



Anthem Blue Cross and Blue Shield | Serving
Hoosier Healthwise, Healthy Indiana Plan, Hoosier
Care Connect, and Indiana PathWays for Aging

Claims Update and Dispute Process

2024 IHCP Works Seminar



Agenda

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

Acronyms

COB — Coordination of Benefits

CMHC — Community Mental Health Center

EDI — Electronic Data Interchange

EOP — Explanation of Payment

HCBS — Home- and Community-Based Services

HEDIS® — Healthcare Effectiveness Data and Information Set

IHCP — Indiana Health Coverage Programs

LTSS – Long-Term Services and Support

MCE — Managed Care Entity

MID — Member Identification Number

NCQA — National Community for Quality Assurance

PA — Prior Authorization

PMP — Primary Medical Provider

RA — Remittance Advice

RCP — Right Choices Program

RHC — Rural Health Center

UM — Utilization Management

Provider Manual

Provider 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

Verifying Eligibility



Always verify a member's eligibility prior to rendering services. Anthem recommends a two-step verification process.


Providers can access this information by visiting:

- [IHCP Provider Healthcare Portal](#):
 - Use to verify eligibility, assigned MCE, and Medicaid product.
- [Avality Essentials](#):
 - Use for PMP verification, benefit limitations, COB, and much more.

Eligibility – Hoosier Healthwise

Anthem assigns the YRH prefix with the member ID.

			
JOHN Q SAMPLE		Primary Medical Provider	
Member ID:			
Prefix:			
RxBIN:	020107		
RxPCN:	IN		
RxGRP:	WKXA		

	
Providers: File claims to the local Blue Cross and/or Blue Shield plan. Please file medical claims using the prefix on the front of this card immediately followed by the Member ID. Do not include a space.	
Anthem providers can submit claims to: Avality.com or Anthem, Mail Stop: IN999 P.O. Box 61010 Virginia Beach, VA 23466	
Possession of this card does not guarantee eligibility for benefits. anthem.com/inmedicaid	
Member Services: 866-408-6131 TTY: 711 24/7 NurseLine: 866-408-6131 Behavioral Health Crisis Line: 833-874-0016 Provider Services: 866-408-6132 Med. & Rx Precert: 866-408-6132 Vision: 866-866-5641 Pharmacy Member Services: 833-235-2023 Help for Pharmacists: 844-916-3654 Dental: 888-291-3762 Transportation: 844-772-6632	
	<small>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.</small>
INH0 10/21	

Eligibility – Hoosier Care Connect

Anthem assigns the YRH prefix with the member ID.

The image shows the front of a member ID card. At the top left is the Anthem logo. At the top right is the Hoosier CARE CONNECT logo. Below the logos, the member's name "JOHN Q SAMPLE" and "Primary Medical Provider" are listed. Underneath, there are two horizontal lines representing the member ID. At the bottom left, the prefix "020107" and state "IN" are listed, with "WKXA" listed below them.

Anthem.	Hoosier CARE CONNECT
JOHN Q SAMPLE	Primary Medical Provider
Member ID:	
Prefix:	020107
RxBIN:	IN
RxPCN:	WKXA
RxGRP:	

The image shows the back of the member ID card. It features the Anthem logo on the left. On the right, there is a list of member services with phone numbers. Below this is a section for providers with instructions on how to file claims. At the bottom, there is a disclaimer and the Anthem logo with a small copyright notice.

anthem.com/inmedicaid

Member Services:	844-284-1797
24/7 NurseLine:	844-284-1797
Behavioral Health Crisis Line:	833-874-0016
TTY:	711
Provider Services:	844-284-1798
Med. & Rx Precert:	844-284-1798
Pharmacy Member Services:	833-235-2024
Help for Pharmacists:	844-916-3653
Vision:	877-478-7561
Dental:	888-291-3762
Transportation:	844-772-6632

Providers: File claims to the local Blue Cross and/or Blue Shield plan. Please file medical claims using the prefix on the front of this card immediately followed by the Member ID. Do not include a space.

Anthem providers can submit claims to:
Avality.com or
Anthem, Mail Stop: IN999
P.O. Box 61010
Virginia Beach, VA 23466



This card does not guarantee benefits or payment. Include your member ID when sending inquiries. In an emergency, go to the nearest ER or call 911. Benefits may be limited outside of Indiana.

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INH2 07/24


Eligibility – Healthy Indiana Plan

Anthem assigns the YRK prefix with the member ID.



JOHN Q SAMPLE Primary Medical Provider
Member ID:

Prefix: _____
RxBIN: 020107
RxPCN: IN
RxGRP: WKXA



anthem.com/inmedicaid

Providers: File claims to the local Blue Cross and/or Blue Shield plan. Please file medical claims using the prefix on the front of this card immediately followed by the Member ID. Do not include a space.

Anthem providers can submit claims to:
Avality.com or
Anthem, Mail Stop: IN999
P.O. Box 61010
Virginia Beach, VA 23466

Possession of this card does not guarantee eligibility for benefits.

Member Services: 866-408-6131
TTY: 711
24/7 NurseLine: 866-408-6131
Behavioral Health Crisis Line: 833-874-0016
Provider Services: 844-533-1995
Med. & Rx Precert: 844-533-1995
Pharmacy Member Services: 833-205-6007
Help for Pharmacists: 844-916-3652
Vision: 866-866-5641
Dental: 888-291-3762
Transportation: 844-772-6632

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INH1 10/21

Eligibility – Indiana PathWays for Aging (non-dual)

Anthem assigns the YRK prefix with the member ID.

The image shows the front of a member ID card. At the top left is the Anthem logo with a cross and shield icon. To its right is the PathWays logo with a play button icon and the text "7 FOR AGING". Below the logos, the member's name "JOHN Q SAMPLE" is printed. Underneath the name are labels for "Member ID:" and "Effective date:" followed by horizontal lines for the information. At the bottom left, there are labels for "Prefix:", "RxBIN:", "RxPCN:", and "RxGRP:" with corresponding values: "020107", "IN", and "WKXA".

The image shows the back of the member ID card. At the top left is the Anthem logo. To its right is the URL "anthem.com/inmedicaid". Below the logo is a section for "Providers" with instructions on how to file claims. To the right of the provider information is a list of services and their phone numbers. At the bottom left, there is a disclaimer about benefits and payment. At the bottom right, there is a small disclaimer about the Anthem logo. The card number "INP2 07/24" is printed at the bottom left.

anthem.com/inmedicaid

Member Services: 833-412-4405
24/7 NurseLine: 833-412-4405
Long-term Services and Supports: 833-412-4405
Behavioral Health & Crisis Hotline: 844-721-1304
TTY: 711
Provider Services: 833-569-4739
Med. & Rx Precert: 833-569-4739
Pharmacy Member Services: 844-691-2486
Help for Pharmacists: 844-691-2487
Vision: 866-866-5641
Dental: 888-291-3762
Transportation: 844-772-6632

Providers: File claims to the local Blue Cross and/or Blue Shield plan. Please file medical claims using the prefix on the front of this card immediately followed by the Member ID. Do not include a space.

Anthem providers can submit claims to:
Avality.com or
Anthem, Mail Stop: IN999
P.O. Box 61010
Virginia Beach, VA 23466



This card does not guarantee benefits or payment. Include your member ID when sending inquiries. In an emergency, go to the nearest ER or call 911. Benefits may be limited outside of Indiana.

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INP2 07/24

Eligibility – Indiana PathWays for Aging (dual eligible)


Anthem assigns the YRK prefix with the member ID.

Anthem.  

JOHN Q SAMPLE
Member ID:
Effective date:

Prefix: **020107**
RxBIN: **IN**
RxPCN: **WKXA**
RxGRP:

Show your Medicare ID card and this ID card when getting healthcare services. Call Member Services if you are asked to pay for covered services, your provider will not see you, or you have questions.

Anthem.  anthem.com/inmedicaid

Member Services: 833-412-4405
24/7 NurseLine: 833-412-4405
Long-term Services and Supports: 833-412-4405
Behavioral Health & Crisis Hotline: 844-721-1304
TTY: 711
Provider Services: 833-569-4739
Med. & Rx Precert: 833-569-4739
Pharmacy Member Services: 844-691-2486
Help for Pharmacists: 844-691-2487
Vision: 866-866-5641
Dental: 888-291-3762
Transportation: 844-772-6632

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INP1 07/24

Right Choices Program

Right Choices Program (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.

[Right Choices Program Provider Reference Module](#)

Right Choices Program (cont.)

- Members enrolled in RCP must see the providers who are assigned per the IHCP Provider Healthcare Portal.
- 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 73 to 77 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 PMP to coordinate their care and one pharmacy to fill prescriptions.**



Managed Care Model (Assigned PMP)

Managed Care Model

- All members must utilize their assigned PMP.
- Specialty providers must have a referral from the PMP:
 - Specialty claims submitted without a referral may deny.
- 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 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) – Exceptions

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) – Exceptions

- Exceptions to this policy include:
 - Services provided after hours:
 - Code 99050 – Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed.
 - Code 99051 – Services 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 healthcare provider or is providing services at a FQHC or urgent care center.



Prior authorization

Precertification Lookup Tool

Visit the provider website to utilize the precertification lookup tool at [Indiana Providers](#) > 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. PA is not a guarantee of payment.



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 EDI - Preferred
- Availity Essentials
- Care Central – Specific for our HCBS partners
- By mail to:

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

Note: Non-participating providers have 180 calendar days from the date of service to submit claims.

Claim Turnaround

Processing time:

- 7 business days for clean HCBS claims.
- 21 calendar days for electronic clean claims.
- 30 calendar days for paper clean claims.

If the claim isn't showing in Availity contact the Provider Services via phone or chat to verify if the claim is in imaging. **Do not resubmit if the claim is on file in the processing or image system.**

Coordination of Benefits (COB)

COB is when a member shows to have other insurance as primary:

- Claims must be filed to Anthem within 90 calendar days of the date on the primary EOP.
- If the primary carrier pays more than the Medicaid allowable, no additional reimbursement is due:
 - **Example one:** Primary pays \$45 for a 99213 and you bill Medicaid as secondary. The Medicaid fee schedule allowed amount is \$31.96. No additional reimbursement is due.
 - **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 the reimbursement to the deductible.

Note: Bill all secondary claims, even if we will not reimburse further; this will assist in the HEDIS data review.

Identifying Denials on the *EOP*

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
TF0	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

GLI 16
GLI 16

EXPL CODES	EXPLANATION
TF0	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:		EXPL CD:							
SERVICE PROVIDER NAME:		SERVICE PROVIDER ID:		RELATIONSHIP TO INSURED:		PLAN TYPE:							
NETWORK:													
	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
	88305TC	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													0.00
	TOTAL NET PAID												0.00

SP. EXPL/ANSI CODE(S) F

NAME: ()

DATE: ()

PL CD:

Y97 252

Y97 252

Y97 252

Y97 252

Y97 252

Y97 252

Y97 252

Y97 252

Y97 252

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Y97 252

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Y97 252

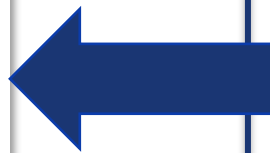
Y97 252

Y97 252

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	Valid consent form required
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	AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE.
27	EXPENSES INCURRED AFTER COVERAGE TERMINATED.



Top Five Denial Codes

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. PH #

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

[IHCP Quick Hit: Box 33](#)

Claims Resolution Process

Follow-up guidelines

Use the Availity Essentials within 30 calendar days to check claim status online. You can also call the appropriate helpline between the hours of 8 a.m. and 8 p.m. eastern time:

Plan	Phone number
Healthy Indiana Plan	844-533-1995
Hoosier Care Connect	844-284-1798
Hoosier Healthwise	866-408-6132
Indiana PathWays for Aging	833-569-4739

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

Claims – Corrected Claim Guidelines

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 RA.
 - Corrected claims can be submitted by paper, electronically through your clearinghouse, or through the Availity Essentials.

Claims – Corrected Claim Submission

Send corrected paper claims to:

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

The [Claim Follow-Up Form](#) is available at [Indiana Providers](#) > Resources > Forms > Claims and Billing.

Claims – Dispute and Appeal Process

- The dispute process is used if a provider disagrees with the full or partial denial on the claim.
- There is a 60-calendar day filing limit from the date on the 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 – Dispute Process

The claims dispute process is as follows:

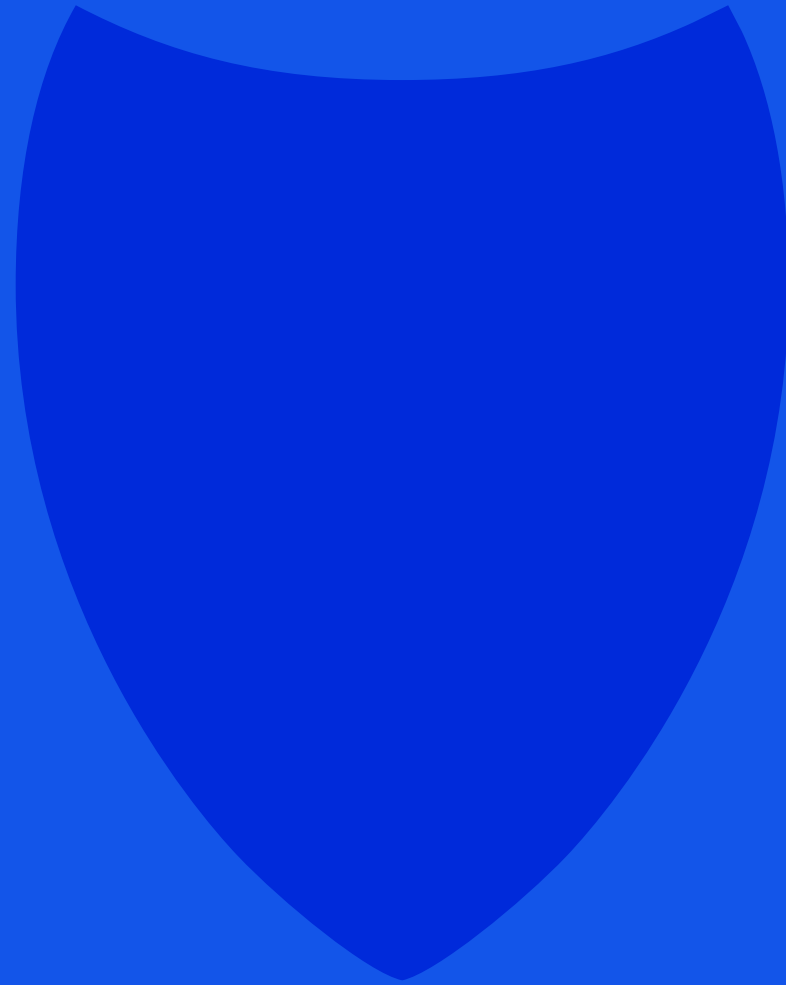
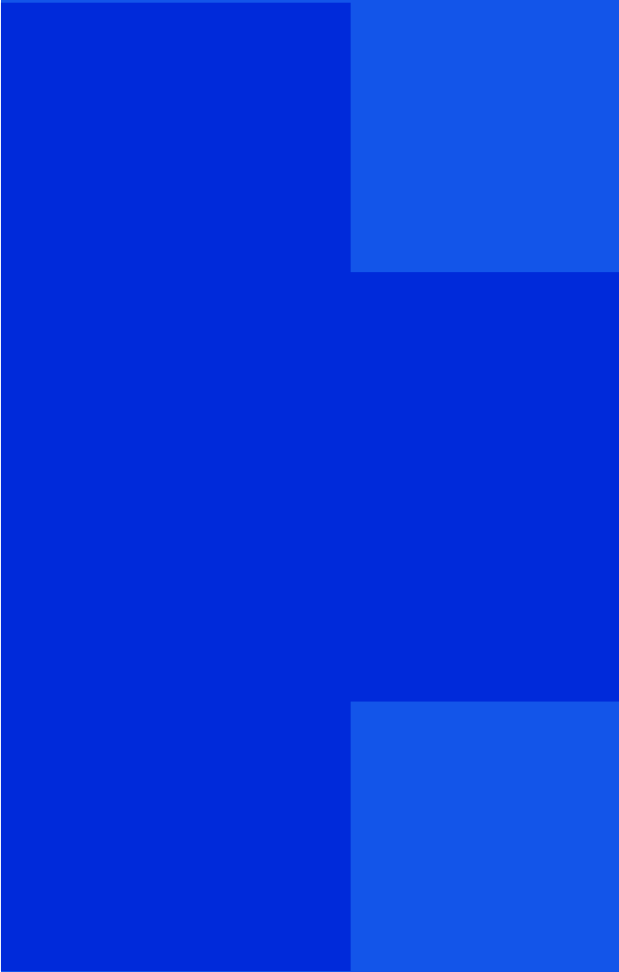
1. **Claims reconsideration** — must be received within 60 calendar days from the date on the RA. Disputes can be done verbally through provider services, in writing, or online through the Availity Essentials. Submit a claims reconsideration if you disagree with full or partial claim rejection or denial, 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 Availability

Claims Disputes in Availity

1. Login and select **Claim Status** on your Dashboard.
2. Select your **Organization** and **Payer**.
3. Fill out the required information as indicated by a red asterisk (*).
4. Select **Dispute Claim**.
5. The claim will go to your Worklist. You can add more claims and then select **Go to Request**.
6. Select the three lines and then select **Complete Dispute Request**.
7. 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 appeal.
 - Select **Next**.
8. If you said yes to adding additional claim numbers, you would those here.
9. 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 and Member Services

Provider Services:

- Hoosier Healthwise: **866-408-6132**
- Healthy Indiana Plan: **844-533-1995**
- Hoosier Care Connect: **844-284-1798**
- Indiana PathWays for Aging: **833-569-4739**

Member Services and 24/7 NurseLine:

Hoosier Healthwise and Healthy Indiana Plan: **866-408-6131**

Hoosier Care Connect: **844-284-1797**

Indiana PathWays for Aging: **833-412-4405**

All call center lines are available 8 a.m. to 8 p.m. ET, Monday through Friday.

Important contact information – PA Requests

- Healthy Indiana Plan: 844-533-1995
- Hoosier Care Connect: 844-284-1798
- Hoosier Healthwise: 866-408-6132
- Indiana PathWays for Aging: 844-284-1798
- Fax: 866-406-2803

Provider Relationship Account Management Physical Health Zone Map

Zone 1
Jamaal Wade
Jamaal.WadeSr@anthem.com
317-409-7209

Zone 2
Angelique Jones
Angelique.Jones@anthem.com
317-619-9241

Zone 3
Whit'ney McTush
Whitney.McTush@anthem.com
317-519-1089

Zone 4
Matthew McGarry
Matthew.McGarry@anthem.com
463-202-3579

Zone 5
David Tudor
David.Tudor@anthem.com
317-447-7008

Zone 6
Matt Swingendorf
Matthew.Swingendorf@anthem.com
317-306-0077

Zone 7
Sophia Brown
Sophia.Brown@anthem.com
317-775-9528



Provider Relationship Account Management Physical Health

Indiana University Health
Michelle Fitch
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Ascension, Parkview Health
Open

Community Health Network, Franciscan
Health, Deaconess Health
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Indiana Orthopedic Hospital (OrthoIndy), South
Bend Clinic, Eskenazi, American Health Network,
Beacon, Union Hospital, Lutheran Health Network,
Community Munster, St. Joseph Regional Health
(Trinity)
Julie Fiedler
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Schneck Medical Center, Goshen Hospital,
Columbus Regional Health, Good Samaritan,
Logansport Memorial Hospital, Major Medical
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Methodist Gary, Hancock Health, Hendricks
Regional Health, Witham, Henry Community
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SUD/OTP

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SME — SUD/OTP

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Indiana PathWays for Aging network relations consultants

Home- and community-based services, home health/personal care attendant

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Central Indiana

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Indiana PathWays for Aging network relations consultants

Nursing Facility/Assisted Living/Adult Day and Adult Family Care

Northern Indiana

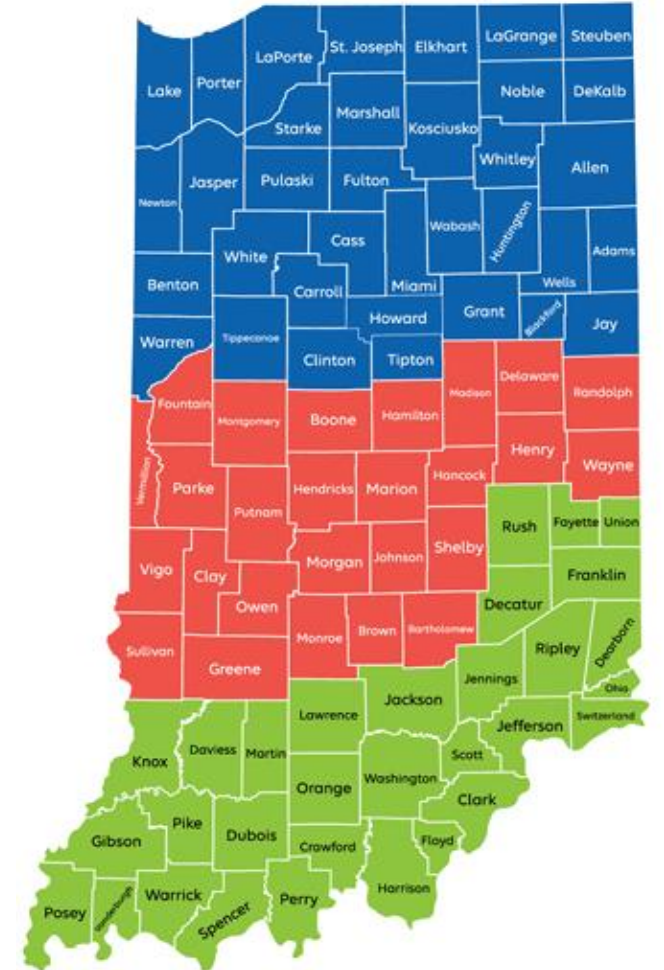
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Southern Indiana

Caitlyn Bourff
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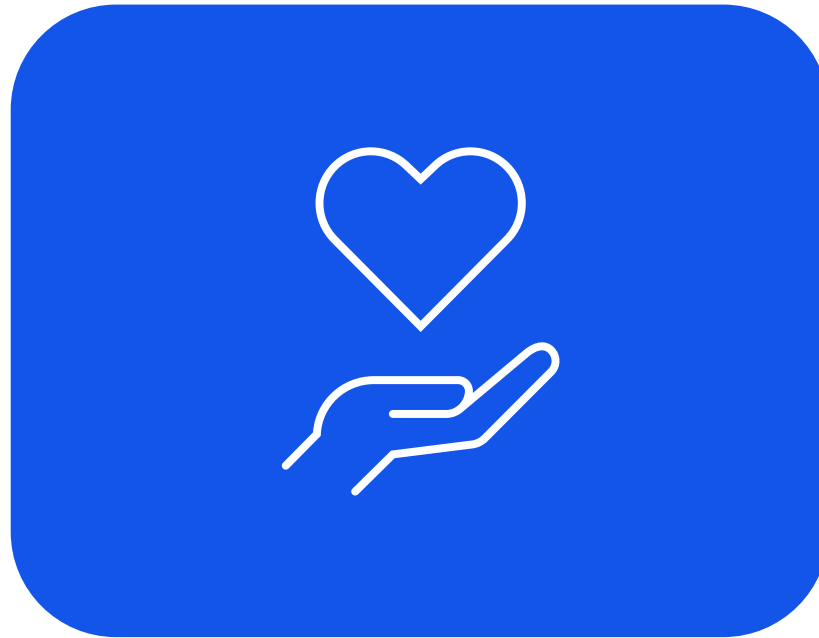
Indiana PathWays for Aging network relations consultants

Additional resources and contacts

Website: providers.anthem.com/in > Patient Care >Indiana PathWays for Aging	Manager, LTSS Network Relations Wendy Dragoo Wendy.dragoo@anthem.com 463-269-3423	Value-Based Program Specialist Haley Osborne Haley.Osborne@anthem.com 317-671-2141
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LTSS Provider Relations phone: 833-569-4739		

Questions?

Thank you for your participation in serving our members enrolled in Hoosier Healthwise, Healthy Indiana Plan, Hoosier Care Connect, and Indiana PathWays for Aging!





Providers who are contracted with Anthem Blue Cross and Blue Shield to serve Hoosier Healthwise, Healthy Indiana Plan, Hoosier Care Connect, and Indiana PathWays for Aging 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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