IHCP Provider

Monthly News

Indiana Health Coverage Programs

http://www.indianamedicaid.com

What's New Inside!

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Common Abbreviations Used in this Newsletter

ACN	Attachment Control Number
ADA	American Dental Association
ASC	Ambulatory Surgical Centers
AVR	Automated Voice Response
CFR	Code of Federal Regulations
CMS	Centers for Medicare & Medicaid Services
COB	Coordination of Benefits
CPS	Child Protective Services
CPT	Current Procedural Terminology
DCS	Department of Child Services
DFR	Division of Family Resources
DME	Durable Medical Equipment
EDI	Electronic Data Interchange
EDS	Electronic Data Systems
EOB	Explanation of Benefits
EOMB	Explanation of Medicare Benefits
EPSDT	Early Periodic Screening, Diagnosis, and Treatment
EVS	Eligibility Verification Systems
HCE	Health Care Excel
HCPCS	Healthcare Common Procedure Coding System
HIPAA	Health Insurance Portability & Accountability Act
ICN	Internal Control Number
IHCP	Indiana Health Coverage Programs
LC	Limited Corporation
LPI	Legacy Provider Identifier
MAC	Maximum Allowable Cost
MAR	Management and Administrative Reporting
MCO	Managed Care Organization
MHS	Managed Health Services
MRO	Medicaid Rehabilitation Option
NDC	National Drug Code
NOA	Notice of Action
NPI	National Provider Identifier
NPPES	National Plan and Provider Enumeration System
NTIOL	New Technology Intraocular Lenses
NUBC	National Uniform Billing Committee
NUCC	National Uniform Claim Committee
OMPP	Office of Medicaid Policy and Planning
PA	Prior Authorization
PMP	Primary Medical Provider
PRTF	Psychiatric Residential Treatment Facility
RA	Remittance Advice
RBMC	Risk-Based Managed Care
SSN	Social Security Number
SUR	Surveillance and Utilization Review
TIN	Tax Identification Number
TPL	Third-Party Liability
VAN	Value-Added Network
V-CAN	Voluntary Community Assistance Network

All Provider News

New Bulletins and Updated Manuals Posted to the IHCP Web Site

The following bulletins and updated manuals were posted to the Indiana Health Coverage Programs (IHCP) Web site in October and November:

- *BT200728 – Annual Hospice Rates Effective October 1, 2007*
- *BT200729 – Employee Education About False Claims Recovery*
- *BT200730 – Healthy Indiana Plan (HIP)*
- *BT200731 – Federal Deficit Reduction Act of 2005, National Drug Codes Required for Billing Procedure Codes on Institutional Outpatient Claims*
- *BT200732 – New Enrollment Broker*
- *Medicaid Rehabilitation Option Provider Manual*
- *HealthWatch Early Periodic Screening, Diagnosis, and Treatment Provider Manual*

A complete list of bulletins is available on the IHCP Web site at http://www.indianamedicaid.com/ihcp/Publications/bulletin_results.asp. E-mail notifications are sent to subscribers as new bulletins are posted. To subscribe, visit the IHCP Web site at http://www.indianamedicaid.com/ihcp/mailing_list/default.asp and click **Open New Account**.

To access the Explanation of Benefits (EOB) codes from the IHCP Web site, click **Provider Services** and then click **EOB descriptions**. Follow the directions at the top of the EOB Web page to print or download the EOB list.

Limits and Restrictions for Depo-Provera Contraceptive Injection

The following changes will be made 45 days after the initial publication of this article. The following changes will be retroactive to January 1, 2005, for Healthcare Common Procedure Coding System (HCPCS) code J1055-*Injection, medroxyprogesterone acetate for contraceptive use, 150 mg*.

- Gender indicator will be changed to "Female."
- Allowable units per date of service (DOS) will be limited to one.

According to the U.S. Food and Drug Administration (FDA), Depo-Provera Contraceptive Injection (CI) is a long-term contraceptive for women and is indicated only for the prevention of pregnancy. The recommended dose to women is 150 mg every three months. An appropriate HCPCS code for billing medroxyprogesterone for non-contraceptive use is J1051-*Injection, medroxyprogesterone acetate, 50 mg.* Code J1051 may be billed for multiple units, per member, on a single DOS.

Voids and Replacements

An paper adjustment request for a previously paid claim can be submitted only when an incorrect or partial payment has been made on a claim, including a claim that incorrectly paid zero dollars. Please note that claims in a **denied** status **cannot** be adjusted unless performed via Web interChange.

The denied claim must be submitted as a new day claim. In addition, line item denials for paid CMS-1500, Pharmacy, and American Dental Association (ADA) Dental Claim forms can be billed as a new claim to the correct claims processing address. Therefore, it is not necessary for the claim to be submitted as an adjustment. Please refer to the *IHCP Provider Manual, Chapter 10*, for exceptions to this policy. When a paper adjustment request is submitted to the Adjustment Unit for processing, the request is reviewed for the following information:

- The claim internal control number (ICN) represents the most recent activity for the claim to be adjusted.
- If the claim or detail has been denied for a limitation audit, the claim cannot be processed through the Adjustment Unit.
- If you are correcting the number of units billed, ensure that the billed amount for the claim detail is reflective of the appropriate billed amount for the units on the claim.
- Each claim must have its own adjustment request form.
- If you are adjusting claim details, ensure that the adjustment request represents all changes for the claim. You cannot submit multiple adjustment forms for multiple details on the same claim.
- If you are submitting a request to remove a third-party liability (TPL) amount, please attach the Explanation of Benefits to support the removal of the TPL amount.
- Adjustment requests that are submitted beyond the one-year filing limit must be submitted with supporting documentation.

As a reminder, providers are always encouraged to perform voids and replacements to paid claims by using Web interChange.

Prior Authorization Transition from HCE

Beginning November 1, 2007, the prior authorization (PA) function will transition from Health Care Excel (HCE) to the entities identified in Table 1.

Table 1 – Prior Authorization Transition

PA Entities	Program	Contact Information
ADVANTAGE Health Solutions, Inc. SM	Traditional Medicaid, Medicaid Select, Hoosier Healthwise Carve-Outs (RBMC)	P.O. Box 40789 Indianapolis, IN 46240 1-800-269-5720
ADVANTAGE Health Solutions, Inc. SM	*Care Select* - Care Management Organization (CMO)	P.O. Box 80068 Indianapolis, IN 46280 1-800-784-3981
MDwise	*Care Select* - Care Management Organization (CMO)	P.O. Box 44214 Indianapolis, IN 46244-0214 1-866-440-2449

The aforementioned information was originally published in provider bulletin *BT200723*. It is important for all providers to understand that this change impacts *all* IHCP providers requesting PA. Providers must contact the member's CMO regarding PA and restricted card services when a member is enrolled in the *Care Select* program. The correct CMO can be verified using one of the available Eligibility Verification Systems (EVS). If an EVS does not identify specific CMO information, then the provider must determine the IHCP program with which the member is associated.

Please note that based on the above table, ADVANTAGE Health Solutions SM plays multiple roles in the PA process. The organization will process PA for *Care Select* members who are assigned to a primary medical provider (PMP) contracted with their organization and will *also* process PA requests for members who are assigned to Traditional Medicaid, *Medicaid Select,* and Hoosier Healthwise carve-out services (RBMC) when the member is not in *Care Select.* (*Care Select* does not have carve-out services.) Because ADVANTAGE Health Solutions is processing PAs in two different capacities, they have designated two separate P.O. Boxes for submitting PA requests. It is important for providers to ensure that PA requests are mailed to the correct P.O. Box for the applicable program.

HCE accepted new and updated PA requests through 6 p.m. October 31, 2007. After this date, HCE's PA telephone and fax numbers will be disconnected. HCE can still be contacted at 317-347-4500 for information about PAs that were submitted to HCE. Providers must submit all PA requests to the appropriate PA vendor on or after November 1, 2007.

VFC Flu Vaccine

It is now the start of flu season. To address the need for immunizations and to deal with potential shortage of available influenza vaccines, the IHCP is not limiting reimbursement for any influenza vaccines, regardless of availability from the Vaccines for Children (VFC) program. This policy allows providers to obtain reimbursement for using a privately purchased influenza vaccine for VFC eligible members, even if they do not have a VFC vaccine available due to delays in receipt of the VFC supply.

If a provider administers a free VFC vaccine, the provider should bill the appropriate Current Procedural Terminology (CPT) procedure code, but not charge more than the $8 VFC vaccine administration fee and not bill the separate administration CPT code. This policy is effective October 1, 2007.

When administering a privately purchased influenza vaccine, providers may bill for both the cost of the vaccine and administration. The IHCP allowable reimbursement is based on the average wholesale price (AWP) of the vaccine. Providers may separately bill an appropriate CPT administration code, 90772-90774, 90779, in addition to the HCPCS J-code or CPT drug code.

If an evaluation and management (E&M) code is billed with the same date of service as an office-administered drug, the provider should not bill a drug administration code separately. Reimbursement for

administration is included in the E&M code allowed amount. Separate reimbursement is allowed when the administration of the drug is the only service billed by the practitioner. In addition, if more than one injection is given on the same date of service and no E&M code is billed, providers may bill a separate administration fee for each injection using 90772 or 90779 as appropriate.

Providers must continue to submit claims to the appropriate delivery system – EDS or MCO – for each member regardless of the source of the vaccine stock. Claims are eligible for post-payment review and providers must maintain documentation and invoices related to private stock when substituting for VFC vaccine. Rural health clinic (RHC) and Federally Qualified Health Center (FQHC) rates include payment for both the vaccine and administration fee.

The *Federal Deficit Reduction Act of 2005* mandates that IHCP require the submission of National Drug Codes (NDCs) on claims submitted with certain procedure codes for physician-administered drugs. This mandate affects all providers who submit electronic or paper claims for procedure-coded drugs. This applies to professional claims, including the paper CMS-1500 and electronic 837P. Providers can obtain additional information from *BT200713*.

Written Correspondence Inquiries

Inquiries about claims can most often be addressed by contacting the EDS Customer Assistance Unit at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278. However, EDS recognizes that some inquiries are complex and better addressed by written correspondence. The Written Correspondence Unit is available to research individual claims and denials for providers experiencing difficulty in receiving claim payment.

If large numbers of claims are involved or providers notice recurring issues with claims, please contact Provider Relations for resolution. Your Provider Relations field consultant can assist you with issues that cannot be easily explained within a letter. You can find your field consultant on the IHCP Web site at http://www.indianamedicaid.com/ihcp/ProviderServices/pr_list_frameset.htm.

Inquiries should not be used to submit new claims or resubmit claims previously rejected. Denied claims should be corrected and then resubmitted electronically or directly to the appropriate claims processing post office box address. Written Correspondence analysts have a 10-day requirement to process incoming correspondence. Submitting claims to Written Correspondence to forward instead of the claims post office box delays adjudication of claims.

How to Obtain the Written Correspondence Form

A copy of the *Indiana Health Coverage Programs Inquiry* form is included on the last page of this newsletter and can be copied for use. This form is also available on the IHCP Web site at http://www.indianamedicaid.com/ihcp/Publications/forms.asp. This form is found under the sub-heading *Provider Correspondence Forms* and should accompany all written inquiries.

How to Submit the IHCP Inquiry Form

Written inquiries submitted on the *Indiana Health Coverage Programs Inquiry* form ensure the Written Correspondence analyst has all the information necessary to research the inquiry. Please limit requests to one per form, and include all the necessary information on the form for research by EDS:

- Your facility's IHCP billing provider number (Legacy Provider Identifier) and name
- The member's name and member identification (RID) number
- The dates of service in question
- The billed amount of the claim
- The original or copy of the claim form and all necessary documentation is attached

The more information provided about the history of a particular issue, the more easily an analyst can reach the resolution. Copies of claims and attachments submitted for special processing must be included with the written inquiry form.

For tracking purposes, responses to inquiries are assigned a letter control number (LCN) on receipt. The LCN, located at the bottom of the response you receive from Written Correspondence, should be referenced in any subsequent correspondence with the IHCP about the inquiry.

All completed written inquiry forms should be mailed to the following address:

EDS Written Correspondence
P. O. Box 7263
Indianapolis, IN 46207-7263

Administrative Reviews and Appeals

Prior to filing an administrative review request or an appeal to the Written Correspondence Unit, the provider must exhaust the following routine measures to receive claim payment:

- On receipt of the claim denial, the provider must review the denial, make applicable corrections, and resubmit the claim through the routine claim-processing channels.
- Call the Customer Assistance Unit with initial questions.
- If the claim is paid and the provider disagrees with the reimbursement, the provider must submit an adjustment request with documentation stating why the provider disagrees with the reimbursement.

If the provider receives the same results following the two previous initial steps, the provider can file a formal administrative review request by completing an *Indiana Health Coverage Programs Inquiry* form stating the reason for disagreement with the denial or amount of reimbursement. The provider must note the words *Administrative Review* clearly on the form and attach all pertinent documentation. The formal administrative review request must be filed within seven days of notification of claim payment or denial from EDS. The provider sends the information to the following address:

EDS Administrative Review
Written Correspondence
P.O. Box 7263
Indianapolis, IN 46207-7263

After all the procedures required for an administrative review have been exhausted, if the provider is still not satisfied with the determination, send a request for an appeal within 15 days of receipt of the final administrative decision, to the following address:

MS27, IFSSA Office of General Counsel
Attn: IHCP Provider Claim Appeals
402 W. Washington Street, Room W451
Indianapolis, IN 46204

For more claim reimbursement administrative review and appeal procedures, refer to *Chapter 10, Section 6* in the *IHCP Provider Manual*.

Fraud and Abuse

If you feel that members are abusing their Medicaid privileges, this information should not be reported to Written Correspondence. Instead, please report this information to the following agencies:

Health Care Excel Surveillance and Utilization Review Department
P.O. Box 531700
Indianapolis, IN 46253-1700

Health Care Excel Provider and Member Concern Line (Fraud and Abuse)
(317) 347-4527
1-800-457-4515

Medicaid Fraud Control Unit
8005 Castleway Drive
Indianapolis, IN 46250-1946
(317) 915-5303

NPI Enrollment at 54.8 Percent

National Provider Identifier (NPI) enrollment is growing, currently reaching **54.8 percent** of active IHCP providers. As we approach Phase III, or mandated use of the NPI, please make sure you are enrolled.

When Phase III is implemented, claims must be submitted with an NPI number. If you do not have an NPI please apply for your NPI and report your NPI to the IHCP via the NPI online reporting tool to prevent claim denials for invalid provider number.

Obtain an NPI today using one of the following options:

- Access the NPI application online at https://nppes.cms.hhs.gov/
- Request a paper application by calling the NPI enumerator (Fox Systems) toll-free at 1-800-465-3203
- Mail the completed application to the NPI enumerator at the following address:

  NPI Enumerator
  P.O. Box 6059
  Fargo, ND 58108-6059

- Access additional NPI information and report your NPI to the IHCP from the IHCP Web site at www.indianamedicaid.com

Qualified Medicare Beneficiary

There are three types of Qualified Medicare Beneficiary (QMB) eligibility categories for members. It is important for providers to understand differences in coverage for the three categories. Understanding the differences will ensure that providers receive appropriate payment from Medicaid, Medicare, and the member.

QMB-Only

The first category is QMB-Only. This means the member's benefits are limited to payment of the member's Medicare premiums, deductibles, and co-insurance for Medicare covered services only. Services not covered by Medicare are the member's responsibility. Upon verifying eligibility, the provider should tell the member that the service is not covered by Medicaid based on their eligibility and aid category.

If the member chooses to have the service performed, the provider should then follow the billing guidelines established in *Chapter 4* of the *IHCP Provider Manual* which include having the member sign a waiver acknowledging financial responsibility for the non-covered service. Items such as dental, routine physicals, hearing aids, and eyeglasses are typically not covered by Medicare. However, a provider should contact Medicare to confirm medical coverage.

QMB-Also without Spend-down

QMB-Also coverage without spend-down is the second QMB category. This means that the member's benefits include payment of the member's Medicare premiums, deductibles, and co-insurance on Medicare-covered services in addition to reimbursement for covered Traditional Medicaid services. For these members, claims not covered by Medicare should be submitted as regular Medicaid claims and not as crossover claims.

QMB-Also with Spend-down

QMB-Also coverage with spend-down means that the member's benefits include payment of the member's Medicare premiums, deductibles, and co-insurance on Medicare-covered services in addition to Traditional Medicaid benefits after the member has satisfied their spend-down amount. It is important to note that claims may process toward the member's spend-down amount. On claims processed toward a member's spend-down, the remittance advice will identify the dollar amount credited to spend down beside *ARC 178*.

Contact Information

A map of provider representative territories and updated information about the provider field consultants are available on the IHCP Web site at http://www.indianamedicaid.com/ihcp/ProviderServices/pr_list_frameset.htm. The *Indiana Health Coverage Programs Quick Reference* is available on the IHCP Web site at http://www.indianamedicaid.com/ihcp/Misc_PDF/Quick_Reference.pdf. These Web documents are updated whenever changes occur.

Provider Relations Field Consultants

Territory Number	Provider Relations Consultant	Telephone	Counties Served
1	Jean Downs	(317) 488-5071	Jasper, Lake, LaPorte, Newton, Porter, Pulaski, Starke
2	Rhonda Rupel	(317) 488-5080	Allen, Dekalb, Elkhart, Fulton, Kosciusko, Lagrange, Marshall, Noble, St. Joseph, Steuben, Whitley
3	Tawanna Danzie	(317) 488-5197	Benton, Boone, Carroll, Cass, Clinton, Fountain, Hamilton, Howard, Miami, Montgomery, Tippecanoe, Tipton, Warren, White
4	Daryl Davidson	(317) 488-5388	Adams, Blackford, Delaware, Grant, Hancock, Henry, Huntington, Jay, Madison, Randolph, Wabash, Wayne, Wells
5	Bill Woodruff	(317) 488-5098	Marion
6	Shantel Silnes	(317) 488-5123	Bartholomew, Brown, Clark, Dearborn, Decatur, Fayette, Floyd, Franklin, Harrison, Jackson, Jefferson, Jennings, Ohio, Ripley, Rush, Scott, Shelby, Switzerland, Union, Washington
7	Virginia Hudson	(317) 488-5148	Clay, Greene, Johnson, Hendricks, Lawrence, Monroe, Morgan, Owen, Parke, Putnam, Sullivan, Vermillion, Vigo
8	Ken Guth	(317) 488-5153	Crawford, Daviess, Dubois, Gibson, Knox, Martin, Orange, Perry, Pike, Posey, Spencer, Vanderburgh, Warrick
9	Tawanna Danzie	(317) 488-5197	Out-of-State

Provider Relations Field Consultants for Bordering States

State	City	Provider Relations Consultant	Telephone
Illinois	Chicago/Watseka	Jean Downs	(317) 488-5071
	Danville	Virginia Hudson	(317) 488-5148
Kentucky	Owensboro	Ken Guth	(317) 488-5153
Kentucky	Louisville	Shantel Silnes	(317) 488-5123
Michigan	Sturgis	Rhonda Rupel	(317) 488-5080
Ohio	Cincinnati/Hamilton/Harrison/Oxford	Shantel Silnes	(317) 488-5123

Out-of-state providers not located in these states, or those with a designated out-of-state billing office supporting multiple provider sites throughout Indiana, should direct calls to (317) 488-5197.

For Provider Concerns

Name	Title	Telephone
Tina King	Provider Relations Supervisor	(317) 488-5154

Indiana Health Coverage Programs Quick Reference

Assistance, Enrollment, Eligibility, Help Desks, and Prior Authorization

AVR System (including eligibility verification) (317) 692-0819 1-800-738-6770	EDS Administrative Review Written Correspondence P.O. Box 7263 Indianapolis, IN 46207-7263	EDS Customer Assistance (317) 655-3240 1-800-577-1278 Opt 1 = Pharmacy, Opt 2 = First Steps	EDS Electronic Solutions Help Desk (317) 488-5160 or 1-877-877-5182 INXIXElectronicSolution@eds.com
EDS Forms Requests P.O. Box 7263 Indianapolis, IN 46207-7263	EDS Member Hotline (317) 713-9627 1-800-457-4584 Opt 1 = First Steps, Opt 2 = Pharmacy	EDS Omni Help Desk (317) 488-5051 1-800-284-3548	EDS Provider Written Correspondence P.O. Box 7263 Indianapolis, IN 46207-7263
EDS Provider Enrollment and Waiver P.O. Box 7263 Indianapolis, IN 46207-7263 1-877-707-5750	EDS TPL (317) 488-5046 1-800-457-4510 Fax (317) 488-5217	HCE Medical Policy Department P.O. Box 53380 Indianapolis, IN 46253-0380 (317) 347-4500	Advantage Health Solutions Prior Authorization – FFS P.O. Box 40789 Indianapolis, IN 46240 1-800-269-5720 Fax: 1-800-689-2759
HCE Provider and Member Concern Line (Fraud and Abuse) (317) 347-4527 1-800-457-4515	HCE SUR Department P.O. Box 531700 Indianapolis, IN 46253-1700 (317) 347-4527 or 1-800-457-4515	IHCP Web Site http://www.indianamedicaid.com	

Pharmacy Services Contact Information

ACS Drug Rebate ACS State Healthcare ACS – Indiana Drug Rebate P. O. Box 2011332 Dallas, TX 75320-1332	EDS Pharmacy Services Help Desk for POS Claims Processing (317) 655-3240 1-800-577-1278 or INXIXPharmacy@EDS.com	EDS Pharmacy Claims P.O. Box 7268 Indianapolis, IN 46207-7268	EDS Pharmacy Claims Adjustments P.O. Box 7265 Indianapolis, IN 46207-7265
Pharmacy Benefit Management Inquiries PDL@fssa.state.in.us	Indiana Administrative Review/ Pharmacy Claims EDS Pharmacy Claims Admin. Review P.O. Box 7263 Indianapolis, IN 46207-7263	PA For Pro-DUR and Preferred Drug List – ACS Clinical Call Center 1-866-879-0106 Fax: 1-866-780-2198	To make refunds to IHCP for pharmacy claims send check to: EDS Pharmacy Refunds P.O. Box 2303, Dept 130 Indianapolis, IN 46206-2303

Hoosier Healthwise – Risk Based Managed Care (MCOs), *Care Select* (CMOs) and Medicaid Select

Managed Care Helplines

AmeriChoice - Hoosier Healthwise
http://www.healthcareforhoosiers.com
1-800-889-9949, Option 3 for Providers
EDS - Hoosier Healthwise Package C Premium Collection Services
Package C Payment Line
1-866-404-7113
Package C Payment Mailing Address
Hoosier Healthwise
P.O. Box 3127
Indianapolis, IN 46206-3127

Medicaid Select

http://www.medicaidselect.com
Claims - EDS Customer Assistance
(317) 655-3240 or 1-800-577-1278
Member Services
1-877-633-7353, Option 1
PA
1-800-269-5720
Provider Services for PMPs
1-877-633-7353, Option 3
Pharmacy
See Pharmacy Services Contact Information located above

Care Management Organizations (CMOs)

Advantage Health Solutions
http://www.advantageplan.com/
Member Services
1-800-784-3981
Provider Services
1-866-504-6708
PA | PA Fax
1-800-784-3981 | 1-800-689-2759
P.O. Box 80068
Indianapolis, IN 46280

MDwise
http://www.mdwise.org
Member Services and Provider Services
1-866-440-2449
Member Services Fax: 1-877-822-7188
PA | PA Fax
1-866-440-2449 | 1-877-822-7186
P.O. Box 44214
Indianapolis, Indiana 46244-0214

Claims - Customer Assistance
(317) 655-3240 or 1-800-577-1278

Maximus
1-866-963-7383

Pharmacy
See Pharmacy Benefit Manager section

Managed Care Organizations (MCOs)

Anthem
http://www.anthem.com
Claims
1-888-232-9613
Member Services
1-866-408-6131
1-888-232-9613 (Prospective Member)
TTY: 1-866-408-7188
Fax: 1-866-408-7087
PA
1-866-408-7187
Fax: 1-866-406-2803
Provider Services
1-866-408-6132
1-800-618-3141 (Prospective Provider)
Fax: 1-866-408-7087
Transportation
1-800-508-7230
TTY: 1-866-910-1603
Fax: (317) 291-9446
Pharmacy
1-866-629-1608
TTY: 1-800-905-9821
PA Fax: 1-866-408-7103

Managed Health Services (MHS)
http://www.managedhealthservices.com
Claims, Member Services, PA/Medical Management, Provider Services, and Nursewise
1-877-MHS-4U4U or 1-877-647-4848
Pharmacy - US Script (PBM)
1-800-460-8988
Pharmacy PA
1-866-399-0928 Fax: 1-866-399-0929

MDwise
http://www.mdwise.org
Claims, Member Services PA/Medical Management, Provider Services, and Pharmacy
(317) 630-2831 or 1-800-356-1204

CareSource
http://www.caresource-indiana.com
Claims and Provider Services
1-866-930-0017

Harmony Health Plan
http://www.harmonyhmi.com
Claims and Provider Services
(317) 423-3000 or 1-800-504-2766

Molina Healthcare
http://www.molinahealthcare.com
Claims and Provider Services
1-800-642-4509

Claim Filing

EDS 590 Program Claims P.O. Box 7270 Indianapolis, IN 46207-7270	EDS Adjustments P.O. Box 7265 Indianapolis, IN 46207-7265	EDS CCFs P.O. Box 7266 Indianapolis, IN 46207-7266	EDS Dental Claims P.O. Box 7268 Indianapolis, IN 46207-7268	EDS CMS-1500 Claims P.O. Box 7269 Indianapolis, IN 46207-7269
EDS Claim Attachments P.O. Box 7259 Indianapolis, IN 46207-7259	EDS Waiver Programs Claims P.O. Box 7269 Indianapolis, IN 46207-7269	EDS Medical Crossover Claims P.O. Box 7267 Indianapolis, IN 46207-7267	EDS Institutional Crossover/UB-92 Inpatient Hospital, Home Health, Outpatient, and Nursing Home Claims P.O. Box 7271 Indianapolis, IN 46207-7271	

Check Submission (Non-Pharmacy)

To make refunds to IHCP: EDS Refunds P.O. Box 2303, Dept. 130 Indianapolis, IN 46206-2303	To Return Uncashed IHCP Checks: EDS Finance Department 950 N. Meridian St., Suite 1150 Indianapolis, IN 46204-4288

Rate Setting

Myers and Stauffer, LC http://www.mslcindy.com 9265 Counselors Row, Suite 200 Indianapolis IN 46240	(317) 846–9521 1-800-877–6927 Fax (317) 571–8481 MDS Help Desk: (317) 816–4122

Indiana Health Coverage Programs

INDIANA HEALTH COVERAGE PROGRAMS INQUIRY

Date _____ **For EDS Internal Use** **CCN#**_____

Provider name _____ **Provider number** _____

Provider address _____

_____

_____

Member name _____ **Member identification number (RID)** _____

Date of service _____ **Total amount of charges** _____

Date billed _____ **ICN from previous bills** _____

Date paid/denied _____

Reason for inquiry _____

_____

_____

_____

_____

_____

_____

_____

_____

Signature

For EDS Internal Use	**Response**
	Signature of analyst

Retain a copy for your records and send the original to:

Provider Written Correspondence
EDS
P. O. Box 7263
Indianapolis, IN 46207-7263