

# Provider Portal FAQ



In addition to the information provided below, MHS Health Wisconsin has provided a detailed Instruction Guide available on the Secure Portal.

## Account Creation and General Information

**Create an account:** Visit our provider website at [www.mhswi.com/providers](http://www.mhswi.com/providers) and select Login/Create an Account. A registration video and step by step PDF are provided to assist in this process.

**Lockouts:** If you are unable to restore access on your own by answering your secret questions, contact your account manager for password resets. Please remember that you will be locked out after 90 days of inactivity. We recommend setting a reminder on your calendar to cue you to log in once every 80-90 days in order to avoid lockout. If you are unaware of who your account manager is, you can call the Provider Inquiry Line at (800) 222-9831.

**Password Changes:**

- 1) Select the drop down arrow next to your name
- 2) Click Account Details
- 3) Select Update Account

### **How do I update my demographic information?**

Click on "Account Details," then "TIN Information," and finally "Edit Location." Provider Demographic Update Instructions are also available on the Account Details page. *To update practice information for claims processing purposes, you must visit our website <https://www.mhswi.com/providers/resources/forms-resources.html> complete and submit "Information Changes about Your Practice" form.*

### **Why don't I have access to any modules in the portal?**

Your account has likely not yet been verified. Please ask the portal account manager at your facility to verify your account by clicking "Manage Accounts" on the home screen. If you are unaware of who your account manager is, you can call the Provider Inquiry Line at (800) 222-9831 for activation.

### **Why is Medicare showing up first in my TIN Drop down list?**

That may be the default, but you as the user can change which line of business is primary for your needs.

- 1) Select the drop down arrow next to your name
- 2) Click Account Details
- 3) Mark TIN/Product as Primary

### **What if I have multiple Tax ID numbers?**

You can add and manage multiple TINs from one account.

## Account Manager

### **What is an account manager?**

The account manager for MHS Health Wisconsin's Secure Provider Portal is the person (or people) designated to monitor access for all the provider's users. It is his/her responsibility to be sure the correct users have the correct access. For example, if a user leaves the company, the account manager would be the person to be sure the former employee's account is disabled.

### **Account Manager Provider Quick Reference Guide (QRG):**

[https://support.mhswi.com/static/provider/docs/PRO\\_39161\\_SPS\\_WI.pdf](https://support.mhswi.com/static/provider/docs/PRO_39161_SPS_WI.pdf)

### **How do I know if I am an account manager?**

If you see the "Manage Accounts" option from your home page, then you are set up as an account manager.

### **How do I request account manager access?**

Call the Provider Inquiry Line at (800) 222-9831.

### **Can more than one person be an account manager for our organization?**

Yes, more than one person can be an account manager.

## Member Information

### **How do I check if a member is eligible?**

Enter Member ID or Last Name and DOB in the Quick Eligibility tool on your homepage to confirm Member eligibility.

### **How often is member eligibility information updated?**

Member eligibility is updated every 24 hours, but Medicaid eligibility is provided to us twice a month, and therefore may not be reflected immediately. Likewise, keep in mind that sometimes eligibility is granted retroactively.

### **How do I find Member's with Care Gaps?**

Click on "Patients," filter the report, and update the check box for "Care Gaps."

## Claim Entry

### **What do we do if one of our claims has been rejected on the web portal?**

Go to Claims >> Submitted >> Find Rejected Claim >> click on Fix Link >> Make Changes and resubmit. The claim will be treated like a new submission.

**I am trying to correct a claim, but the portal says that I have already started one and will not let me continue.**

If you go to claims>> saved, you will see a copy of your claim correction. Click on “Edit” to complete and submit.

**I am unable to see status of a claim correction**

- 1) Check the original claim status. If you see an adjustment section, click on it to view correction status.
- 2) If the status is not on the original claim, search with the new claim number, which can be found under Claim >>Submitted. Search by your web reference number.

**How long does it take to see a claim status after it is submitted?**

If the claim is submitted before 5pm, the status should be updated within 24 hours.

**Am I able to see a claim that has been rejected by the Clearinghouse?**

No, if a claim is rejected up front, then the portal will not show any information.

**Can attachments be submitted with a claim?**

Primary Carrier EOBs and Consent Forms can be attached with first-time claims, as can invoices for DME and Pharmacy. When submitting a corrected claim, the option to add Medical Records, Proof of Timely Filing, and a Claim Adjustment Form can be added. Please note that medical records CANNOT be attached with first-time claims; they can only be attached if correcting after denial.

**I am having Batch Claim submittal issues, who can I contact?**

To contact the EDI Help Desk, please call 800-225-2573 ext. 6075525 or Fax 866-266-6985 or email [EDIBA@Centene.com](mailto:EDIBA@Centene.com)

## **Prior Authorizations**

**Will submitting an authorization on the Portal expedite the process time for my authorization?**

No. Turnaround time is consistent no matter how the request is submitted. Urgent requests are processed within 72 hours. Standard requests are handled in 5-14 days.

**How will I be notified of my authorization request is approved or denied?**

According to NCQA guidelines, we will complete notification of approval within 14 days, regardless of the authorization’s origin (portal, fax, etc.). That approval is typically faxed. Notification of a denial is made by phone within 24 hours of the decision (letter mailed to member and provider within 14 days).

**Will all authorizations be visible on the portal, or only ones submitted online?**

Yes, all authorizations from the most recent 90 days will be visible on our portal, regardless of how they were submitted.

**How often is authorization data in the portal updated?**

Authorizations are updated every 24 hours.

**If an authorization is submitted online, and supporting documentation is faxed (due to systems not allowing the attachment directly), will the information be connected to the authorization? Is there anything that the user needs to do to help ensure they are connected?**

If a provider submits an online authorization through the portal and separately faxes supporting documents (that would otherwise be attached directly via the portal), they authorization and documents will be connected. There is a system in place to catch records faxed without the authorization form that is checked daily and attached manually.