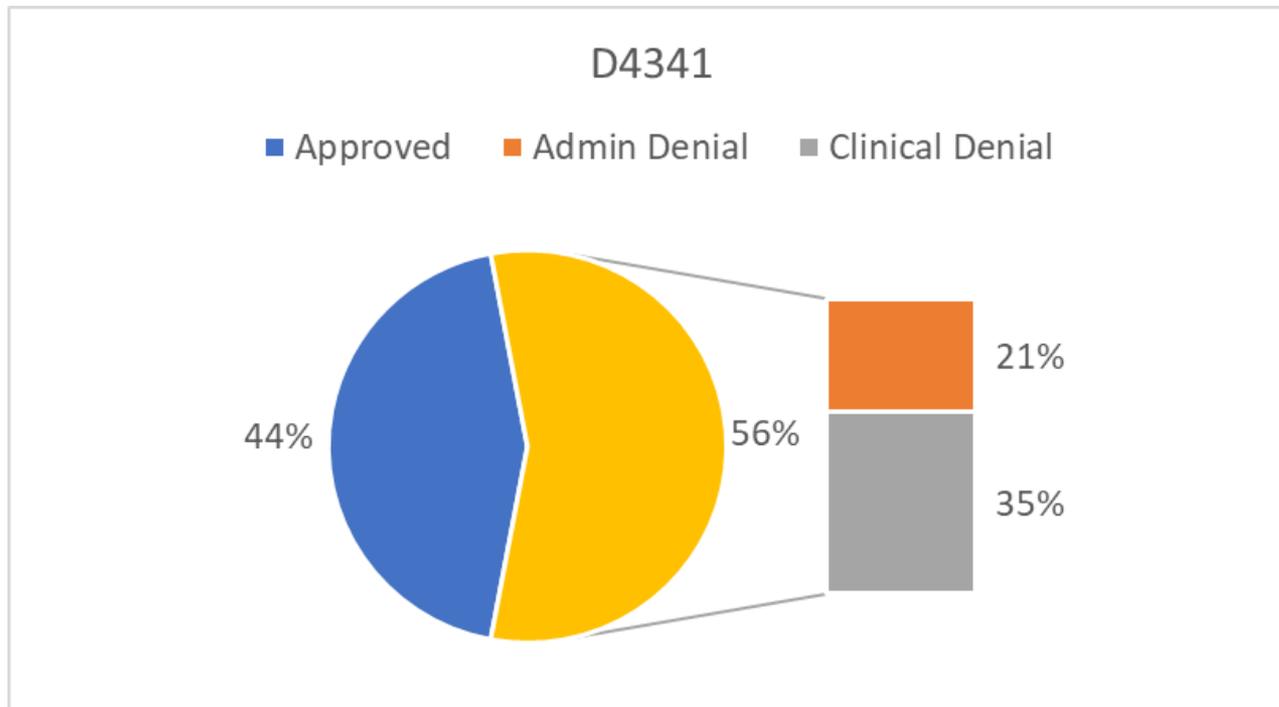
Orthodontics					
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations
D8010	limited orthodontic treatment of the primary dentition	0 - 20		Prior Authorization Required	One of (D8010) per 1 Lifetime Per patient. One per member, per lifetime.

Understanding and Minimizing Denied Claims

- Two types of denials:
 - Administrative
 - Automatic and automated
 - No human intervention
 - Duplicate service, benefit not covered, untimely filing, etc.
 - Clinical
 - Reviewed by a CRS
 - Checked by a dentist
 - Does not meet criteria for medical necessity
 - Good documentation is required

D4341 – Periodontal Scaling and Root-Planing

- Represents 19% of all services reviewed



D4341 Requirements

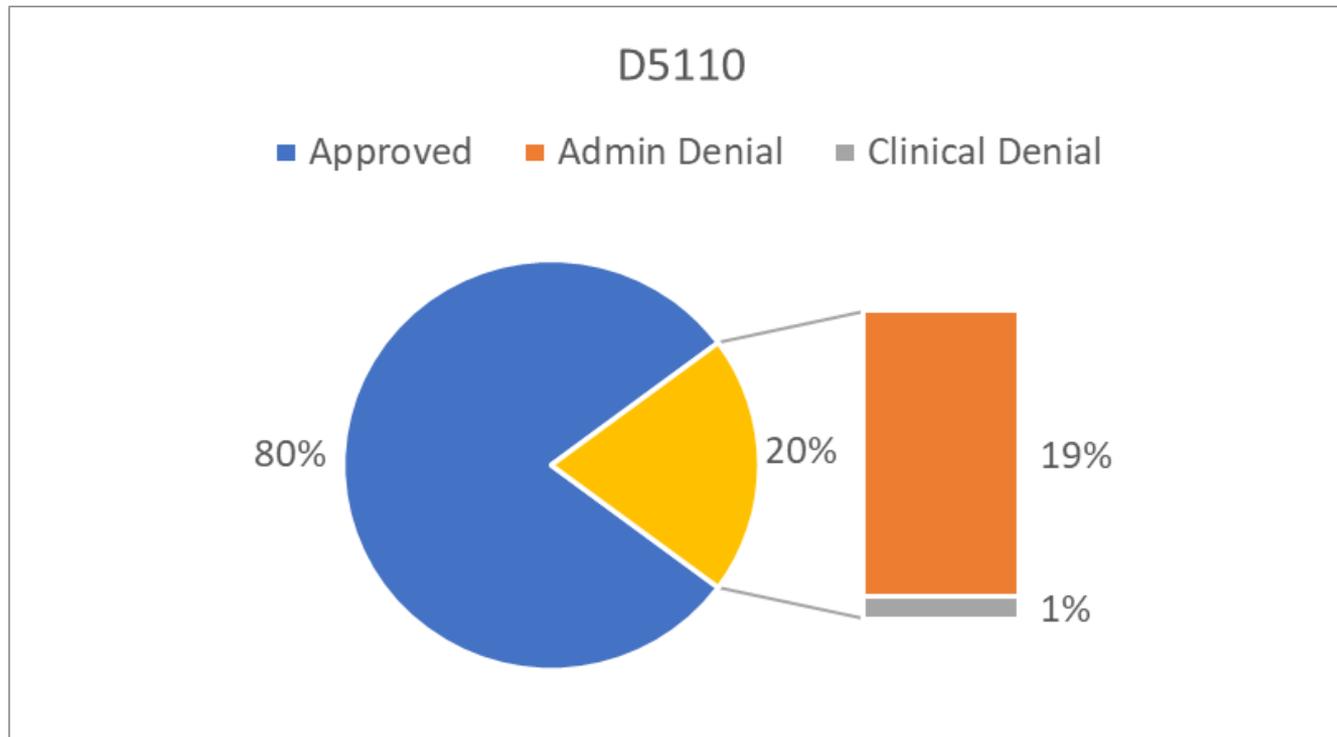
- What qualifies:

- Radiographically visible bone loss at least 2.5 mm below the CEJ on at least four teeth in the quadrant.
- Radiographically visible calculus on the root surface (not the coronal surface) on at least four teeth in the quadrant.

- What does not qualify:

- Fewer than four teeth.
- Less than 2.5 mm radiographically visible bone loss.
- Radiographically visible, subgingival calculus that is only on enamel.
- Difficulty of procedure.
- Duration of procedure.

D5110 – Complete Upper Denture



- Authorization not required
- 15% of all reviewed services
- 80% approved
- 1% of denials are clinical

Code Specific Questions

D7411D7820 D7640 D7220D7261 D2391
D776D741 D5214 D771 D572 D575191
D719910 D4341 D333 D7410 D6657 D2990
D732850 D7440 D3427 D3420 D660
D992084 D992084 D7320D5730D7472
D4260D69306 D7670 D52881
D5760D2932 D92230 D7710 D1575
D8050D8010 D29330 D3330 D7241
D7720D7610934 D4240 D7310 D2941
D82205 D91205 D8020 D6081
D323055 D334622392 D2160 D7288
D7295 D2910 D3426 D8090 311
D7730 D7730 D5212 D8020 D7485
D7650 D3222 D7280 D5110 D6951
D9223 D7780 D7929 D2933 D
D3425 D5750 D4130 D5213
D7473320 D7240 D798 D798
D798300 D5630 D3480 D3310
D7982 D7982 D7620D7415
D8080 D5226D5660 D5993
D8030 D2920 D763023D7740
D7260 D4342 D922 D7210
D2940 D4346 500 D77502
D21619 D4346 61 D77502 D5761
D5620 D7282 D32405
D42390 D741356 D512015
D4241 D92436 D2394D7280D7412

Space Maintainers

- Codes that require a tooth number
 - D1510, D1550, and D1555
- Codes that do not require a tooth number
 - D1516, D1517, D1526, and D1527
- If a tooth number is required, it needs to be in Box 27.

X-rays

- As is common in the insurance industry, DentaQuest bundles radiographs taken on or near the same date of service by the same provider or location.
- Radiographs submitted with claims must be of diagnostic value.
- Digital images are preferred and can be submitted through the DentaQuest portals or through NEA, National Electronic Attachment.
- If digital images cannot be submitted, we encourage submission of duplicate films, however they cannot be returned.
- Original films will be returned if a self-addressed stamped envelope is supplied with the claim.

X-rays (cont.)

- Photocopies of X-ray films are discouraged as they are rarely of diagnostic quality.
- Do not fax X-rays or photos of X-rays.
- Always remember to use code D0230 after the first initial PA, D0220 is taken for the year. This follows IHCP guidelines.

We want to hear from you!

DentaQuest

Proven Experts in Dental Program Administration



So Much More than...



How to Contact your Provider Engagement Representative?



- Cindy Cobb: 317-416-2022
- Melanie Brune: 317-416-2033
- Courtney Stanton: 317-432-8946
- Michelle O’Nail: 630-453-7339

Melanie Brune, 317-416-2033

melanie.brune@dentaquest.com

Counties Served: Benton, Boone, Carroll, Cass, Clinton, Fountain, Hendricks, Howard, Marion, Montgomery, Parke, Putnam, Tippecanoe, Tipton, Vermillion, Warren and White

Cindy Cobb, 317-416-2022

cindy.cobb@dentaquest.com

Counties Served: Adams, Allen, Blackford, DeKalb, Dearborn, Decatur, Delaware, Elkhart, Fayette, Franklin, Grant, Hamilton, Hancock, Henry, Huntington, Jay, Jennings, Kosciusko, LaGrange, Madison, Miami, Noble, Ohio, Randolph, Ripley, Rush, Shelby, Switzerland, Union, Wabash, Wayne, Wells and Whitley

Michelle O’Nail, 630-453-7339

Michelle.O’Nail@dentaquest.com

Counties Served: Fulton, Jasper, Lake, LaPorte, Marshall, Newton, Porter, Pulaski, Starke, and St Joseph

Courtney Stanton, 317-432-8946

courtney.stanton@dentaquest.com

Counties Served: Bartholomew, Brown, Clark, Clay, Crawford, Daviess, Dubois, Floyd, Gibson, Greene, Harrison, Harrison, Jackson, Jefferson, Johnson, Knox, Lawrence, Martin, Monroe, Morgan, Orange, Owen, Perry, Pike, Posey, Scott, Spencer, Sullivan, Vanderburgh, Vigo, Warrick, and Washington

Questions?

Please use the QR code or the weblink below to complete a survey about the session you just attended. Each session has a unique survey so be sure to complete the appropriate one for each session you attend. We will be taking your feedback from this survey to improve future IHCP events.



<https://tinyurl.com/fssa1023>