MississippiCAN Provider Orientation

Transforming the health of the community, one person at a time

7/7/2022

magnolia health™

Welcome to Magnolia Health!

Welcome to Magnolia Health (Magnolia). We thank you for being a part of Magnolia's network of participating providers, hospitals, and other healthcare professionals. Our number one priority is the promotion of healthy lifestyles through preventive healthcare. Magnolia works to accomplish this goal by partnering with the providers who oversee the healthcare of Magnolia members.

Cultural Awareness and Sensitivity

Providers must ensure that:

- Members understand that they have access to medical interpreters, signers, and TDD/TTY services to facilitate communication without cost to them.

- Medical care is provided with consideration of the member's race/ethnicity and language and its impact/influence of the member's health or illness.

Agenda

- What is Managed Care?
- Centene Overview
- Magnolia Health Overview
- Member Eligibility
- Credentialing Overview
- Cultural Awareness and Sensitivity
- Population Health
- Claim Guidelines
- Appeals, Grievances, and Complaints
- Vendors
- Resources (Provider Services and Provider Relations)
- Questions

What is Managed Care?

Managed Care is a health care delivery system organized to manage utilization, quality, and cost. In 2011, the Mississippi Division of Medicaid (DOM) implemented a managed care program called Mississippi Coordinated Access Network (MississippiCAN). MississippiCAN was designed to get a better return on Mississippi's health care investment by improving the health and well-being of Medicaid beneficiaries.

MississippiCAN is a statewide coordinated care program designed to meet the following goals:

- Improve beneficiary access to needed medical services,
- Improve quality of care, and
- Improve program efficiencies as well as cost predictability.

Who is Eligible?

Who qualifies for MississippiCAN:

- Supplemental Security Income (SSI) eligible
- Department of Human Services foster care children
- Disabled children living at home
- Working Disabled
- Breast/Cervical Cancer Program Members
- Pregnant Women and Infants
- Family/Children on the Temporary Assistance for Needy Families (TANF)
- All newborns

Excluded from Enrollment

- Persons in an institution such as a Nursing Facility, ICF/MR (Intermediate Care Facility with Intellectual Disabilities (ICF/ID) or Correctional Facilities
- Persons with both Medicare and Medicaid (Dual Eligible)
- Persons enrolled in a waiver programs such as Elderly and Disabled, Independent Living, Traumatic Brain Injury/Spinal Cord Injury, Assisted Living, and Intellectual Disabilities/Developmental Disabilities

The program is statewide covering all 82 Mississippi counties

Centene Overview

Centene Overview & National Footprint

magnolia health

WHO WE ARE

Founded as a single health plan in 1984, and headquartered in St. Louis, MO, Centene Corporation (Centene) has established itself as a national leader in the healthcare services field. Centene provides access to high-quality healthcare, innovative programs and a wide range of health solutions that help families and individuals get well, stay well, and be well.

PURPOSE Transforming the health of the community, one person at a time

BRAND PILLARS Focus on the Individual + Whole Health + Active Local Involvement

WHAT WE DO

Serving 1 in 15 Individuals

50 states

with government-sponsored healthcare programs

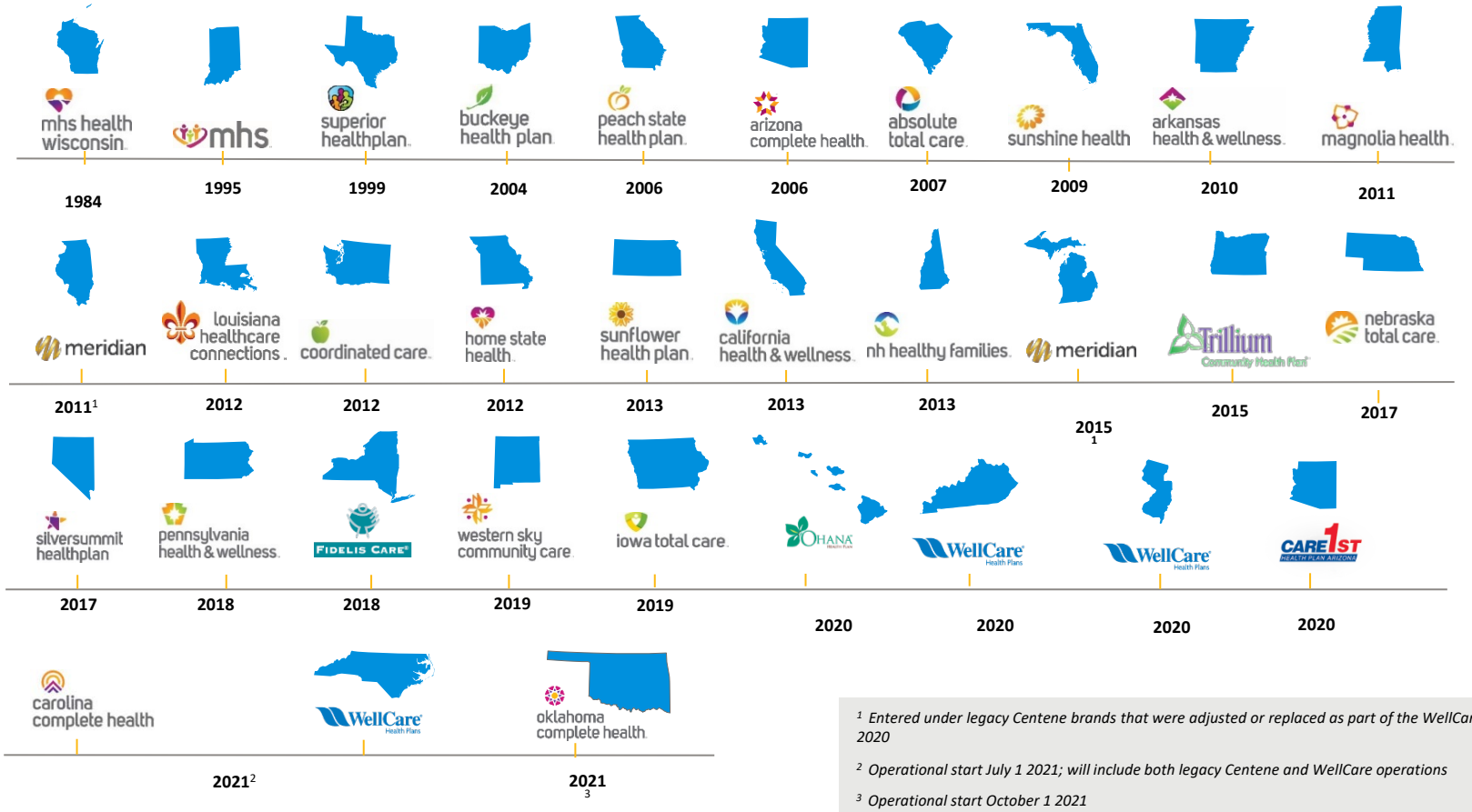
Centene successfully provides **high quality, whole health solutions for our diverse membership** by recognizing the significance of the many different cultures our members represent and by forming partnerships in communities that bridge social, ethnic and economic gaps.

25+ million Managed Care Members

400+ Product / Market Solutions

**As of December 31, 2020.*

Medicaid Footprint



[1] *Entered under legacy Centene brands that were adjusted or replaced as part of the WellCare acquisition in 2020*

[2] *Operational start July 1 2021; will include both legacy Centene and WellCare operations*

[3] *Operational start October 1 2021*

Magnolia Health Overview

Magnolia Health Overview

- Medicaid Coordinated Care Organization (CCO)
- Experienced MississippiCAN health plan since 2011
- Locally-based, locally led ***Mississippians serving Mississippians***
- NCQA Accredited
- Nationally supported through parent company Centene Corporation

Magnolia Health Purpose

Transforming the health of the community one person at a time

OUR MISSION

Better health outcomes at lower costs

OUR BRAND PILLARS

Focus on Individuals + Active Local Involvement + Whole Health

OUR BELIEFS

- We believe in treating the whole person, not just the physical body.
- We believe healthier individuals create more vibrant families and communities.
- We believe we have a responsibility to remove barriers and make it simple to get well, stay well and be well.
- We believe local partnerships enables meaningful, accessible healthcare.
- We believe treating people with kindness, respect and dignity empowers healthy decisions.

Credentialing Overview

7/7/2022

Credentialing Overview

Credentialing

The credentialing process is to ensure that participating providers meet the criteria established by Magnolia, as well as government regulations and standards of accrediting bodies.

- Magnolia Health will verify the following information submitted for Credentialing :
  - Mississippi License through appropriate licensing agency
  - Board certification, residency training, or medical education
  - National Practitioner Data Bank (NPDB) for malpractice claims and license agency actions
  - Hospital privileges in good standing at a participating Magnolia Health Plan Hospital
  - Review five (5) year work history (if applicable)
  - Review federal sanction activity including Medicare/Medicaid services (OIG-Office of Inspector General and EPLS-Excluded Parties Listing)

Re-Credentialing

To comply with accreditation standards, Magnolia conducts re-credentialing for providers at least every three (3) years from the date of the initial credentialing decision.

Delegated

Delegated credentialing is a formal process by which an organization gives another entity the authority to perform credentialing functions on its behalf.

Note: *All providers who participate in the Magnolia MississippiCAN Program must have an active Medicaid ID and are also required to register NPI with the DOM. Failure to obtain an active Medicaid ID and register NPI with the DOM, will result in denied credentialing or claim denials.*

Credentialing Overview

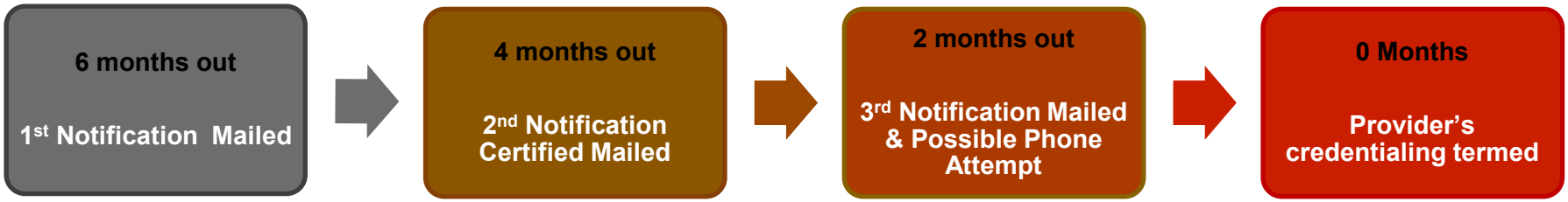
To add a new provider to an existing contract, submit the following documents:	To add a new location to an existing contract, submit the following documents:
✓ Provider Data Form ✓ Current licensure ✓ Collaborative practice agreement (Nurse Practitioners and Physician Assistant ✓ W-9 ✓ Locations page	✓ Provider Update Form for contracted providers ✓ Locations Page ✓ W9

- Submit all credentialing documents to Magnoliacredentialing@centene.com

- **Credentialing Guidance Reminders**
  - ✓ Provider's start date cannot precede the contract effective date.
  - ✓ Provider's contracted payment eligibility cannot precede state Medicaid eligibility
  - ✓ Provider's state date should be the date the provider group or practitioner notified the health plan that they have joined a contracted group via a roster submission or provider add process. Magnolia will not grant retro effective participation.

Recredentialing

Recredentialing is required every 3 years or as otherwise stated within your contract. The re-credentialing process begins 6 months before your credentialing is set to expire.



- Minimum of 3 outreach attempts will occur before termination
- Notifications will be mailed to all primary non-delegated locations
- Recredentialing documents should not be mailed to the health plan
- Recredentialing documents must be mailed to the address on the notification letter
- If Recredentialing is not completed before the deadline, credentialing will expire and participation in the network will be termed
- If participation in the network is termed a new application and contract will be required to Join the Network

Eligibility Verification

Verify Eligibility

As a provider, you're responsible for verifying eligibility every time a member schedules an appointment and arrives for services; and we are here to help you.

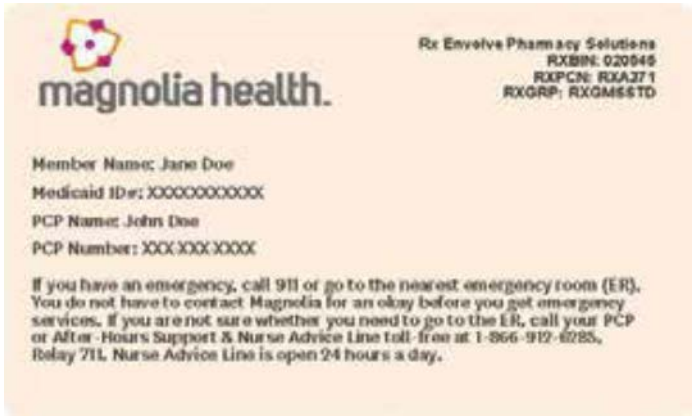
Log on to the Medicaid Envision website at:
WWW.ms-medicaid.com/msenvision/

Log on to the secure provider portal at
WWW.MagnoliaHealthPlan.com

Call 1-866-912-6285 to reach health plan

Verify Eligibility

MSCAN Member ID card


magnolia health.

Rx Envolve Pharmacy Solutions
RXBIN: 020046
RXPCN: RXAJ71
RXGRP: RXGM66TD

Member Name: Jane Doe
Medicaid ID#: XXXXXXXXXX
PCP Name: John Doe
PCP Number: XXX XXX XXXX

If you have an emergency, call 911 or go to the nearest emergency room (ER). You do not have to contact Magnolia for an okay before you get emergency services. If you are not sure whether you need to go to the ER, call your PCP or After-Hours Support & Nurse Advice Line toll-free at 1-866-912-6285, Relay 711. Nurse Advice Line is open 24 hours a day.


MEMBERS:
Member Services Line 1-866-912-6285
Relay 711
After-Hours Support &
Nurse Advice Line 1-866-912-6285
Dental/Vision 1-866-912-6285
Transportation 1-866-912-6285

Magnolia Address
111 East Capitol Street
Suite 500
Jackson, MS 39201

PROVIDERS:
IVR Eligibility inquiry - Prior Auth 1-866-912-6285
Envolve Pharmacy Solutions Help Desk 1-800-460-8988
Behavioral Health 1-866-912-6285

Medical claims:
Magnolia
Attn: CLAIMS
PO Box 3090
Farmington, MO 63640-3825

Provider/claims information via the web: MagnoliaHealthPlan.com

(MEMBER ID CARDS ARE NOT A GUARANTEE OF ELIGIBILITY AND/OR PAYMENT)

Population Health

Population Health

- Hours of operation are Monday through Friday from 8:00 a.m. to 5:00 p.m., CST (excluding holidays)
- Services include the areas of utilization management, case management, disease management, pharmacy management, and quality review
- Clinical services are overseen by the Magnolia Medical Director (Medical Director). The Vice President of Medical Management has responsibility for direct supervision and operation of the department.

To reach the Medical Director or Vice President of Population Health, please contact:

Magnolia Health Population Health

1-866-912-6285

Fax 1-866-534-5979

www.magnoliahealthplan.com

Clinical Protocols

Magnolia affirms that utilization management decision making is based only on appropriateness of care and service and the existence of coverage. Magnolia does not specifically reward practitioners or other individuals for issuing denials of service or care. Consistent with 42 CFR 438.6(h) and 422.208, delegated providers must ensure that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member.

Magnolia has adopted utilization review criteria developed by McKesson InterQual® products to determine medical necessity for healthcare services. InterQual appropriateness criteria are developed by specialists representing a national panel from community-based and academic practice. InterQual criteria cover medical and surgical admissions, outpatient procedures, referrals to specialists, and ancillary services. Criteria are established and periodically evaluated and updated with appropriate involvement from providers. InterQual is utilized as a screening guide and is not intended to be a substitute for practitioner judgment. Magnolia's Medical Director reviews all potential medical necessity denials and will make a decision in accordance with currently accepted medical or healthcare practices, taking into account special circumstances of each case that may require deviation from the norm in the screening criteria.

Please visit Clinical and Payment Policies at www.magnoliahealthplan.com for Clinical Practice Guideline and Preventative Guidelines

Prior Authorization

Prior Authorization is a request to the Magnolia Population Health department for a medical necessity determination for services to be rendered. Prior authorization is required for all services included in the prior authorization list prior to the delivery of such services.

- Prior to rendering services, providers should check the Pre-Auth Tool at www.magnoliahealthplan.com to determine if the code requires authorization.
- Authorization must be obtained prior to the delivery of services. Failure to obtain authorization may result in an administrative claim denial.
- All out-of-network services require prior authorization

Pre-Auth Tool

Be Sure to Select the Correct Product when utilizing the PA Tool.

Medicaid Pre-Auth

DISCLAIMER: All attempts are made to provide the most current information on the Pre-Auth Needed Tool. However, this does NOT guarantee payment. Payment of claims is dependent on eligibility, covered benefits, provider contracts, correct coding and billing practices. For specific details, please refer to the provider manual. If you are uncertain that prior authorization is needed, please submit a request for an accurate response.

Vision services, including all services rendered by an Optician, Ophthalmologist or Optometrist need to be verified by Envolve Vision
Dental services need to be verified by Envolve Dental
Behavioral Health/Substance Abuse need to be verified by Cenpatico
Complex imaging, MRA, MRI, PET, and CT Scans need to be verified by NIA

Non-participating providers must submit Prior Authorization for all services.
For non-participating providers, Join Our Network.

Basic laboratory chemistries and basic radiology do NOT require prior authorization for participating or non-participating providers.

Are Services being performed in the Emergency Department or Urgent Care Center, FQHC or RHC, or Family Planning services billed with a V25 to V25.9 diagnosis?

☐ Yes ☐ No

Types of Services	YES	NO
Is the member being admitted to an inpatient facility?	○	○
Are anesthesia services being rendered for pain management or dental surgeries?	○	○
Is the member receiving hospice services?	○	○
Are services other than DME, orthotics, prosthetics, and supplies, being rendered in the home?	○	○

To submit a prior authorization Login Here.

Prior Authorization Request

Prior Authorization Form(s) can be located on our website at:
http://www.magnoliahealthplan.com/for-providers/provider-resources/

Secure Web Magnoliahealthplan.com/login/	**Email** **Magnoliaauths@centene.com**
Phone 1.866.912.6285 **Fax** 1.877.650.6943	**Mail** Magnolia Health Attn: Utilization Management 111 E. Capital Street, Suite 500 Jackson, MS 39201

It is highly recommended to initiate the authorization process at least 5 calendar days prior to service. For authorization updates, contact authorization department at 1-866-912-6285. Authorization should be updated prior to filing claim or the claim may deny.

* Process above is for Medical MSCAN Authorization Only

Authorization Complaints

Authorization and coverage complaints must follow the Appeal process. Appeals can be requested orally or in writing by the member or the member's representative within **sixty (60) calendar days** from the date on the Adverse Benefit Determination notice unless an acceptable reason for delay exists.

Magnolia will review, resolve and provide the member and provider with written or electronic notification of the appeal decision as quickly as the member's health condition requires but no later than:

Standard pre-service appeals: No more than **thirty (30) calendar days**. Expedited appeals: are based on the medical immediacy of the condition, procedure or treatment under review provided that the resolution of the appeal may not exceed **72 hours** from the receipt of request. Expedited appeal decisions and notification will be made as expeditiously as the member's medical condition requires. Magnolia Health may extend resolution timeframe to **fourteen (14) calendar days** upon member request or need for additional information that is in the members best interest.

If Magnolia is going to reduce or stop a service, you have the right to keep getting the service until a decision has been made on your appeal if: Magnolia approved you to get the service from the provider. The time limit Magnolia approved has not ended. To keep getting the service, you must ask to continue the service and file an appeal on or before the later of the following: within **ten (10) calendar days** of the mailing date of this notice or the intended effective date of the proposed action. If you appeal the action and continue the service, you may have to pay for it if the appeal decision is not in your favor.

Care Management

Magnolia's Care Management Program uses a multidisciplinary team approach to provide individualized process for assessment, goal planning and coordination of services. The Care Management Program is available to **all** members, emphasizing prevention and continuity of care.

- **Start Smart for Your Baby®**
  - Special program designed to educate women who are pregnant

- **Nurtur®**
  - Provides a full spectrum of Disease Management outreach and education to members with chronic conditions such as asthma, congestive heart failure (CHF), diabetes, hypertension, and obesity

Claims

Claim Guidelines

Plan Regulations

Magnolia is required by State and Federal regulations to capture specific data regarding services rendered to its members. The provider must adhere to all billing requirements in order to ensure timely processing of claims and to avoid unnecessary rejections and/or denials.

CMS Guidelines

In general, Magnolia follows the CMS (Centers for Medicare & Medicaid Services) billing requirements

Claim Billing Accuracy

Claims will be rejected or denied if not submitted correctly

Claims Rendering/Billing Provider

Claims for billable services provided to Magnolia members must be submitted by the provider who performed the services or by the provider's authorized billing vendor

EDI Clearinghouse

If a provider uses EDI software but not setup with a clearinghouse, they must bill MHP via paper claims or through our website until a clearinghouse is established. Centene EDI Help desk: 1-800-225-2573, ext. 25525. WWW.EDIBA@CENTENE.COM. For a complete listing of approved EDI clearinghouse partners, please refer to MagnoliaHealthPlan.com

Timely Filing

- ALL Claims must be filed within 180 days from the Date of Service (DOS). When Magnolia is the secondary payer, claims must be received within three hundred sixty-five (365) calendar days of the final determination of the primary payer. Claims received after this time frame will be denied for failure to file timely.

- All requests for correction, reconsideration (optional) or adjustment must be received within 90 days from the date of notification of payment or denial.

- Adjusted or corrected claims can be filed on our secure portal at **www.magnoliahealthplan.com**, through your preferred clearinghouse, or by mail to Magnolia Health Attn: Corrected Claim PO Box 3090 Farmington, MO 63640-3800.

Claims Filing

Option to file electronically through clearinghouse (payer ID 68069)

Option to file directly through Magnolia Secure Portal at www.magnoliahealthplan.com

When filing claims via the web portal it is vital to enter the other insurance carrier payment information to ensure accurate caption, adjudication and timely processing of your submitted claims.

Below are the Steps to take when submitting other insurance carrier reimbursement via Magnolia's web portal:

1: Select "Add Coordination of Benefits“

2: Enter Carrier Type and Policy Number

Claims must be completed in accordance with Division of Medicaid billing guidelines

All member and provider information must be complete and accurate

Providers should include a copy of the Explanation of Payment (EOP) when other insurance is involved or provide information when billing electronically

Option to file on paper claim – 1ST time paper claims, mailed to:

Magnolia Health

Attn: CLAIMS DEPARTMENT

P.O. Box 3090

Farmington, MO 63640-3825

Paper claims are to be filed on approved CMS 1500 (NO HANDWRITTEN OR BLACK AND WHITE COPIES)

To assist our mail center in improving the speed and accuracy to complete scanning please take the following steps when filing paper claims:

- Remove all staples from pages
- Do not fold the forms
- Make sure claim information is dark and legible
- Please use a 12pt font or larger
- Please use the CMS 1500 printed in red (***Approved OMB-0938-1197 Form CMS-1500 (02-12)***
- Red and White approved claim forms are required when filing paper claims as our Optical Character Recognition ORC scanner system will put the information directly into our system. This speeds up the process and eliminates potential sources for errors and helps get your claims processed faster

Clean/Non-Clean/Rejected Claims

- **Clean Claim Definition:**

A clean claim means a claim received by Magnolia for adjudication, in a nationally accepted format in compliance with standard coding guidelines and which requires no further information, adjustment, or alteration by the provider of the services in order to be processed and paid by Magnolia.

- **Non-Clean Claim Definition:**

Non-clean claims are submitted claims that require further documentation or development beyond the information contained therein. The errors or omissions in claims result in the request for additional information from the provider or other external sources to resolve or correct data omitted from the bill; review of additional medical records; or the need for other information necessary to resolve discrepancies. In addition, non-clean claims may involve issues regarding medical necessity and include claims not submitted within the filing deadlines.

- **Rejected Claim Definition:**

An unclean claim that contains invalid or missing data elements required for acceptance of the claim into the claim processing system. Rejections are not proof of timely submissions. Rejected claims must be resolved and resubmitted within the timely filing guidelines. For questions about a claim rejection please contact Centene EDI Help desk: 1-800-225-2573, ext. 25525 or WWW.EDIBA@CENTENE.COM

Corrected Claim, Reconsideration, and Appeal

Corrected Claim

- Submit via Secure Web Portal
- Submit via an EDI Clearinghouse

- Submit via paper claim:
  - **Magnolia Health**
  - **PO BOX 3090**
  - **Farmington, MO 63640-3825**
  - **(Include original EOP)**

Reconsideration *(Optional)*

- Providers can use the **Reconsider Claim** button on the Claim Details screen within the portal
- By mail using the claim reconsideration request form which can be obtained at **www.magnoliahealthplan.com**
- Mail reconsideration to:

- **Attn: Claim Reconsideration**
- **P.O. Box 3090**
- **Farmington, MO 63640-3800**

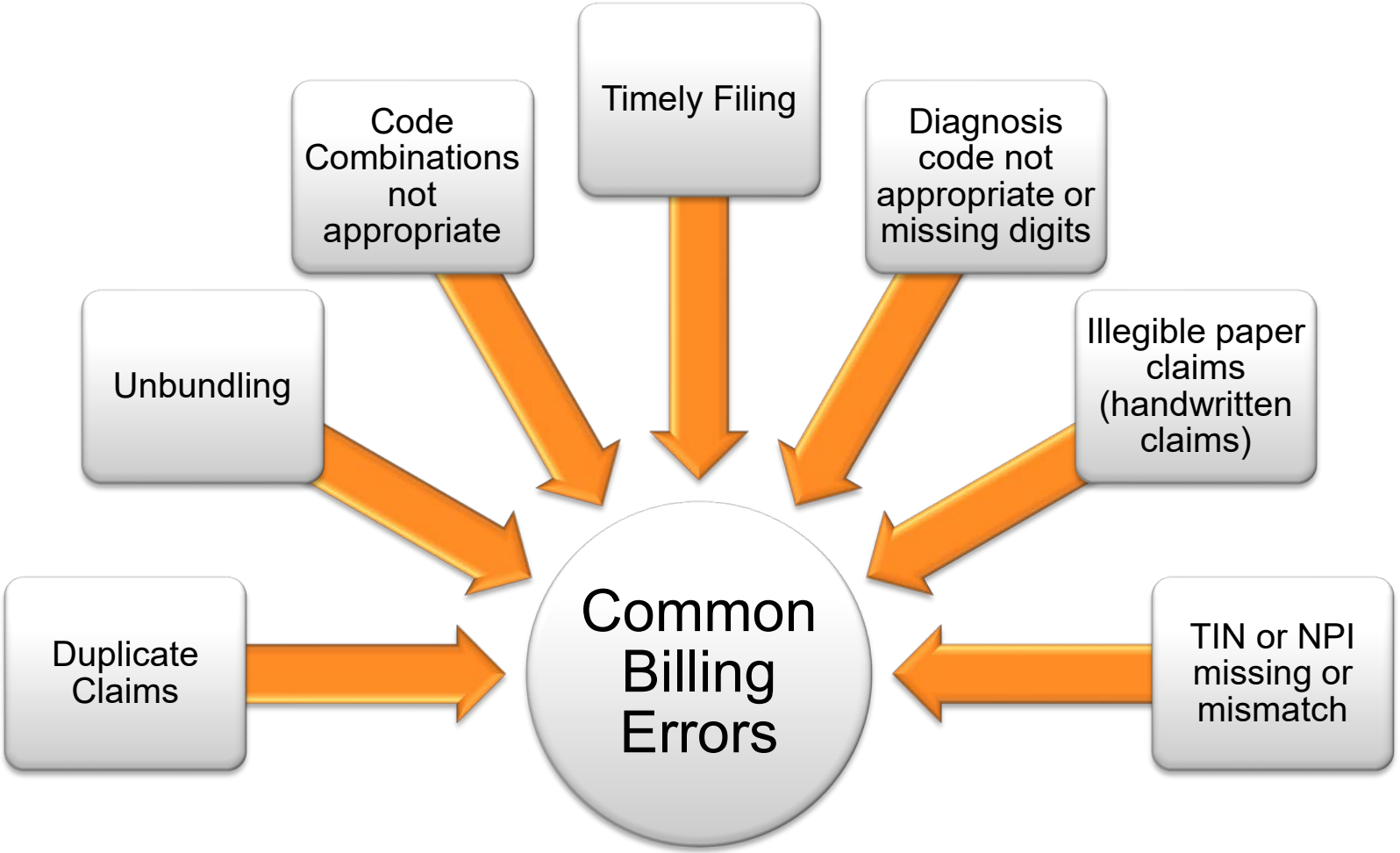
- *Important: Please note that a request for reconsideration cannot be filed after a request for a claim appeal or exhausting the claim dispute process.*

Appeal

A Claim Appeal is written request for review of an adverse benefit determination and must be accompanied aby the Claim Appeal Form which can be obtained at **www.magnoliahealthplan.com**

Request for Claim Appeal must be submitted by mail to Magnolia Health Attn: Dispute PO Box 3090 Farmington, MO 63640-3800

Common Billing Errors



For a complete list of common billing errors refer to the claims filing manual and provider manual

PaySpan Health

- Magnolia offers Payspan Health, a free solution that helps providers transition into electronic payments and automatic reconciliation
- Online remittance advices (ERA's/EOPs)
- HIPAA 835 electronic remittance files for download directly to HIPAA-compliant Practice Management or Patient Accounting System

- **Set up your PaySpan account:**
  - Visit www.payspanhealth.com and click Register
  - You may need your National Provider Identifier (NPI) and Provider Tax ID Number (TIN) or Employer Identification Number (EIN)

For further information contact 1-877-331-7154, or email Providerssupport@PAYSPANHEALTH.COM

Waste, Abuse, and Fraud (WAF) System

Fraud & Abuse

Centene Corporation and Magnolia Health, Inc. are dedicated to conducting business in an ethical and legal manner. As a key partner, it is critical that you understand that we are committed to preventing, detecting and responding to fraud, wrongdoing or any type of misconduct. If you ever have any concerns or are ever asked by anyone, including a Centene and/or Magnolia employee, to engage in any behavior that you believe is wrong, unethical or illegal, please immediately contact Magnolia Health at the number below.

Our Pledge Our Ethics and Compliance department will promptly investigate allegations of wrongful, illegal or unethical business practices by any Magnolia employee or any provider and when necessary report allegations of the Anti-Kickback Statute, Stark Law violations and the False Claims Act to government regulators.

Centene's Ethics & Compliance Helpline:

1-800-345-1642

www.mycompliancereport.com/brand/centene

or

Centene's Waste, Fraud & Abuse Helpline

1-800-685-8664

Available 24 hours a day, seven days a week. Callers are not required to give their names and all calls will be investigated and remain confidential. Local contact information:

Will Simpson

Vice-President, Compliance

601-863-3352

William.M.Simpson@CENTENE.COM

If you suspect or witness a provider inappropriately billing or a member receiving inappropriate services, please call our anonymous and confidential hotline at 1-866-685-8664

Appeals/Complaints/Grievances

Complaints/Grievances

A complaint is an expression of dissatisfaction received orally or in writing, that is of a less-serious or informal nature, and that is resolved within **one (1) calendar day** of receipt. Complaints may be received orally or in writing and may be submitted to Magnolia by the member or the member's authorized representative, including the member's provider. Complaints must be submitted to Magnolia within **thirty (30) days** of the date of the event causing dissatisfaction.

A Grievance is an expression of dissatisfaction about any matter other than an Adverse Benefit Determination. An Adverse Benefit Determination is Magnolia's decision to deny or limit authorization or payment (in whole or in part) for health care services, including new authorizations and previously authorized services; the reduction, suspension, or termination of a previously authorized service; Magnolia's failure to provide services in a timely manner; or a failure to resolve Complaints, Grievances, or Appeals within the time frames specified in the contract. A member may file a grievance either orally or in writing with Magnolia any time after the grievance has occurred. Written resolution will be provided within **thirty (30) calendar days** of receipt.

The Claim appeal process must be followed first for Complaint/Grievance related to a claim determination.

Full details of the claim reconsideration, claim dispute, complaints/grievances and appeals processes can be found in our Provider Manual at: MagnoliaHealthPlan.com

Member Grievances

- The member should contact Member Services at 1-866-912-6285. Magnolia will provide reasonable assistance to members in filing a grievance. The member can also write a letter and mail or fax their grievance to Magnolia 1-877-851-3995. The member will need to include:
    1. First and last name
    2. Their Medicaid ID number
    3. Their address and telephone number
    4. The reason for their dissatisfaction
    5. What they would like to have happen to resolve or correct the issue

- If the member choose to submit a written grievance, it should be submitted to:

Magnolia Health
Grievance Coordinator
111 E. Capitol Street, Suite 500
Jackson, MS 39201

Member Appeal

An appeal is a request for review of a “Notice of Adverse Benefit Determination.“

***A Notice of Adverse Benefit Determination* is:**

- The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
- The reduction, suspension, or termination of a previously authorized service.
- The denial, in whole or part of payment for a service.
- The failure to render a decision within the required timeframes.
- The failure of an MCO, PIHP, or PAHP to act within the timeframes provided in § 438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.
- For a resident of a rural area with only one MCO, the denial of an enrollee’s request to exercise his or her right, under § 438.52(b)(2)(ii), to obtain services outside the network.
- 7.The denial of an enrollee’s request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.

Magnolia Health
Attn: Appeals Coordinator
111 E. Capitol Street, Suite 500
Jackson, MS 39201
Fax Number: 1-877-264-6519

Vendors

Magnolia Health Vendors

- Envolve Pharmacy Solution
- Envolve Vision
- Envolve Dental
- National Imaging Association (NIA)
- Payspan Health
- MTM- Non-Emergent Medical Transportation (NEMT)

Website and Secure Portal

Magnolia Health Website

What's on the Public Website?

- Provider Directory
- Provider Manual
- Clinical and Payment Policies
- Reference Guides
- Important Forms (Prior authorization fax form, claim appeal form, etc.)
- Important Notifications
- Practice Improvement Resource Center (PIRC)

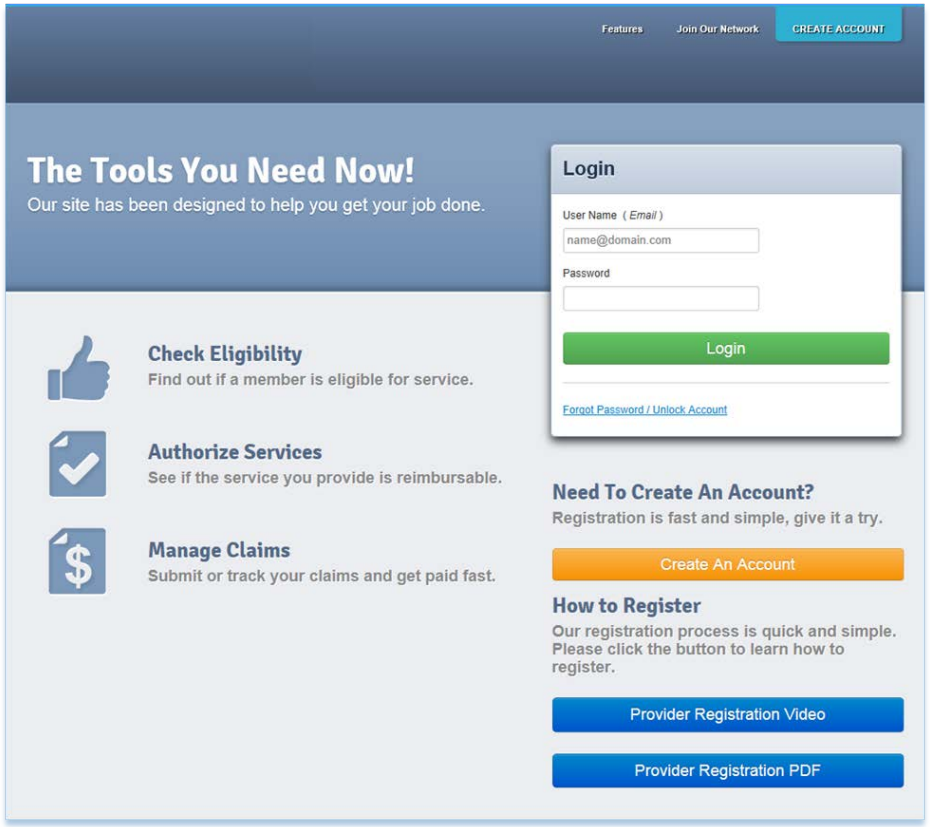
www.MagnoliaHealthPlan.com

Magnolia Secure Web Portal

REGISTER FOR THE MAGNOLIA SECURE WEB PORTAL

BENEFITS INCLUDE:

- Member eligibility & patient listings
- Health records & care gaps
- Authorizations
- Claims submissions & status
- Corrected claims & adjustments
- Claim audit tool
- Payment history
- Monthly PCP cost reports
- Provider analytics reports
- Updates….. and more!!



Resources

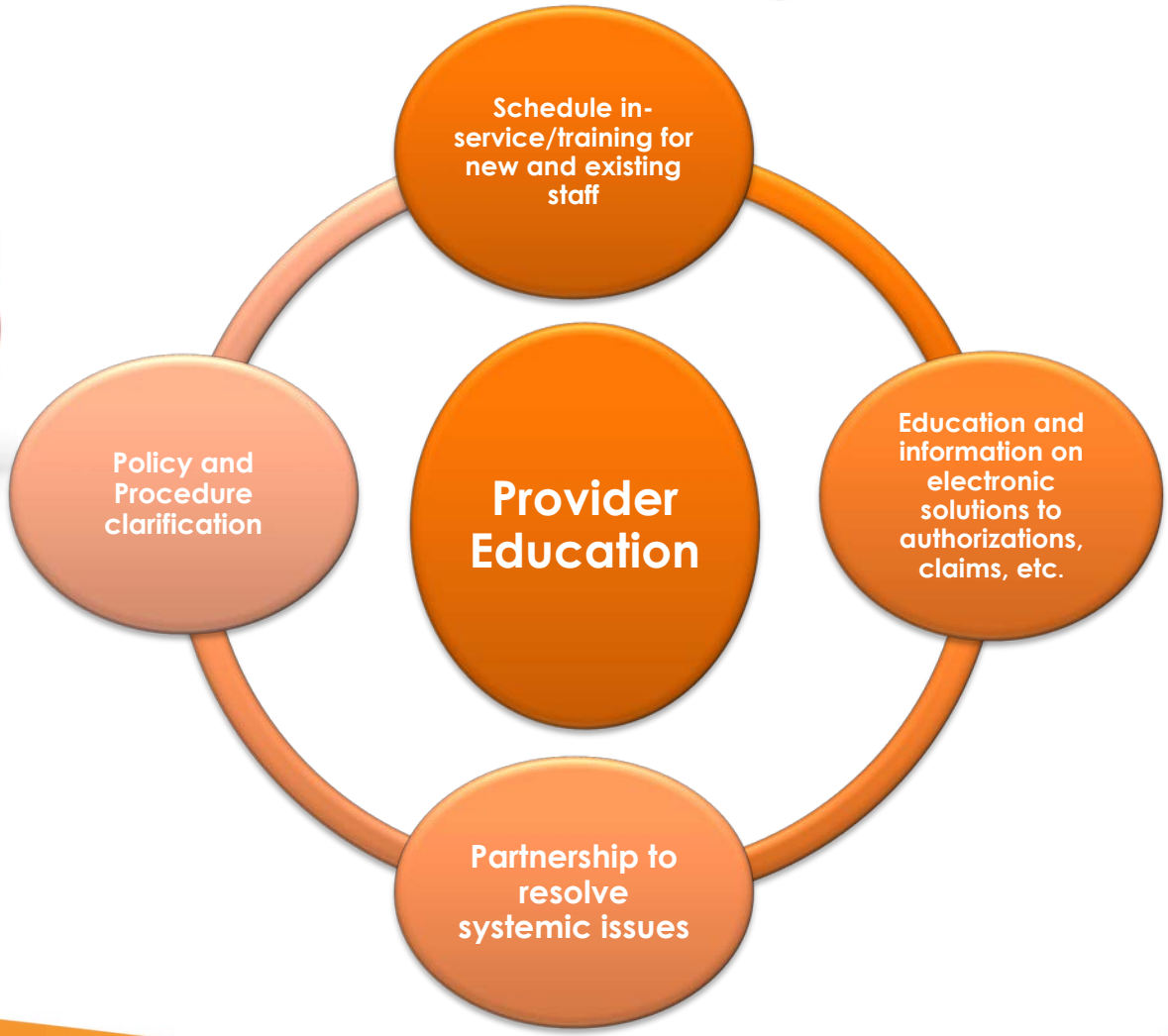
Provider Services (Call Center)

magnolia health

Provider Services Call Center:

- Provides phone support
- **First line of communication**
- Answer questions regarding eligibility, authorizations, claims, and payment inquiries
- Available Monday through Friday, 7:30 a.m. to 5:30 p.m. CST **1-866-912-6285**

Provider Relations



Contact Magnolia

- **Magnolia Provider Services Line**
  Call: (866) 912-6285
  Fax: (877) 811-5980
- **Magnolia Member Services Line**
  Call: (866) 912-6285
  Fax: (877) 779-5219
- **Magnolia Prior Authorizations**
  Call: (866) 912-6285
  Fax: (877) 650-6943
- **Magnolia EDI Department**
  Call: (800) 225-2573, ext. 25525
  Email: EDIBA@centene.com
- **PaySpan**
  Call: (877) 331-7154
- **Magnolia Contracting**
  Call: (866) 912-6285
- **Magnolia Credentialing**
  Call: (866) 912-6285
- **Envolve Dental and Vision**
  Call: (844) 464-5636
  Fax: (844) 815-4448
  Email: ProviderRelations@envolvehealth.com
- **MTM (Non-Emergency Transportation)**
  Scheduling: (866) 331-6004
  Complaint: (866) 436-0457
  Where's My Ride: (866) 334-3794
- **National Imaging Associates (NIA)**
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QUESTIONS

Thank you!