2019 IHCP Combined MCE Intro to Billing

- A joint presentation on MCE billing guidelines.

IHCP/MCE Overview

Provider Enrollment

Provider Maintenance

Eligibility/Provider Portals

Prior Authorization

Claims

Resources

IHCP Overview

- Indiana Medicaid Program commonly referred to as Indiana Health Coverage Programs provides a healthcare safety net for low-income children and adults, including those who are aged, disabled, blind, pregnant, or meet other eligibility requirements.
- The administrative rules for the IHCP including but not limited to member eligibility, provider types, and covered services are published in Titles 405 and 407 of the Indiana Administrative Code (IAC).
- The State of Indiana selected Anthem Blue Cross and Blue Shield (Anthem), CareSource, MDwise and MHS as Managed Care Entities to provide access to health care services for Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect members

MCE Overview

MCE Overview

- Under the managed care system, members are enrolled with a managed care entity (MCE), which is responsible for the members' healthcare services. Each MCE maintains its own provider network, provider services unit, and member services unit.

- All providers wanting to offer services to MCE members must first enroll with the IHCP prior to contracting with the MCEs. This provision also includes out-of-state providers.

- The MCE pays claims, performs PA, and is responsible for subrogation activities. The MCE with which the member is enrolled should be contacted for specific billing, Prior Authorization (PA), and reimbursement policies and guidelines as the MCE may have different requirements.

- The MCE is responsible for the delivery and payment of most care for its members; however, certain services are not paid by the MCE. These services, referred to as *carved-out services*, are billed for reimbursement as Fee For Service (FFS) claims.

Provider Enrollment

Provider Enrollment

- To receive reimbursement for services covered under the IHCP, including Medicaid services, a provider must be eligible and actively enrolled in the IHCP (IAC *405 IAC 5-4-1*).

- IHCP provider enrollment requirements are based on the type and specialty of the prospective provider and on rules established under *Code of Federal Regulations 42 CFR 455*, *Indiana Code IC 12-15,* and *Title 405 Office of the Secretary of Family and Social Services.*

- The enrollment effective start date is the date the Provider Enrollment Unit receives the completed IHCP provider packet or online enrollment application. As such, providers should not begin treating IHCP members until confirmation is received that the enrollment paperwork has been processed.

- *If the provider requests an enrollment effective date before the received date, federal requirements mandate that a copy of a paper claim form or remittance from a primary carrier be submitted with the application as proof of service rendered.*

Provider Enrollment Classifications

- ***Billing*** – A practitioner or facility operating under a unique taxpayer identification number (TIN). The TIN may be the practitioner's Social Security number (SSN) or a federal Employer Identification Number (EIN), but a sole proprietor's TIN may not be shared or used by any other practitioner, group, or facility.
- ***Group*** – Any practice with one or more practitioners (rendering providers) sharing a common TIN. A group may be a corporation or partnership, or any other legally defined business entity. The group must have one or more rendering providers linked to the group. Group providers must ensure that rendering providers are linked to each service location where they render services for the group practice.
- ***Rendering*** – The provider that performs the services. Reimbursement for these services is paid to the group and reported on the group's TIN.
- ***Ordering, Prescribing, and Referring (OPR)*** – Practitioners who do not bill the IHCP for services rendered but may order, prescribe, or refer services or medical supplies for IHCP members. These non-billing providers are required by the *Affordable Care Act* (*42 CFR* Parts 405, 447, 455, 457, and 498) to enroll in the Medicaid program to participate as an OPR provider.

Enrollment Classification Fields

Required for *CMS-1500*:

- Box 17b: Ordering, Prescribing, and Referring (OPR) (**If applicable**)
- Box 24J: rendering provider NPI
- Box 33: group/billing provider's **service** location on file with IHCP-complete address with complete 9-digit zip code (**no PO Box or remit address**)
- Box 33A: group billing provider NPI
- Box 33B: group billing taxonomy code

Note: The National Provider Identifier (NPI) number, Tax Identification Number (TIN) and Taxonomy Code are ***required on all claims***.

- Note: Be sure you report all of your NPI numbers and taxonomies with the State of Indiana at www.IN.gov/Medicaid.

Enrollment Classification Fields

Required for UB-04

- Box 1:billing provider **service** location name, address and expanded ZIP Code + 4
- Box 56: 10 digit NPI for the billing provider
- Box 78: Attending provider's NPI
- Box 81ccA: Billing taxonomy (required for Anthem)

Note: The National Provider Identifier (NPI) number, Tax Identification Number (TIN) and Taxonomy Code are ***required on all claims***.

- Note: Remember to attest all of your NPI numbers with the State of Indiana at www.IN.gov/Medicaid.

Claim Enrollment Rejections

- IHCP payers must be able to make a one-to-one match between the billing provider's NPI reported on the claim and one of the billing provider's service locations. When the claims processing system cannot make this match, the claim is either rejected or denied.
- It is the provider's responsibility to ensure that the enrollment information on file for that provider is complete and current, and to notify the IHCP and MCE's of any changes within 10 business days of the change.
- Failure to notify IHCP/MCE of changes can result in claim rejections and/or denials
- Rejected claims may be corrected and resubmitted.
- Anthem does not reject claims with missing or invalid information; instead claims are processed in the system and denied.

Claim Enrollment Denials

Anthem

Explanation of Benefit (EOB) codes related to enrollment include but are not limited to:

- GBA — Resubmit with the rendering provider NPI
- M52 — Provider not attested with the state
- Z01 — Entity's NPI must be used
- Z33 — Billing provider not registered with the state
- Z34 — Rendering NPI not registered with the state
- Z51 — Ordering, prescribing, referring (OPR) provider not certified

Claim Enrollment Denials

CareSource

Explanation of Benefit (EOB) codes related to enrollment include but are not limited to:

- Y10 – Missing provider ID
- KNP/OR7/IP2 – Incomplete/invalid rendering provider
- IP1 – Incomplete/Invalid ordering provider NPI
- IP3 – Incomplete/Invalid attending provider NPI
- KTA – Incomplete/Invalid rendering provider taxonomy

Claim Enrollment Denials

Explanation of Benefit (EOB) codes related to enrollment include but are not limited to:

- 272 – Coverage/program guidelines were not met (The provider has not enrolled or has not submitted a W-9 form).
- N130 – Provider may not be enrolled to perform specialized codes. Consult plan benefit documents/guidelines for information about restrictions for this service.
- N95 - This provider type/provider specialty may not bill this service.

Claim Enrollment Denial

Explanation of Benefit (EOB) codes related to enrollment include but are not limited to:

- GN – Deny: Resubmit with Individual Servicing Providers NPI in Box 24J
- tB – Deny: Rendering Provider Taxonomy Code Missing or Invalid

Additional Information for Denial Codes can be found using this link https://www.mhsindiana.com/content/dam/centene/mhsindiana/medicaid/pdfs/0917-OS-P-WM-EX-Code-Descriptions-MHS-Denial-Codes-11-17-2017.pdf

Common Rejection Codes related to enrollment:

B2 Rejection – Not enrolled with MHS with rendering NPI/TIN on DOS. Enroll with MHS and resubmit claim.

B1 Rejections – Rendering and Billing NPI are not tied on state file

Provider Maintenance

Provider Maintenance

- Providers must make changes with IHCP **prior to** making changes with the MCE's.
- Provider information updates include:
  - Address changes including mail-to, pay-to, service location or legal address
  - Tax Identification Number (TIN) changes
  - Provider specialty
  - Enrollment status (disenrollment requests)
  - Legal name or doing business as (DBA) name

Provider Maintenance

- Provider information can be updated using the Provider Maintenance Form
- This form is for physicians, providers, professionals and ancillary providers to apply for participation with Anthem Blue Cross and Blue Shield in Indiana.
- This form can also be used for non-contracted providers who are interested in joining Anthem's network.
- Questions regarding this form?
  - Call: 1-800-455-6805

Provider Maintenance

- Provider information can be updated using the Health Partner Change Request Form.
- Changes can also be submitted using the CareSource Provider Portal.
- Questions regarding this form?
  - Call: 1-844-607-2831

Provider Maintenance

- Provider information can be updated using one of the following forms:
  - Provider Update Form (for PMPs)
  - MCE Provider Enrollment/Update Form
- Questions regarding this form?
  - Call: 317-822-7300, extension 5800

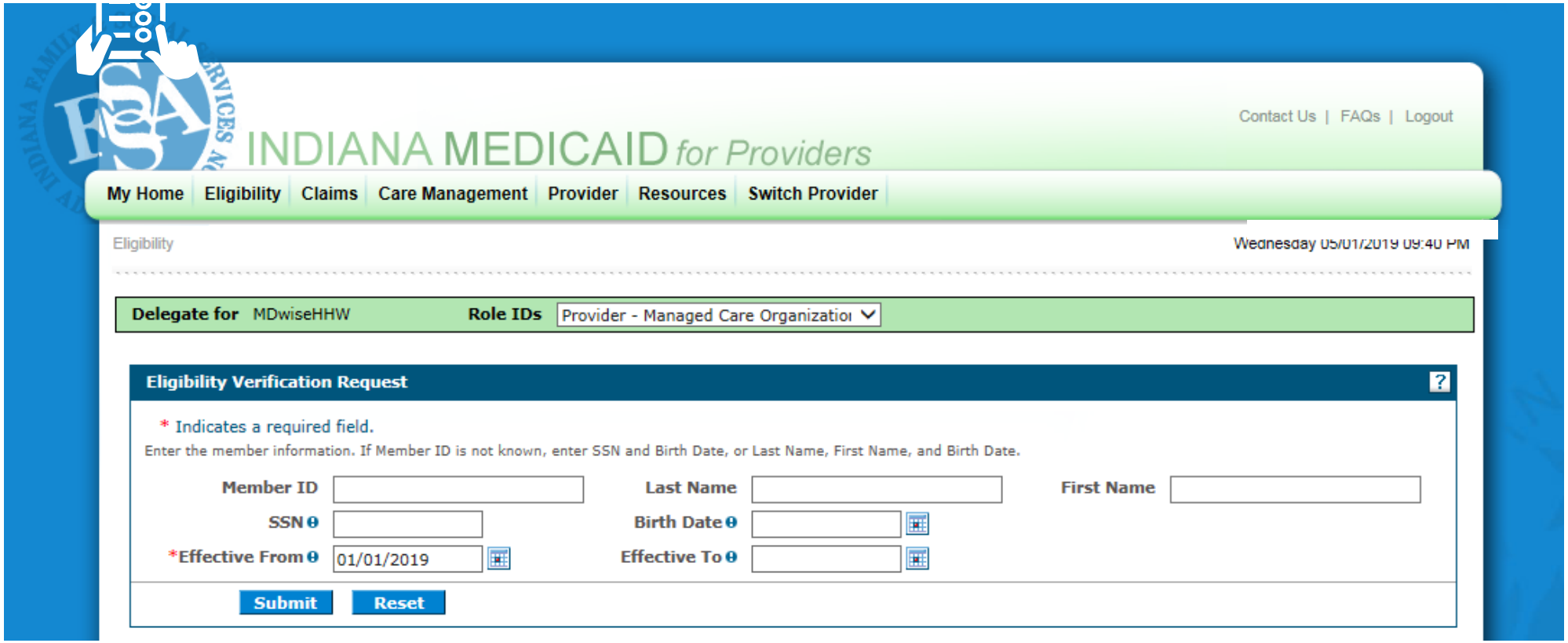
Provider Maintenance

- Provider information can be updated using the Provider Demographic Update Tool.
- Questions regarding this form:
  - Call: 1-877-647-4848

Eligibility

Eligibility

Member eligibility can be confirmed using the IHCP Provider Healthcare Portal or the MCE provider portals.



MCE Portals

- Anthem – via Availity
- CareSource
- Managed Health Services
- MDwise

Through the MCE portals providers can:

- Eligibility and Benefits Inquiry
- Claim Submission and Inquiry
- Provider Grievances and Appeals
- Authorizations
- Patient Care Summaries
- Care Management
- Access Explanation of Payment

MCE Portals

Availity is a secure multi-health plan portal that will get you the information you need instantly. It can be accessed at www.availity.com and used to do the following:

- Verify Eligibility and Benefits Inquiry
- Claim Submission and Inquiry
- Provider Grievances and Appeals
- Request authorizations
- Patient Care Summaries
- Care Management
- Access Explanation of Payment

MCE Portals

CareSource

The CareSource Provider Portal allows providers to save money and time.

Providers can access the following:

- Verify Member Eligibility
- Provider Membership Lists
- Clinical Practice Registry
- Provider Grievance
- Provider Appeals
- Submit Claims
- Claim Recovery Request
- Care Management Referral
- Provider Maintenance

MCE Portals

MDwise
A McLaren Company

The myMDwise Provider Portal allows registered providers to:

- View member eligibility information
- View member claims information
- View member PMP information
- View PMP patient rosters
- Submit requests to Care Management/Disease Management programs
- Request access to Quality Reports
- Request access to Member Health Profiles
- Contact MDwise Provider Relations securely online

MCE Portals

Providers may register at mhsindiana.com to access MHS' Secure Provider Portal, where they can:

- Manage multiple practices under one account
- Check member eligibility
- View member panels
- View medical history and gaps in care
- Submit/check authorizations
- Submit/check/adjust claims
- View HEDIS Pay for Performance Reports
- Access explanation of payments
- Communicate electronically with MHS, with one business day response time
- Access electronic copies of manuals, presentations, training material and various forms
- Access free online health library with click & print patient education material

Prior Authorization

Prior Authorization

Who determines it?

- The MCE must operate and maintain its own prior authorization requirements.
- The MCE may limit coverage based on medical necessity or utilization control criteria, provided the services furnished can reasonably be expected to achieve their purpose.
- The MCE is prohibited from arbitrarily denying or reducing the amount, duration, or scope of required services, solely because of diagnosis, type of illness, or condition.
- Remember, prior authorization is not a guarantee of payment but an authorization for the rendering of service(s).

Prior Authorization

When *is* it needed?

- Inpatient care – *always*
- Continuation of emergent care
- Surgery
- Changes in level of care
- Non-contracted providers (Anthem, CareSource, MDwise)
- Right Choices Program

And more…

When is it *not* needed?

- Preventative services
- Self-referral services
- Emergencies
- Home health post-discharge
- Preferred drug list

And more…

Prior Authorization

What are the timelines?

- All elective inpatient/outpatient services must be prior authorized at least 2 business days prior to the date of service
- All urgent and emergent services must be called into MCE within 2 business days after the admit
- Previously approved prior authorizations can be updated for changes in dates of service or CPT/HCPCS codes within 30 days of the original date of service
- Remember: Prior Authorization Appeals must be initiated within **30 calendar days (60 for MHS, 33 for MDwise)** of the denial to be considered. Please note, this is different than a claim dispute, which must be requested within **60 calendar days (67 for MHS).**

Claims

Claims

Claim Submission

Timelines:

- Contracted or In-Network providers: 90 calendar days from the date of service or discharge date.
- Non-Contracted or Out-of-Network providers: 180 calendar days from the date of service or discharge date

Exceptions:

- Newborns: Services rendered within the first 30 days of life have a 365 day timely filing limit. (CareSource members must see an in-network provider)
- Other insurance as primary: 90 days from the date of the primary remit

Claims

Claim Processing

Timelines:

- 21 days for electronic clean claims
- 30 days for paper clean claims
- Before you resubmit a paper claim, check the claim status via the portals. If there is no record of the claim, resubmit.

Note: A “clean claim” is one in which all information required for processing the claim is present.

Claims

Claim Acceptance & Adjudication (applies to all MCEs)

- System reviews claim for errors and critical fields (i.e. dates of service, billing/rendering provider, etc.) prior to acceptance.
- Regulatory requirements (federal and state) mandates certain information to be present in order to accept and pay a claim.
- NPI common rejection/denial; provider information on claim **must** match record at State – a State requirement. (SAPI)
- Depending on services or claim components, claim may need to be manually processed by claims processor.

Claims

Anthem

Claim Submission for Medical and Behavioral Health

- Online through www.Availity.com
- Paper claims:
  Anthem Blue Cross and Blue Shield
  Attn: Claims
  Mail Stop: IN999
  P.O. Box 61010
  Virginia Beach, VA 23466
- Electronic submission:
  Professional Claims: 00630
  Facility Claims: 00130

Claims

CareSource

Claim Submission

- Online through CareSource Provider Portal
- Paper claims:

  CareSource
  Attn: Claims Department
  P.O. Box 3607
  Dayton, OH 45401

- Electronic submission:

  CareSource payer ID number: **INCS1**

Claims

MDwise
A McLaren Company

Claim Submission for Medical and Behavioral Health

- Paper claims:
  MDwise/McLaren Health Plans
  P.O. Box 1575
  Flint, MI 48501

- Electronic submission:
  Hoosier Healthwise EDI/Payer ID: 3519M
  Healthy Indiana Plan EDI/Payer ID: 3135M

Claims

Claim Submission

- Online through MHS Provider Portal
- Electronic submission:

  Electronic Payer ID: 68069
- Paper claims:

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

Claim Submission for Behavioral Health

- Online through MHS Provider Portal
- Electronic submission:

  Behavioral Health Payer ID: 68068
- Paper claims:

  Managed Health Services
  P.O. Box 6800
  Farmington, MO 63640-3818

Correcting Common Claim denials

Enrollment related denials

- Verify if information on the claim matches IHCP profile

Duplicate Submission

- Verify if claim was submitted as a corrected claim

Deny PA Not Obtained/ Service requires authorization

- Verify if you are in network with the plan, the claim processed in network, the services required PA, PA number entered on the claim

Submitted after plan filing limit

- Verify if the claims was submitted as a corrected claim and received with required timeframe for corrections.

Correcting Common Claim denials cont

Services not eligible for this provider / Service not payable for provider / Not a covered service

- Verify if the service is on IHCP fee schedule and/or code set

W9 is required

- Verify if W9 is on file with the insurance

Member has other insurance information/ Resubmit with primary Explanation of Payment (EOP)

- Coordinate other benefits with insurance and submit claim with EOP

Correcting Common Claim denials cont

Member not enrolled with health plan/ Member not eligible

- Verify eligibility on IHCP profile

Claim requires valid condition code

- Verify correct condition code was used and dates are correct

Denied After Review of Patients Claim History/ Max benefit meet

- Verify benefits and utilization

Invalid or missing modifier

- Verify acceptable modifiers

Claims

- After validating claim denials verify if the denial is related to a billing error or a processing error.
- Billing errors can be corrected through correspondence/corrected claims.
- Processing errors can be corrected through disputes/appeals

Claims

Claim Adjustment (applies to all MCE's)

- A corrected claim can be submitted following IHCP claim adjustment processes.
- A claim adjustment code is required on all claims, based on the type of claim submitted.
  - Example: Frequency 7 entered in Box 22 of the CMS 1500 form.
  - Example: Frequency 7 used as the last digit for the bill type on a UB04 form (i.e. 1x7)
- The original claim number must also be listed on the corrected claim.
  - Box 22 on the CMS 1500 and box 64 on the UB04.
- Handwriting or stamping on a claim will not be accepted as submission of a corrected claim.

Claim Disputes

Claims disputes must be:

- Filed within 60-calendar days from the date on the remittance (MHS allows 67 days)
- Submitted in writing (Anthem takes verbally or through Availity, CareSource can be done via portal) – add submission information
- Completed prior to requesting an appeal

Note:

- Disputes that are not filed within the defined time frames will be denied without a review for merit.
- Disputes are available for participating and non-participating providers

Claim Appeals

Claims appeals must be:

- Be filed after the dispute decision.
- While FFS requires filing within 15 days of the date of dispute determination, Anthem and CareSource allows 30 days, MDwise allows 60 days and MHS allows 67 days.

Appeals will be resolved within 30-45 calendar days from the date of the receipt of the appeal.

All appeal decisions are final.

Claim Disputes & Appeals

Anthem

Claim Reconsideration/Payment Appeals

- Submit Reconsideration and Payment Appeals electronically at www.availity.com, through provider services.
- Mail: Anthem Blue Cross and Blue Shield
  Provider Disputes and Appeals
  P.O. Box 61599
  Virginia Beach, VA 23466
  (this address includes Claim Payment Appeals)
- Fax: 1-855-535-7445

Claim Disputes & Appeals

CareSource

Claim Disputes/Appeals

- Electronically on the CareSource Provider Portal
- Mail:
  CareSource
  Attn: Health Partner Appeals
  P.O. Box 2008
  Dayton, OH 45402
  Fax: 844-417-6262
- If you believe the claim was processed incorrectly due to incomplete, incorrect or unclear information on the claim, you should submit a corrected claim.
- Claim Dispute form: https://www.caresource.com/documents/claims-dispute-form-in-med-provider/

Claim Disputes & Appeals

MDwise
A McLaren Company

Claim Dispute (in order of process)

- Call the Provider Customer Service Unit (PCSU): 1-833-654-9192
- Submit the Claim Adjustment Request Form
- Dispute the claim by emailing the form to cdticket@mdwise.org or mailing to:

  MDwise
  P.O. Box 441423
  Indianapolis, IN 46244-1423
  Attn: Disputes

Claim Disputes & Appeals

Claim Disputes/Appeals

- Level One and Two Appeals: Must be made in writing by using the MHS informal claim dispute/objection form, available at www.mhsindiana.com/provider-forms.
- Submit all documentation supporting your objection to:

  Managed Health Services
  Attn: Appeals
  P.O. Box 3000
  Farmington, MO 63640-3800

To follow up on your dispute or appeal submission, please call 1-877-647-4848.

Claim Disputes & Appeals

Claim Disputes/Appeals

- 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.
  - The letter should explain arbitration is being requested, the reason the provider still believes the claims should be paid or adjusted, along with sufficient information to allow MHS to identify the claims and verify they have been considered at both the dispute/objection and the appeal stage prior to the arbitration request.
- Send such requests to*:

  MHS Arbitration
  550 N. Meridian Street
  Suite 101
  Indianapolis, IN 46204

*unless otherwise directed in the letter

Resources

IHCP Provider Reference Modules

- https://www.in.gov/medicaid/providers/810.htm

MCE Manuals

- Anthem: www.anthem.com/inmedicaid
- CareSource: https://www.caresource.com/documents/in-hip-hhw-health-partner-manual/
- MDwise: https://www.mdwise.org/for-providers/manual-and-overview
- MHS: https://www.mhsindiana.com/providers/resources/guides-and-manuals.html

Resources

Bulletins & Banners

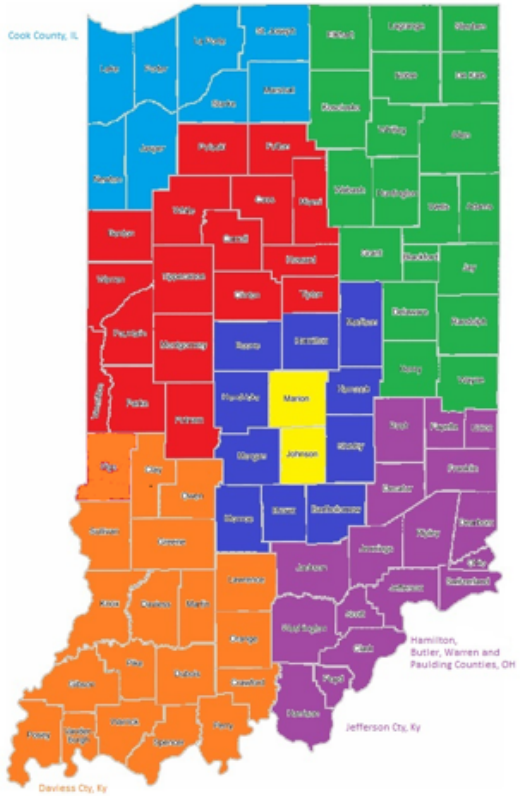
- IHCP: https://www.in.gov/medicaid/providers/737.htm
- Anthem: www.anthem.com/inmedicaid
- CareSource: https://www.caresource.com/in/providers/tools-resources/updates-announcements/medicaid/
- MDwise: https://www.mdwise.org/for-providers
- MHS: https://www.mhsindiana.com/providers/provider-news.html

Resources

Anthem

Network Relations — State of Indiana Territory Map

Northwest region	Northeast region/Parkview	Southwest region/Deaconess
Jessi Earls –Network Relations Consultant, Sr. jessica.wilkerson-earls@anthem.com 1-317-452-2568	David Tudor – Network Relations Consultant, Sr. david.tudor@anthem.com 1-317-447-7008	Jonathan Hedrick – Network Relations Consultant, Sr. jonathan.hedrick@anthem.com 1-317-601-9474
West Central region/St. Vincent	**Southeast region**	**Community health**
Angelique Jones – Network Relations Consultant, Sr. angelique.jones@anthem.com 1-317-619-9241	Sophia Brown – Network Relations Consultant, Sr. sophia.brown@anthem.com 1-317-775-9528	Ron Gibson -- Network Relations Consultant Manager rondinel.gibson@anthem.com 1-317-287-6429
Marion & Johnson/Eskenazi	**Central Region/IU Health**	
Marvin Davis marvin.davis@anthem.com 1-317-501-7251	Matt Swingendorf – Network Relations Consultant Manager matthew.swingendorf@anthem.com 317-306-0077	
Franciscan, Out of State Providers	**Indiana Provider Network Solutions**	
Nicole Bouye, Network Relations Consultant, Sr. nicole.bouye@anthem.com 1-317-517-8862	1-800-455-6805	
Management		
Jacquie Marsalis - Manager Jacqueline.Marsalis@anthem.com		



Resources

Anthem

Provider Network Relations
Behavioral Health

Michele Weaver
1-317-601-3031
Michele.Weaver@anthem.com

Alisa Phillips
1-317-517-1008
Alisa.Phillips@anthem.com

Matthew McGarry
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Resources

CareSource®

Leadership

Denise Edick, Manager, Health Partnerships
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Denise.Edick@caresource.com

Amy Williams, Team Lead, Health Partnerships
317-741-3347
Amy.Williams@caresource.com

Behavioral Health

Angelina Warren, Behavioral Health Partner Engagement Specialist
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Angelina.Warren@caresource.com

Associations & Dental

Brian Grcevich, Ancillary, Associations and Dental
317-296-0519
Brian.Grcevich@caresource.com

Contracting Managers – Hospitals/Large Health Systems

Tenise Hill – North
317-220-0861
Terise.Hill@caresource.com

Mandy Bratton – South
317-209-4404
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Regional Representatives

Sylvia Vargas
219-713-7775
Sylvia.Vargas@caresource.com
Franciscan Alliance, St. Joseph Regional Medical Center

Cathy Pollick
260-403-8657
Catherine.Pollick@caresource.com
Parkview, Lutheran

Tonya Thompson
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Maria Crawford
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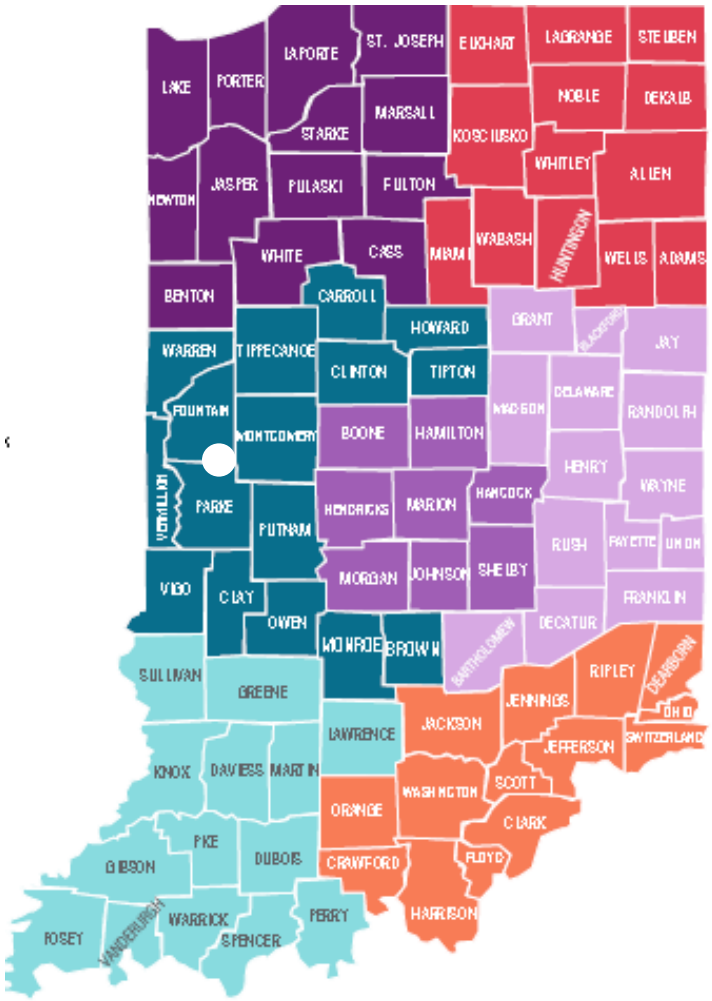
Indiana University, Suburban Health Organization

Jeni Little
765-993-7118
Jennifer.Little@caresource.com
Community Health Network, Eskenazi

Bonnie Waelde
812-454-5832
Bonnie.Waelde@caresource.com
Deaconess & St. Vincent Health

Paula Garrett
812-447-6661
Paula.Garrett@caresource.com
KentuckyOne, Norton, Baptist Health Floyd



Resources

MDwise
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Region 1
Paulette Means
pmeans@mdwise.org
317-822-7490

Region 2
T. A. Ward
tward@mdwise.org
317-983-6137

Region 3
Michelle Phillips
mphillips@mdwise.org
317-983-7819
(Home Health & Hospice)

Region 4
Jamaal Wade
jwade@mdwise.org
317-822-7276

Region 5
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317-983-7823

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

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

Region 8
Sean O'Brien
sobrien@mdwise.org
317-308-7344

Region 9
Whitney Burnes
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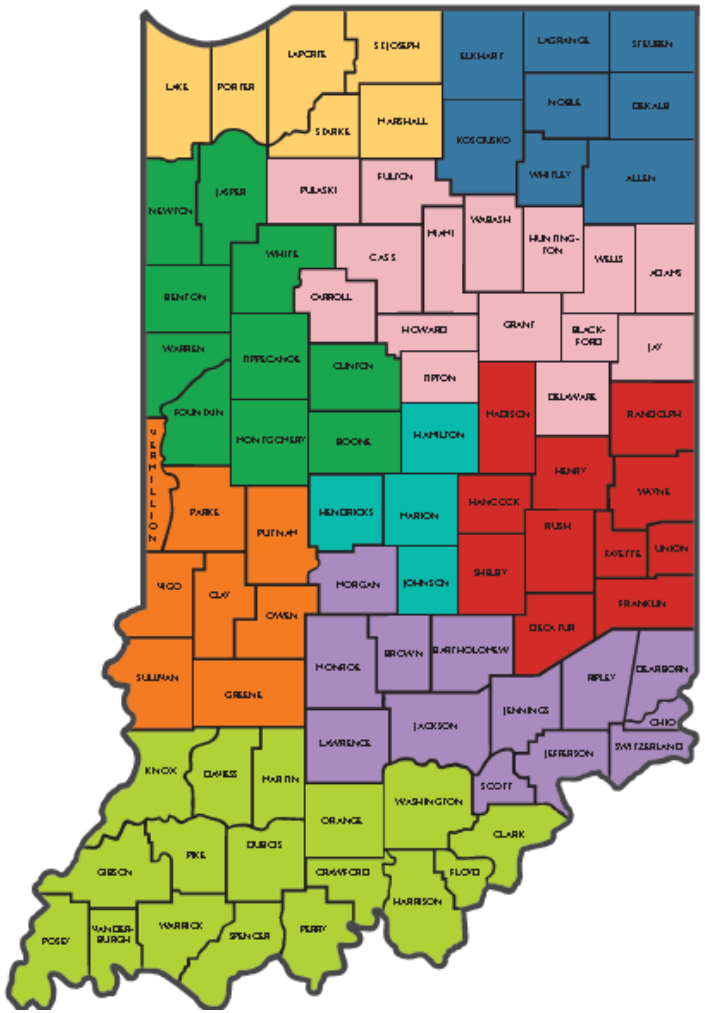
317-308-7345

Nichole Young, RN
nyoung@mdwise.org
317-822-7509
(Behavioral Health - CMHCs, OTPs, MDs, Residential)



Resources

Territory Map

NORTHEAST REGION

Claims Issues: MHS_ProviderRelations_NE@mhsindiana.com
Chad Pratt, Provider Partnership Associate
1-877-647-4848 ext. 20454
ripratt@mhsindiana.com

CENTRAL REGION

Claims Issues: MHS_ProviderRelations_C@mhsindiana.com
Esther Cervantes, Provider Partnership Associate
1-877-647-4848 ext. 20947
Estherling.A.PimentelCervantes@mhsindiana.com

NORTHWEST REGION

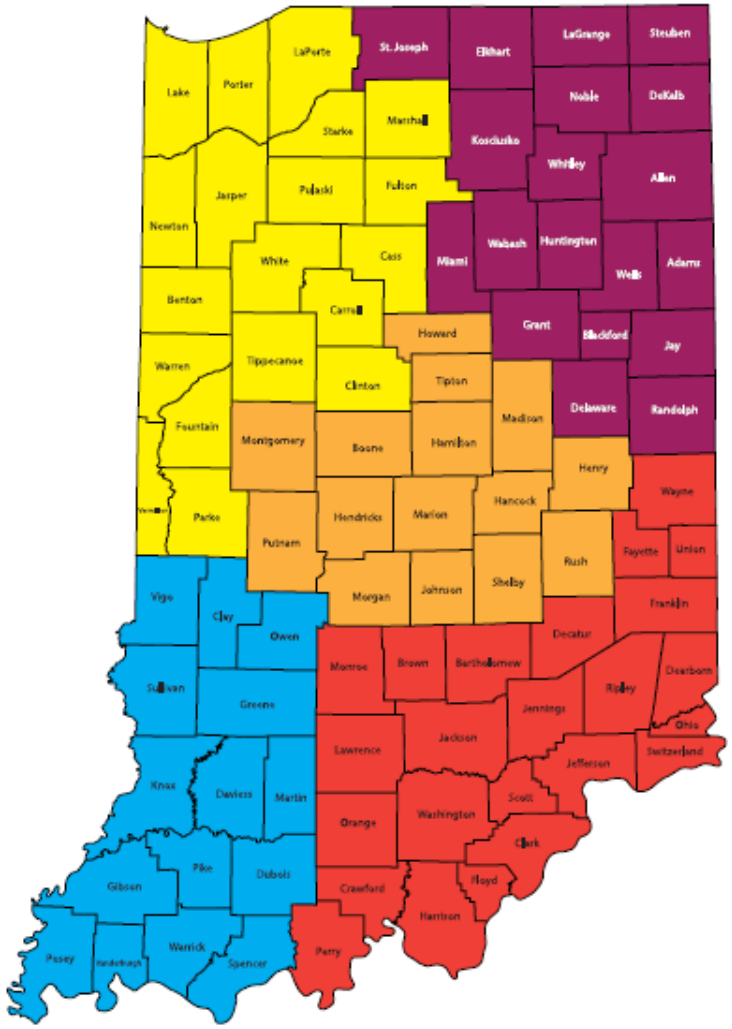
Claims Issues: MHS_ProviderRelations_NW@mhsindiana.com
Candace Ervin, Provider Partnership Associate
1-877-647-4848 ext. 20187
Candace.V.Ervin@mhsindiana.com

SOUTHWEST REGION

Claims Issues: MHS_ProviderRelations_SW@mhsindiana.com
Dawn McCarty, Provider Partnership Associate
1-877-647-4848 ext. 20117
Dawnalee.A.McCarty@mhsindiana.com

SOUTHEAST REGION

Claims Issues: MHS_ProviderRelations_SE@mhsindiana.com
1-877-647-4848



Resources

Territory Map

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Community Care Network
Franciscan Alliance
Goshen Health System
HealthLinc
Heart City Health Center
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Lutheran Medical Group
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Good Samaritan Hospital Physician Services
HealthNet
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Thank You!

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